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	145469	A. BUILDING ______ B. WING ______	08/23/2006

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F 333	Continued From page 28 errors....must be promptly reported to the Director of Nursing Services, attending Physician, and the pharmacist." On 8/16/06 at 10:55 a.m., when Z1, Cardiologist, was asked if running Dobutamine for sixteen hours instead of the ordered four hours could have caused R22 harm; Z1 stated he saw R22 the next day and there was no ill effects from this. Z1 stated R22 was in end stage heart disease. Z1 stated R22 "was in no danger from this medication running eleven and half hours over and it would not have changed (R22's) outcome."	F 333		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)3) 300.1210b)6) 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 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	F9999		

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F9999		F9999		

Continued From page 29

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.
Interview with E2, Director of Nurses on 8-17-06 at 10:25 A.M. states that no incident reports are made out, observations are recorded in the Nurses Notes.

Section 300.3100 General Building Requirements
d)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.

These requirements were not met as evidenced by:

A.) Based on observation, record review, and interview, the facility failed to provide supervision for 1 of 6 residents (R24) identified as at risk for leaving the facility out of 13 in-house sampled residents. R24 was assessed as, and was known as, an elopement (leaving the building unnoticed) risk. R24 left the facility without staff's knowledge on three occasions, twice on the

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F9999	Continued From page 30	F9999		

same day.

The findings are:

According to the August 2006 Physician Order Sheet (POS), R24 was admitted to the facility on 4-3-06. R24's diagnoses include Alzheimer's Disease, Dementia, Anxiety, and Agitation. Physician orders include 2 medications for the treatment of Alzheimer's/ Dementia, an antianxiety and an antipsychotic to be given seven days a week.

The Resident Assessment Instrument (RAI) with the assessment reference date of 4-13-06, documents the following (in part): R24 has short term and long term memory deficits, is moderately impaired for daily decision making and requires supervision and cues. R24 is easily distracted (difficulty paying attention; gets sidetracked), has periods of altered perception or awareness of surroundings (she is somewhere else; confused night and day), has episodes of disorganized speech (speech is incoherent, nonsensical or rambling from subject to subject; loses train of thought) and periods of restlessness. The RAI documents R24's speech is unclear (slurred and mumbled words), R24 is able to sometimes understand others and can make herself understood, sometimes with limited concrete requests. The RAI documents that R24 has a wandering behavior that occurs daily and is not easily altered. The RAI documents a limited range of motion to both sides of R24's neck and has a partial loss of voluntary movement.

The Social Progress Notes dated 4-13-06 documents the following: "New admit of 4-3-06 from (another facility) placed in dementia special

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F9999	Continued From page 31 care unit. No discharge plans. Alert - oriented to self. Poor decision / safety awareness skills. Dependent on staff to monitor for needs - speech clear but nonsensical - does not express needs - follows some simple basic directions with hands on assist - very short attention span. Restless / paces throughout unit. Several exit attempts." The 4-13-06 Cognitive Loss/Dementia Resident Assessment Protocol (RAP) documents in this area "will proceed on the care plan." The note on the bottom of the RAP documented "Dx (diagnosis): Alzheimers/Dementia. Alert - oriented to self. Makes simple daily decisions with simple choices. Cues/assist with daily tasks/routine. Poor attention span/safety awareness. Poor expression of needs - follows step by step directions." The 4-3-06 Elopement Risk Assessment documents R24 to have confusion, have a cognitive deficit, to be disoriented, and to have advanced Alzheimers/Dementia. R24 is documented to be independently ambulatory. The assessment states that R24 wanders aimlessly and exhibits wandering/ seeking to find spouse and/or family. The Elopement Risk Assessment lists the following interventions: "Personal safety alarm device, exit alarms, secured unit, frequent monitoring, bed alarms and resident electronic monitoring device placed on resident ankle on 4-3-06." The 4-3-06 Physician Notification sheet documents R24 "exited the facility door at 3:00 P.M. Resident redirected and reoriented to facility with 2 staff. Exit Monitoring every 15 minutes started per facility protocol."	F9999		

