STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E178	A. BUILDING _____ B. WING _____	C 08/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYBERG, THE	EAST MONROE STREET CUBA, IL 61427

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F 324	Continued From page 8 monitors would be utilized. Staff is to be inserviced and given handouts. On July 27, 2007 the care plans were updated. 12. On July 23, 2007 at 1:00 pm all on duty staff was inserviced on the elopement policy, elopement book, resident monitoring, changing of the exit door alarm codes and the importance of not giving the new code out to anyone but staff. 13. July 23, 2007 the elopement drills were implemented daily. 14. On July 26, 2007 the functioning of the electronic monitoring device bracelets daily check was added to the Medication Administrator Record of the resident's with the bracelets. The function tests are to be completed daily from the hours of 10:00 pm to 6:00 am. Nurses to be inserviced on July 27, 2007 that they are to pass the information on down in their 24 hour report. 15. On July 27, 2007 the residents with the electronic monitoring device bracelets that are not on psychotropic medications were added to the daily behavior tracking. 16. July 27, 2007 all of the door alarms will be checked daily.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a) 300.1210b)4) 300.1210b)6) Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 9 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided 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. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent visitors from resetting their door alarm code. This failure allowed 1 of 3 residents reviewed (R1) to leave the facility unattended and without staff knowledge. R1 was found by a member of the community down the street from the facility next to a State highway. Findings include: On 7-27-07 at 8:45 am, E1, Administrator, related the following information. On 7-22-07 at about 6:00 pm, Z1, a member of the community called	F9999		

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F9999	Continued From page 10 the facility stating he saw an older man he did not recognize at his neighbors's house with a white bracelet on. Z1 suspected it might be someone from the facility and called the facility to report it. About the same time, E8, Activity Aide, was coming out of her residence and saw a gentlemen sitting on the next door neighbor's front steps. This house is located on the corner of Monroe Street and Route 97. The gentlemen got up and went around the side of the house toward Route 97 followed by E8. Z2, R1's POA (Power of Attorney) saw R1 and E8 from his vehicle while coming into town. Z2 stopped and assisted E8 in getting R1 into his vehicle to be transported back to the facility. E1 stated when the facility was notified by Z1, they did a head count and sent staff to the scene to assist bringing R1 back to the facility. R1 was assessed and found to be all right. E1 was notified of the incident somewhere between 6:00 pm and 6:30 pm. E1 and E4, Maintenance Director, arrived at the facility around 7:00 pm and checked all doors and alarms and found them to be operational. E1 started her investigation and completed it 7-25-07. E1 states R1 was wearing an electronic monitoring device (EMD) and thinks a family member heard the alarm on 7-22-07, entered the code and shut it off before staff could respond when R1 left the building. On 7-27-07 at 9:50 am, E8, Activity Aide, stated she lives on the south side of Monroe Street one house west of Route 97. E8 stated on 7-22-07 about 6:00 pm when she came out of her house she noticed a man sitting on the steps of the house next door. When she walked toward him he left the steps and walked around the house in	F9999		

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F9999	Continued From page 11 the grassy area parallel to Route 97. E8 followed him calling out his name with no response. E8 saw Z2, R1's POA, and while he parked his vehicle, she ran after R1 catching up to him before he crossed the next street over into the ballpark area. E8 states R1 was in the grassy area between the last house and Route 97. The ballpark area is sunken and accessed by numerous stone steps leading down to the field with a fence around the perimeter. E8 related R1 has no safety awareness and did not know where he was or why. R1 was dressed in pants, shirt, shoes and socks and a white ball cap. E8 stated several family members she knew of had the code to the front door alarm system. E8 said family was not always good about letting staff know if they shut off the alarm. R1's face sheet shows he was admitted 5-17-07 with diagnoses of Dementia with Associated Behavioral Symptoms and Alzheimer's Disease. R1's assessment dated 6-14-07 shows R1 has impaired cognition and needs assistance with activities of daily living. On 5-15-07, R1's Elopement Risk Assessment shows R1 to be at high risk for elopement. An EMD was placed on R1 along with initiation of 30 minute checks and daily behavior tracking. R1's care plan dated 6-14-07 states "resident is at risk for wandering from facility unattended per elopement assessment." One intervention put into place states "check promptly when alarm system goes off to insure (R1's) safety/whereabouts..." R1's care plan also notes R1 to be at risk for falls with the latest fall occurring 7-17-07.	F9999		

