STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E230	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINE CARE CENTER	**120 SOUTH LAND STREET HARRISBURG, IL 62946**

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F 324	Continued From page 5 elopement which corrected the deficient practice: 1. On 10-06-05, the facility staff reviewed the alarm systems to verify that all door alarms were functioning properly. 2. On 10-06-05 at 2:30 pm. the electronic monitoring system was reviewed and found to be functioning properly. 3. On 10-06-05, the facility staff continued 15 minute checks were continued with 1 to 1 re-direction given to all resident who are at risk to wander. 4. On 10-06-05, staff reassessed all wanderers on side II. 5. On 10-06-05, E-1 contacted contractors who do the mowing and inserviced them on the importance of keeping the fence gates locked. 6. On 10-06-05, key staff reviewed the following policies: elopement prevention and search, A.W. O.L. Resident, door security alarms, and the wandering residents policy. No changes were made to the policies. 7. On 10-06-05, the facility completed an investigation report and determined that the mowing contractors left the fenced in patio area unlocked. 8. Per surveyor observations on 10-18-05, staff promptly respond to door alarm signals.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210 a) 300.1210 a)5) 300.1210 b)3) 300.1210 b)6)	F9999		

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F9999	Continued From page 6	F9999		

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.
Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent the elopement of one

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F9999	Continued From page 7	F9999		

resident (R-4) from the sample of four. R-4, who is cognitively impaired and wears an alarming to device to prevent elopement, left the facility on 10 -06-05 without staff knowledge.

The findings include:

1. R-4 is a 71 year old resident admitted to the facility 10-04-05 with diagnoses that include Alzheimers Dementia with Agitation. R-4's admission Minimum Data Set dated 10-07-05 documents that R-4 has long and short term memory problem, is moderately impaired (daily decisions poor, cues/supervision required), has periods of altered perception or awareness of surroundings, and wanders with no rational purpose, seemingly oblivious to needs or safety, has physically abusive behaviors, and resists care. The care plan dated 10-11-05 identifies a problem for R-4 of "tries to open doors, looking for a place to work."

R-4 was observed on 10-18-05 at various times during the day to be wearing an electronic monitoring device that activates at all the exits except the patio door. E-1, Administrator, E-2, Director of Nurses, and E-3, Licensed Practical Nurse, stated during interviews on 10-18-05 that upon admission R-4 had an electronic monitoring device applied.

The facility incident report dated 10-06-05 sent to the Illinois Department of Public Health on 10-07-05 documents that R-4 has a history of confusion with wandering and being ambulatory and is very mobile. The facility considered him "at risk" for wandering and placed an electronic monitoring device on at admission and placed him on 15

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F9999	Continued From page 8 minute monitoring. The facility incident report and interview with E-1 verified the following. On 10-06-05 at 1:30 pm, E-5, Certified Nurses Aide, was doing the 15 minute checks and was unable to locate R-4. When R-4 was not located an elopement search was initiated per facility policy. While staff were conducting an off grounds search, the facility received a call from the Harrisburg Police Department that advised them that R-4 had been located. Staff returned R-4 to Saline Care Center at 2:30 pm. R-4's electronic monitoring device caused the door alarm to sound upon entering the door on Side II. R-4 was assessed from head to toe with no injuries noted. The temperature outside was 68 degrees. The weather was clear and R-4 was dressed in a flannel shirt, pants, socks, and rubber sole house slippers. R-4 stated he was looking for a ride to the town he lived in before coming to the facility which is approximately 67 miles from Harrisburg. E-4, Licensed Practical Nurse, was interviewed on 10-18-05 at 9:15 am and verified the information on the search in the incident report. E-4 stated during this interview that she thinks R-4 does not know dangers and he is a follower. E-5, Certified Nurses Aide, was interviewed at 1:40 pm on 10-18-05 and verified that she last saw R-4 at 1:15 pm in the dining room and at 1:30 pm she could not find him. E-5 stated that during the search, the fenced in area gates outside of the patio door exit were not locked. E-7, Licensed Practical Nurse, was interviewed on 10-18-05 at 11 am and stated that the fenced	F9999		

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F9999	Continued From page 9	F9999		

in patio area had been mowed that day and both gates were left unlocked. E-7 also stated that R-4 would not really know dangers and that his cognitive status is better some days than others.

E-8, Social Worker, was interviewed at 1:40 pm on 10-18-05 and stated that she went after R-4. E-8 stated that R-4 was confused when she picked him up and is almost always confused. She stated that R-4 would not know environmental dangers. E-8 stated that R-4 told her, "I feel like I have walked 10 miles." E-8 stated that R-4 was very tired so he did not ask him very many questions.

Z-1, physician, stated during a telephone interview on 10-18-05 at 2:10 pm that R-4 is confused and needs constant supervision. Z-1 stated that R-4 would not know environmental dangers, has no clue about dangers, everyone is his friend so he would accept a ride from anyone.

Z-2, maintenance man from a different nursing home, stated during an interview on 10-18-05 at 12:05 pm, that the nursing home where he works received a call around 1:45 pm saying an older man with a white wrist band was seen walking down McHaney Street and the caller wanted to know if they were missing a resident. Z-3, administrator of the nursing home where Z-2 is employed, told Z-2 to go to the area while the rest of the staff did a head count. Z-2 stated he saw the gentlemen walking in the road by the Nazarene Church. There are no sidewalks in that area. Z-2 asked him if he need help and R-4 climbed in his truck. R-4 stated when asked where he was from that he was from Pinckneyville (which is 67 miles from Harrisburg).

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F9999	Continued From page 10 Z-2 then took R-4 back to the nursing home where he works. Z-3 stated the police were called and an investigator arrived at 2:05 pm to question R-4. Z -3 stated that the officer called in to the police department who then called Saline Care Center to see if they were missing a resident. At 2:35 pm, staff from Saline Care Center arrived to assist R-4 back to their facility. Saline Care Center is located at 120 South Land Street in Harrisburg, Illinois. The facility is one block from a busy state highway and is surrounded by single dwelling houses. There is a deep ditch that is directly behind and to the side of the facility. R-4 was found approximately 1.5 miles south west of the facility at the edge of town. During this survey, the patio door was observed to be equipped with a buzzer but not with an electronic monitoring sensor. This sensor can be by-passed by placing something against the facing side to imitate door contact. During random observations made on 10-18-05, staff do not always respond to this door alarm Resident and staff use this door to go out to the fenced in patio area to smoke and to sit outside. The fence to the back of this area has two gates which were locked during this survey. (A)	F9999		