STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145274	A. BUILDING _____ B. WING _____	C 12/07/2006

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FOUR SEASONS LIVING CENTER	**303 NORTH JACKSON STREET MORRISON, IL 61270**

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F 324	Continued From page 11 change of every shift by the oncoming and off going nurses. 3. On 11/11/06, R1 was place on every 15 minute checks. 4. The incident was reviewed with all staff on Monday, November 13, 2006 and Tuesday, November 14,2006. Staff were informed to monitor all residents closely and let administration know of any further elopement attempts. 5. On 11/15/06 the Budget and Finance Committee met and approved a new alarm and door lock system purchase for the unit. 6. On 11/28/06, the order was placed for all parts needed and the new alarm system and automatic door lock system. 7. On 11/28/06 the staff received a second inservice, with all staff aware of continuously monitoring all residents on their safety and the every 15 minute monitoring on the resident involved in the incident. 8. On 11/28/06 the Safety Committee met and reviewed the incident. 9. On 12/4/06 at 8:00 AM, R1's elopement risk care plan was re-evaluated and updated. 10. On 12/5/06 the Quality Assurance Committee met and reviewed the incident.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.3100d)2)	F9999		

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F9999	Continued From page 12 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 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's	F9999		

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F9999	Continued From page 13 orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3100 General Building Requirements d) Doors and Windows 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 are not met as evidenced by: Based on interview, record review and observation the facility failed to provide for the safety of a cognitively impaired resident by not assuring the stairwell alarm reset procedure was known to all staff; and failed to develop approaches for R1 to minimize her wandering; a failed to have fall prevention interventions in place. These failures resulted in R1 leaving the unit through an exit door and falling down 8 steps onto a cement landing while in her wheelchair on 11/11/06. R1 required treatment in the emergency department of the hospital and sutures to the left upper mouth area.	F9999		

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F9999	Continued From page 14 This applies to 2 of 3 residents identified at risk for elopement. (R1, R2) Findings include: 1) The Physician order sheet dated 12/1/06 shows R1's diagnosis as Senile Dementia, Depressive Disorder, Hip Replacement, Closed Fracture of the Pelvis and Fractured Femur. The Minimum Data Set (MDS) dated 10/4/06 shows R1 to have problems with short and long term memory and is moderately impaired in cognitive skills in decision making. The MDS shows R1 to have wandering behaviors occurring between 4 to 6 times a week and the behavior is not easily altered. R1's initial elopement risk assessment dated 4/7/04 identified R1 at a safety level II. (The facility form states that level II residents are confused, have intermittent confusion at night, are disoriented to person, place or time and are restless.) R1 remained at a level II until 10/4/06, when R1's safety level for elopement increased to a safety level III. (The form states that level III residents are at risk for elopement, and includes wandering patients, ambulatory confused patients, and patients with sundown symptoms.) R1's care plan dated 10/3/06 does not identify R1 as an elopement risk or address elopement risk prevention measures to be used for R1. The nurses notes between 11/1/06 and 11/11/06 show 3 documented entries of R1 making attempted elopements from the facility. The notes show 9 documented entries of R1 being restless and/or agitated, and 5 entries of R1 wandering about the unit self propelling herself.	F9999		

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F9999	Continued From page 15 The facility incident investigation dated 12/5/06 states, "R1 at 8:10 PM on 11/11/06 fell down a flight of eight steps in an exit hallway off the unit. R1 was in her wheelchair with a padded lap cushion in place as a reminder to her not to get up per self. The resident is non-ambulatory and requires a lift transfer to move her from bed to chair or toilet stool. R1 wears a personal alarm at all times, so when she tries to get out of her chair or bed by herself, the alarm goes off which alerts staff to her efforts to get up on her own. The exit door that R1 went out had an alarm which had not been reset by someone who had previously come in through the door. The alarm requires a person to press the numbers 111 to shut off the alarm and then requires the numbers 111 to be pressed again and a red light comes on for only a second to allow the person setting the alarm to know it has been reset." The emergency department report for R1 dated 11/11/06 at 8:30 PM, states "Complaints of back pain and head hurts. Laceration above left lip, teeth protruding through. Broken bridge work was removed." Skin tears of the left hand arm were noted. R1's blood pressure was 187/100 and pulse was 105. On 12/4/06 at 2:55 PM, E8 (RN) stated, "R1 was her usual self that night. She was confused and restless.R1 gets that way in the evening hours. I was at the nursing station around 8:00 PM and heard a loud crash, sounded like a pile of folding chairs falling, then I heard a chair alarm. We found R1 on the landing in the exit stairwell. She was still in her wheelchair with her lap buddy on. She was screaming for someone to get her out of here."	F9999		