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F9999	Continued From page 32 The 15 minute resident monitoring policy and procedure was reviewed. The 15 minutes monitoring protocol was initiated at the time of the incident. The protocol requires a visual check of the resident every 15 minutes for 12 hours, visual check of the resident every hour for 12 hours and a visual check of the resident every 2 hours for 24 hours according to the 15 minutes documenting sheet and interview with E5, Assistant Director of Nursing on 8-15-08 at 2:30 P.M. The nurses notes dated 4-9-06 at 3:00 P.M. documented, "resident paced Harvest wing most of the shift. 6 witnessed exit attempts. 15 minute monitoring continued." The nurses notes dated 4-10-06 at 10:00 A.M. documented, "Resident continue to pace non stop all over Harvest (Wing). She was witnessed opening and stepping out east door, but was very quickly brought back in by nurse. Re started on 15 minute monitor." The nurses notes dated 4-15-06 at 7:45 A.M. documented, "Resident exit front door, unwitnessed. Resident assisted back inside per this writer." The next documentation at 8:00 A.M. stated, "Called (E5) on call person this weekend, to notify her of resident exit." The nurses notes dated 4-16-06 at 5:50 A.M. documented, "Resident exit East Door, Harvest, unwitnessed resident assisted back inside per staff member. Exit monitoring re-initiated." The next nurses note on 4-16-06 at 6:45 A.M. documented, "Resident exit East Door, Harvest unwitnessed, resident assisted back inside per	F9999		

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F9999	Continued From page 33	F9999		

staff member without difficulty. Exit monitoring re-initiated."

E5 was interviewed on 8-15-06 at 2:30 P.M. and stated that she was called by E10 ,Licensed Practical Nurse (LPN) on 4-15-06 at 8:00 A.M. that R24 eloped and was found on front patio of the facility. E5 asked E10 if the alarm sounded and E10 told E5 that no alarm sounded. E5 told E10 to check the electronic resident monitoring device, it may have to be replaced. E5 asked E10 to call E19 the former Administrator and place R24 on exit monitoring. E5 stated that R24 exited the facility from the east Harvest door because it malfunctioned or was disarmed. E5 stated she believed R24 exited and walked around the building to the front patio and parking lot. E5 stated R24 was found in the front parking lot on 4-16-06 at 5:50 A.M. by staff coming into work. E5 stated that she believed when staff went check on R24 at 6:45 A.M. for the 15 minutes check, they found her outside at the front patio.

Based on observations, in order for R24 to get around to the front of building from the East Harvest door, R24 would have to follow a sloped concrete sidewalk south to the concrete sidewalk along a busy major two lane State highway to the parking lot. R24 could have also gone north over a sloping grass area behind the Harvest Wing, south to the delivery drive, and then east to the front patio and parking lot.

R24 was interviewed on 8-16-06 at 11:30 A.M. R24 was not aware of time, place or surroundings. R24 said she was in Sullivan, Illinois. Her speech was slurred, nonsensical, and hard to understand. Her head was tilted at

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F9999	Continued From page 34 approximately 30 to 45 degrees toward the ground. She was observed to walk with her head at the same angle. R24 appeared to have impaired safety awareness. During the General Observation tour on 8-15-06, accompanied by E18, Maintenance Supervisor and E20, the Housekeeping and Laundry Supervisor, the exit door alarms were checked and were found to function as designed. If a door was opened, the alarm would sound at the door and alarmed at the nurses station. The alarm would continue to sound until the door was closed and was reset at the door or the nurses station. The front door and the west harvest wing door are equipped with electronic resident monitoring device alarms. E18 was interviewed on 8-22-06 at 9:00 A.M. E18 stated she or her assistant checks the door alarms five days a week (Monday thru Friday). E18 stated the doors were checked on Friday 4-14-06 prior to the elopement of R24 on Saturday 4-15-06 and the door alarms functioned as designed. E18 stated she does not check the doors on weekends. E18 stated the nurses may check the doors. E18 stated that at the morning meeting on 4-17-06 was first time she was aware of a malfunction with the East Harvest door alarm. She stated she replaced the door alarm key pad switch at the East Harvest door on the morning of 4-17-06. She stated that the old key pad could be set on disarm so the door alarm would not alert staff if that door would be opened. She stated that the new key pad cannot be permanently disarmed. E18 stated she does check the electronic resident monitoring device sensors at the West Harvest wing door and front door 2 to 3 times a week but she does not	F9999		

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F9999	Continued From page 35 document it. E5 was interviewed on 8-22-06 at 8:50 A.M. E5 was asked if the door alarms were checked on weekends by staff. E5 stated "it was one of the things the weekend on call person is to do, but it is not always done." E5 stated "the electronic resident monitoring device bracelet placement is checked and documented on each shift (3 times a day) and the function of the device checked weekly." According to the monitoring sheets, R24 was last seen on 4-16-06 at 5:30 A.M. location not documented, prior to being seen in front of the facility at 5:50 A.M. R24 was seen to be ambulating in the hallway at 6:35 A.M. prior to being found at the front patio at 6:45 A.M. How long R24 was outside on 4-15-06 prior to being found at 7:45 A.M. is unknown. According to Z7 (an Internet weather reporting service) , the area weather was clear and 63 degrees Fahrenheit between 4:53 A.M. and 7:53 A.M. (A)	F9999		