STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. BUILDING ______ B. WING ______	C 02/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM TERRACE OF MATTOON	**1000 PALM MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 7 northeast end of the courtyard to provide complete visual control of the courtyard. 10-11-05 - The smoking policy was amended. 10-11-05 - A monitoring log was implemented in which staff members sign every resident out when going into the courtyard area and signs every resident back into the facility as they return to keep proper tracking of each resident. 10-11-05 - Staff members were reassigned to specific locations within the courtyard any time residents are outside to provide full visual control.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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. 300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-week basis. 300.3100d)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	F9999		

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F9999	Continued From page 8	F9999		

there is constant 24-hour-a-day supervision of the door, a signal is not required

Based on record review, interview, and observation, the facility failed to implement a monitoring system for the unsecured East Annex courtyard to provide complete visual supervision. This resulted in 2 of 55 residents (R1 and R2) leaving the facility without staff knowledge or supervision.

The findings are:

1. According to the facility's Resident Admission Information sheet, R1 was admitted on 7-29-05 from a mental health center. R1's Physician's Order Sheet (POS) of 12-1-05 lists diagnoses as Schizophrenia, Schizoaffective Psychosis, and Bipolar with Psychotic features, and Physician Orders for antipsychotic, antianxiety, and antidepressant medications seven days a week.

The 8-2-05 Resident Assessment Instrument (RAI) for R1 documents the following: R1 has a short term memory deficit, is moderately impaired for daily decision making and requires supervision and cues. R1 is easily distracted (difficulty paying attention; gets sidetracked) and mental function varies over the course of the day. R1 exhibited verbally abusive behavioral symptoms and socially inappropriate/disruptive behavioral symptoms daily. R1 ambulates independently. The Specific Level of Functioning Assessment dated 8-12-05 documents R1 is totally dependent for "traveling from residence without getting lost and recognizing and avoiding common dangers (traffic safety, fire safety, etc)."

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F9999	Continued From page 9 E5, Certified Nurse Assistant (CNA) was interviewed at 1:05 P. M. on 2-7-06. E5 stated that she observed R1 and R2 outside for the 8:00 PM smoke break on 10-10-05. She let R1 back into the facility at 8:15 PM, but she did not see R 2 come in or R1 go back out. She stated that she was helping with a wheelchair resident get in and toileted. E5 reported in her written statement dated 10-10-05 about the incident that the facility got a call at 9:20 PM that R1 was at a local gas station. She stated a head count was started, windows and doors were checked and E4, Registered Nurse (RN) went to get R1. E5 stated staff were not aware R1 had left the facility until they were called by the gas station staff. On 10-10-05 at 9:25 PM the nurse's notes state " Staff alerted that resident was not in building." At 11:00 PM the nurse's notes state "Resident returned to building and had been with staff since 2137 (9:37 PM). Total body assessment completed (no) injuries noted." The nurse's notes were charted by E4 . E4 was interviewed on 2-7-06 at 2:10 PM. His hand written statement about the incident was reviewed with him. According to E4's statement and interview, he was notified by E6, Certified Nurse Assistant (CNA) at 9:25 PM that E7, CNA from another unit received a phone call from a gas station employee saying that a resident was at the gas station and the employee was calling the police. E4 stated it was believed that the gas station employee had worked at the facility at one time. E4 drove to the gas station and talked R1 into returning to the facility. E4 was interviewed again on 2-8-06 at 2:40 PM	F9999		

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F9999	Continued From page 10	F9999		

regarding the procedure for monitoring residents when they are outside of the facility smoking. He stated prior to the incident on 10-10-05, there were to be two to three staff members in the courtyard with the residents. E4 stated that following the 10-10-05 incident, one staff member is to be on the eastside side walk monitoring the east side and the two unlocked wooden gates. One staff member is to pass out the cigarettes and light them. The third staff person enters the code to open the door to get inside and outside of the facility. E4 stated that R 1 had said previously that he wanted to get out of here and he wanted to leave.

The gas station location was observed to be 1.1 miles west and north of the facility. The gas station is on US Route 45, a major north south four lane thoroughfare in the city.

2. According to the facility's Resident Admission Information sheet, R2 was admitted on 3-29-05 from a mental health center. R2's Physician's Order Sheet (POS) of 2-1-06 lists his diagnoses as Psychotic, Parkinson's Disease, Bipolar Affective Disorder, Alzheimer Dementia and Mild Mental Retardation. Physician orders include antipsychotic and antianxiety medications seven days a week.

The 9-28-05 Resident Assessment Instrument (RAI) for R2 documents the following: R2 has short-term and long term memory deficit, and is moderately impaired for daily decision making and requires supervision and cues. In addition, the RAI documents that R2 is easily distracted (difficulty paying attention; gets sidetracked), periods of altered perception or awareness of

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F9999	Continued From page 11 surroundings (moves lips or talks to someone not present; believes he is somewhere else; confuses night and day), and mental function varies over the course of the day. R2 resists care 4 to 6 days in a 7 day period. The 9-28-05 Elopement Risk Assessment for R2 documents the following: R2 has poor decision making skills, R2 has a history of elopement, he has inability to identify safety needs and has altered perception of awareness. The Elopement Risk Assessment indicated that R2 was at high risk for elopement. R2's nurses notes were reviewed. The notes documented the following: "10-10-05 2143 (9:43 PM) notes resident out of building. 10-10-05 2300 (11:00 PM) Resident returned to building - Total body assessment completed by E3, RN with no injuries noted." On 2-7-06 at 2:10 PM, E4's written statement was reviewed and discussed with regards to R2. E4 stated he ordered the staff to conduct a head count while he was on the way to pick up R1. E4 stated the head count revealed that R2 was also missing and the facility's elopement procedure was implemented. Additional staff began the search. E4 found R2 at the US Route 45 and Interstate 57 intersection on the south bound ramp trying to hitchhike to Memphis at 10:43 PM. The intersection is 3.2 miles west and south of the facility. R2 was interviewed in his room on 2-8-06 at 1:35 PM. R2 did not know the day of the week, the time of day, and the year. He was asked where he was going on 10-10-05. He said "To Memphis,	F9999		

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F9999	Continued From page 12	F9999		

to see Dad." He was asked how he left the facility. He said that he did not know. He was asked how he got to the interstate? He said that he did not know.

E4 stated on 2-7-06 at 2:10 PM that both residents were wearing jackets when they returned to the facility. E4 was asked about the temperature on 10-10-05. E4 said " it was in the 40's but comfortable." E4 stated the door alarms functioned at the time of the incident.

Both R1 and R2 resided on the facility's Annex Addition which consists of 2 secure units. The facility's plan of supervision consists of alarmed doors and visual control. The exterior door alarms were observed on 2-14-06 between 10:30 AM and 11:15 AM. All the exiting doors off the units have a touch sensor push bar that sounds in the local area. When the bar is pushed, the tone and pitch increases and the door would open after 15 second delay. When the door opens, the alarm becomes louder and can be heard. Each door has a key touch pad to temporarily disalarm the door and disconnect the alarm from sounding following the door being opened. The alarms automatically resets once the door has closed and 5 second delay as occurred.

The East Annex exterior patio door opens onto an outside courtyard. This area is at least 150 feet by 80 feet. The East Annex wing patio door is used to let residents in and out of the courtyard to smoke. The courtyard is enclosed by 3 exterior walls of the building and a fence. There are wooden gates at each end of the fence. The gates are not equipped with locking devices.