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F9999	Continued From page 16 On 12/4/05 at 2:30 PM, E5 (Certified Nursing Assistant - CNA) stated she was on duty on 11/11/06. E5 and E7 (CNA) were with R1 in the dining room. "R1 was in her wheelchair with the padded lap cushion on and chair alarm on. E7 and I responded to another chair alarm and left R1 in the hallway. When we brought the other resident out in the hall, we heard a loud crash and then a chair alarm. We searched all the rooms and finally found the noise was coming from the exit stairwell and there she (R1) was. R1 was at the bottom of the steps on the landing still in her wheelchair. The chair was tipped on the left side and it looked like she hit the left side of her face. I did not hear the door alarm go off, I only heard the chair alarm." E5 stated, "I didn't know how to reset the alarms before, but I do now. No one checked to see if the alarm was on as far as I know." On 12/4/06 at 2:40 PM, E7 (CNA) confirmed she was with E5 on 11/11/06 and was just coming out of the resident's room when she heard R1's alarm. "I ran down the hall. I was the first one to find her. I heard her yelling in the hallway. I opened the stairwell door and saw R1 down the steps." E7 stated, "R1 was very anxious that night. She kept saying she was looking for somebody. R1 has tried to leave the unit through the entrance door and the sun porch doors several times in the past. R1 had never tried the hall exit door." E7 continued, "I was the only one that knew that to reset the door you had to enter the numbers twice, even the nurses didn't know." On 12/4/06 at 9:05 AM, E2 (Director of Nurses) stated, "R1 can navigate with her feet and hands in her wheelchair, but cognitively she is very	F9999		

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F9999	Continued From page 17	F9999		

demented. She needs reminders and assistance to eat, and is totally dependant on staff to take her to the bathroom. She has periods of being very lethargic to being restless and on the move. R1 is not aware of day from night." E2 continued, "R1 is strong enough to open the door herself. She has tried to leave through the sunporch and front entrance before but has never tried the back hall door. R1's really smart at figuring things out. R1 can activate the door alarm on the sun porch but knows it's too heavy for her to open. R1 can open the unit entrance door and we have found her out in the hallway."

On 12/4/06 at 1:35 PM with E9 (Maintenance supervisor) the exit door alarms were activated. On the unit side of the door, E9 demonstrated the procedure to press 111 to silence the alarm and to press 111 a second time to reactivate the alarm after it has been activated. E9 stated the exit door alarm cannot be reset from inside the stairwell. Someone coming through the door into the stairwell can silence the alarm but cannot reactivate the alarm once the door has closed. E9 stated, "The alarm is very confusing when trying to make sure it is reset. The red light only flashes for a second, the light does not stay on." E9 stated that routine checks of the door alarms were not in place prior to the incident.

On 12/7/06 at 10:05 AM, E3 (Assistant Administrator) stated the facility did not have any recorded staff inservices on operation of the door alarms.

On 12/4/06 at 9:30 AM, R1 was seated in a reclined chair sleeping. A healed scar above the left upper lip was noted.

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F9999	Continued From page 18 The hall exit door leads into a stairwell that provides access to the second floor of the hospital and to the building's ground level where the physical therapy department is located. The facility policy for elopement lists hourly checks for residents identified at a safety level II, and 15 minute checks for safety level III. No other interventions are listed. The facility policy for use of personal alarms states the resident will be re-evaluated at their care plan review as to the continuing need. The facility policy for prevention of resident falls states all residents scoring 10 or more points on the fall assessment tool will be addressed on care plans and approaches will be individualized. 2) The Physician order sheet dated 12/1/06 shows R2's diagnoses as Malignant Neoplasm of the eye, Palliative care and is receiving hospice services. The Minimum Data Set of 11/7/06 shows R2 has short and long term problems and is severely impaired in decision making. The MDS shows R2 to have wandering behaviors. R2's initial elopement risk assessment dated 8/8/06 identified R2 at a safety level II. R2's care plan dated 8/17/06 does not identify R2 as an elopement risk or address elopement risk prevention measures to be used for R2. (A)	F9999		