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F9999	Continued From page 12 The facility's policy dated 10-2-06 titled Facility Policy Regarding Missing Residents and Elopements states ..."missing resident inservice training sessions shall cover the environmental and considerations to prevent elopements, common distraction and redirection techniques, the critical importance of responding to and investigating the cause of an alarm sounding,..." On 7-27-07 at 9:15 am, E4, Maintenance Director, stated at 5:00 pm each evening, the main entrance alarm system automatically converts to the loud continuous alarm used for the EMD system every time the door is opened instead of the chiming used during the daytime. This alarm can only be turned off by entering a code into the system to reset it. On 7-27-07 at 10:10 am, E5, Certified Nursing Assistant (CNA) stated on 7-22-07, she last saw R1 about 5:30 to 5:45 pm when she served him supper in the small dining room. She did not see him again until after 6:00 pm when they were notified he had been seen in the community. E5 stated there were five CNAs and one nurse on duty that evening and all were in the main dining room assisting residents with supper. The main dining room is behind the small dining room and the door leading to the rest of the facility. E5 stated after 5:00 pm, the front door alarm goes off loudly anytime the door is opened whether the person is wearing an EMD or not. Staff rely on the alarm sounding to let them know if someone was coming or going from the facility. E5 stated some of the family members knew the code to the front door and would shut off the alarm themselves when coming and going and would not always tell staff when they did. E5	F9999		

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F9999	Continued From page 13 stated if the alarm sounded and then was shut off, staff would not necessarily leave the dining room to check, assuming someone was just coming or going. E5 related there is one family member, Z3 who comes nightly to visit his wife. Z3 would sit by the front door during supper and "help out" by shutting the alarm off when it sounded. E5 states there are a lot of visitors who come to the facility during supper time. E5 said the alarm did sound numerous times that evening. E12, Licensed Practical Nurse, interviewed on 7-30-07 at 2:00 pm, also stated R1 was last seen in the dining room after 5:30 pm. R1 was returned by Z2 and staff sometime after 6:00 pm with no injuries found. E12 stated R1 at one time was using a wheelchair but since receiving a pacemaker, his condition has improved and he can now ambulate steadily by himself. R1 had not made any recent attempts to leave the facility but had tried the doors in the past. E12 verified R1 had no safety awareness. E12 also stated she was aware that some family members knew the code to the front door and would at times shut off the alarm without notifying staff. On 7-27-07 between 1:45 pm. and 2:10 pm, E7, E10 and E11, CNAs, were interviewed. All stated R1 was observed feeding self in the small dining room somewhere between 5:30 and 5:45 pm. One CNA observed R1 get up and leave the dining room but did not know where he went. All stated R1 is fairly steady on his feet but is not aware of safety issues. The CNA's were aware that family members would come and go and would shut off the alarm at the front door when it sounded since staff were usually in the dining room assisting residents. All stated it was their	F9999		

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F9999	Continued From page 14 practice to check the door whenever the alarm sounded. On 7-27-07 at 11:50 am, R1 was up in a chair in the dining room. When asked where he was living or where he used to live, R1 responded he did not know. When asked what he would do before crossing the street, R1 just smiled and shook his head. On 7-30-07 at 12:55 pm, R1 was observed getting up from the dining room table and ambulating slowly but steadily hand in hand with a CNA. During interview on 7-27-07 at 2:40 pm, E1 stated since she started in December 2006, she was aware that family members had the code to shut off the alarm at the front door. E1 was unaware how the families came to know the code but that since the incident, the code has been changed. It will not be given out to family members. On the night of the incident, R1 was found approximately one tenth of a mile down Monroe Street on the same side of the street as the facility. R1 was found on the corner of Monroe Street and Route 97. The posted speed limit on Route 97 is 40 miles per hour coming into town by that corner. On 7-27-07 at 12:50 pm, four cars and one semitrailer were observed passing on Route 97 in one minute's time. There are no sidewalks on either side of Monroe Street from the facility to Route 97. Across Route 97 is a corn field with corn higher than 6 feet tall. During interview on 7-31-07 at 9:50 am, Z3, Climatologist reported temperature in the area on 7-22-07 around 6:00 pm to be 75 degrees with 48% humidity, clear skies with winds at 5 miles	F9999		