STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. BUILDING ______ B. WING ______	C 05/05/2006

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the right door (the specific one R1 used to elope) of the double door service hall exit.
5. Elopement policy in-services were started.
6. Signs were put on doors used by visitors to be alert for residents attempting to leave the facility.
7. The Elopement Policy was reviewed. No updates were indicated.
On 04/26/2006:
8. A keypad alarm was installed on the interior service hall double doors leading to service hall exit doors.
9. Another elopement drill was conducted.
10. Elopement in-services continue to be conducted.
On 04/27/2006:
11. A plan was made to develop a "rounds" policy and procedure.

F9999 FINAL OBSERVATIONS — F9999

LICENSURE VIOLATIONS:

300.1210a)
300.1210b)
300.12106)
300.3100d)1)
300.3100d)2)

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

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personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
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.

Section 300.3100 General Building Requirements
d) Doors and Windows
1) Main entrance and exit doors shall swing outward and be provided with door closers and panic-hardware.
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

Findings include:

Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent the elopement of one resident (R1) of 11 residents assessed by the facility to be elopement risks at the time of the incident. This resulted in R1 eloping from the facility without staff knowledge on 04/25/2006. Z1 (neighbor) found R1 laying down in a grassy ditch next to her wheel chair about 110 feet from the rear service exit of the facility about 2:20 A.M. No

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staff on duty at the facility heard a door alarm or knew that R1 eloped.

The facility's incident investigation included a " Time Line of Resident Elopement Tuesday, April 25, 2006" written by E1 (Administrator) on 04/25/ 2006. It states:
"1:45 A.M.: Resident (R1) was observed sitting in her w/c (wheel chair) in the doorway of room 206 by E5 CNA (Certified Nurses Aide).
"2:20 A.M.: a gentelman (Z1) knocked on North back door...Z1 stated he observed resident outside when he came home (lives in apartment complex behind facility)...He picked R1 up, put R 1 in her w/c, and pushed R1 to the North back door.
"2:30 A.M.: VS (vital signs) taken, within normal limits. Resident denies pain or discomfort, able to move all extremities without difficulty."

Facility investigation statement written by E8 (Licensed Practical Nurse; LPN) on 04/25/2006 states:
"At 2:20 A.M. man came to North door with resident from South Hall. He stated he found R1 on ground, he went into his house, changed clothes. Came back to see if R1 was still there and picked R1 up and put her in wheel chair."

On 04/28/2006 in the afternoon, E8 indicated that she noticed R1 had grass on her head when she received her from Z1. E8 indicated R1 expressed she was OK by nodding her head. When E8 asked R1 how she got out of the facility, R1 pointed to the back service exit doors. E8 indicated she checked that door right then and noted the right door of the 2-door exit was not locked and only the left door was magnetically

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F9999	Continued From page 7 secured and alarmed. All the other door alarms in the building were checked and worked fine. E6 (CNA) indicated on 04/28/2006 that R1 had slacks, a shirt, a sweater and shoes on when she was brought in after the elopement. This is usual for R1. Interviews with E1 (Administrator), E4, E5, E6, E 12 (CNA's) and E7 (Registered Nurse) on 04/28/2006 verified the above indicated events of the insident. Z1 (neighbor) indicated on 04/28/2006 that he saw R1 at about 2:20 A.M. as he drove along the parking lot of his apartment complex and thought R1 was a homeless person sleeping there in the grass. Z1 went to his apartment first but came back out to see if R1 needed food or water. It was then Z1 realized R1 was a resident, and proceeded to help her get back into the facility. The outdoor temperature was 65 degrees Fahrenheit with a dew point of 55 on 04/25/2006 at 1:45 A.M. according to national Weather Service records. E9 (LPN) indicated on 05/03/2006 that R1 is up at night a lot and sits out in the hall by her room. She dresses herself after being put to bed and always wears a sweater. She independently ambulates and transfers but would not be able to get back up and into her wheel chair if she fell out onto the ground. E9 stated that she "could see her (R1) fall out of her wheel chair because she kind of leans." R1's Minimum Data Set-MDS (resident full assessment form) dated 03/21/2006 indicates R1	F9999		

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F9999	Continued From page 8	F9999		

has diagnoses which include: Alzheimer's Disease, Depression and Anxiety Disorder. This MDS assessment indicates R1's Cognitive Skills for Daily Decision-making is at the Modified Independence level. This MDS also indicates R1 has short-term and long-term memory problems.

R1's Rehabilitation Notes dated 04/11/2006 indicate R1 "exhibits extremely poor safety awareness."

Two incident reports, both dated 03/04/2006, indicate R1 had two falls that day: one at 10:00 A .M., and one at 6:45 P.M. Each had no apparent injury.

Attempts to interview R1 were made on 04/28/ 2006 and 05/03/2006. R1 refused to be interviewed. She would only look away and then wheel herself away.

On 05/03/2006 at 10:45 A.M., Z2 (R1's Physician) stated that R1 is suspicious of everybody, so she chooses not to speak to people in general. Z 2 indicated he doubts if R1 "fully grasps what happened. R1 is a fairly vulnerable person. With a change in surroundings, R1 would have more difficulty getting to where she needed to be."

The Nursing Home is located on a short dead end street, 1/2 a block from a busy two lane throughway which has a speed limit of 35 miles an hour. The rear area of the facility, where R1 exited, has a 30 foot width of blacktop used for deliveries and parking. There is a 15 foot wide grassy strip which then separates the Nursing Home property with another blacktop parking lot where a apartment complex exits. (Z1 resides

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F9999	Continued From page 9 there.) The grassy spot where Z1 found R1 laying down was uneven and in the shape of a ditch. The grassy ditch's incline dropped about two feet from the edge of the blacktop where R1's wheel chair was located at the time. (A)	F9999		