| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **HELIA HEALTHCARE OF ENERGY** | **210 EAST COLLEGE ENERGY, IL 62933** |

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| F 000 | INITIAL COMMENTS<br><br>Complaint Investigations:<br>0752512 / IL29242 ==> F324<br>0752582 / IL29320 ==> F441<br><br>A partially extended survey was conducted. | F 000 | | |
| F 324 SS=J | 483.25(h)(2) ACCIDENTS<br><br>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews, the facility failed to provide adequate supervision for 1 of 2 sampled residents identified as a wander-risk for elopement and with previous attempts to elope from the facility (R1).<br><br>The facility identified 18 current residents at risk for elopement that wear an electronic monitoring device. R1, who is cognitively impaired for decision making, at risk for elopement, and who requires staff assistance with ambulation due to an unsteady gait, left the facility on 06-05-07 without staff's knowledge. R1 was found lying in the street of a residential area. R1 sustained abrasions to both knees from a fall.<br><br>The elopement resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 06-05-07 when the resident was returned to the facility by the police, the facility remains out of compliance at a level that is not actual harm with the potential for more than minimal harm for failing to implement a system | F 324 | | 7/19/07 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 324 | Continued From page 1<br>that assures supervision of the exit doors when the door alarm sounds and assuring all door alarms are operational. The front door alarm on C hall was not operational when checked on 06-11-07 at 10:57AM.<br><br>The findings include:<br><br>R1 is a 64 year old resident admitted to the facility on 03-16-07 with diagnoses that include: Lung Mass, Weight Loss, Dementia, Depressive Disease, and Alcohol Abuse according to the Nursing Admission History and Physical dated 03-29-07. A psychiatric assessment dated 06-10-07 states R1 has Severe Dementia with impairment of memory, judgement, executive function, and attention.<br><br>R1's Minimum Data Set (MDS) dated 03-30-07 states R1 is moderately impaired for daily decision making (decision poor cues/supervision required). R1 was also assessed to require limited assistance of 2 plus person physical assistance for transfers and total dependence with one person assistance for locomotion on and off the unit. The MDS and facility's initial Elopement Assessment dated 03-16-07 did not identify R1 as an elopement risk.<br><br>R1 was observed on 06-11-07 at 11:40AM propelling himself in a wheelchair with his feet. On 06-12-07 at 3:15PM, R1 was ambulating with a walker with assistance; his ambulation was unsteady. R1 was observed to have an electronic monitoring device on his right wrist and another on his wheelchair. An electronic monitoring device was ordered by the physician and placed | F 324 | | |

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| F 324 | Continued From page 2<br>on R1 after an attempted elopement on 05-04-07 according to the facility incident report dated 05-04-07. An elopement re-assessment was completed on 05-04-07 identifying R1 as an elopement risk. R1's care plan was updated on 05-04-07 with approaches for R1's risk for elopement.<br><br>The facility incident report dated 06-05-07 and interviews with E7 (Registered Nurse) on 06-13-07 at 9:16AM confirmed that R1 was last seen in the facility going into his room in a wheelchair at 1:45AM on 06-05-07 by E7.<br><br>E6 (Licensed Practical Nurse) was interviewed on 06-13-07 at 10:25AM. E6 stated on 06-05-07 at 3:15AM the local police department called the facility and asked if they were missing R1. The police found R1 at 303 Brenda Lane lying in the street. The police requested E6 send someone to pick up R1. Before other facility staff could be located to go get R1, the police and ambulance returned R1 to the facility according to E6.<br><br>According to E7's interview, an assessment was completed when R1 returned. Abrasions were noted on both of R1's knees. E7 stated R1's electronic monitoring device was in place on his right wrist and sounded when he returned through the front door on A Wing. An assessment with neurological checks was done on R1 by E7.<br><br>All door alarms were checked upon R1's return, and R1 was placed on 15 minute location checks by staff. R1's electronic device failed to sound 3 out of 5 times when tried at the door according to interview with E7 on 06-13-07 at 9:16AM. A new electronic device was placed on R1 by E7. | F 324 | | |

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| F 324 | Continued From page 3<br>According to the 06-05-07 police report and interview with Z2 (police officer) on 06-12-07 at 2:35PM, the dispatcher received a phone call at approximately 3:16AM that a man was laying in the street at 303 Brenda Lane calling for help. Upon Z2's arrival an elderly black man was lying flat in the street in some apparent distress. R1 responded to Z2 that he had leg injuries and could not walk. An ambulance was requested. R1 told Z2 that he had been riding a bicycle from Chicago to Alabama and had fallen off the bicycle. R1 knew his name and date of birth but was not aware of his location or his current residence.<br><br>A search of the area discovered a wheelchair approximately 100 yards away from R1 in a driveway on Ford street. Z2 stated it was obvious that R1 had crawled across 2 residential lawns in the grass. Z2 stated R1 had dried blood on both knees, and it looked as if R1 had fallen on his knees several times. Z2 stated R1 was appropriately dressed in pants, shirt, and shoes and had an electronic monitoring device on his right wrist. Z2 had the police dispatcher call the facility and ask if they were missing R1. The facility was unaware R1 was missing from the facility at that time. R1 was returned to the facility per ambulance, and the electronic monitoring alarm sounded when R1 was brought back in the facility.<br><br>E7 was interviewed on 06-12-07 at 9:16AM. E7 stated R1 was up and dressed the night he eloped. He talked to her about going to see his sick wife. This was not unusual for R1 to be up and dressed at night and to wander in the halls.<br><br>E9 stated on 06-12-07 at 3:03PM that R1 often | F 324 | | |

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| F 324 | Continued From page 4<br>wanders in the halls and tries to get out the exit doors frequently setting off the door alarms. Per interview with R1 on 06-11-07 at 11:40AM, he worked the night shift for 10 years on the transit system and usually eats at 1:30AM.<br><br>E3 (Licensed Practical Nurse-Care Plan Coordinator) was interviewed on 06-13-07 at 11:40AM. The facility was unaware of R1's past history of night shift work and eating patterns. This was not included in R1's care plan to help identify times and approaches to prevent elopement, confirmed with E3.<br><br>R1's care plan dated 03-29-07 identifies elopement and wandering as a problem with approaches but does not identify changes in approaches as R1 continued to attempt elopement. The current care plan did not identify the 15 minute whereabouts checks and the extra monitoring device applied to R1's wheelchair after the 06-05-07 elopement. This was confirmed with E3 on 06-13-07 at 11:40AM during the daily status meeting.<br><br>According to the website accuweather.com, on 06-05-07 the weather for Energy, IL ranged from a high of 82 degrees to a low of 72 degrees with no precipitation.<br><br>R1 was interviewed on 06-11-07 at 11:40AM, and was oriented to person but thought he was in a facility in Chicago, IL. R1 did not know the date or current residence. R1 recalled leaving the facility at night recently and stated he went out to get something to eat. R1 stated he fell out of the wheelchair when he came to a ditch. He said the grass was slippery. He fell and crawled up the street to get help. R1 stated when he fell the 2nd | F 324 | | |

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| F 324 | Continued From page 5<br>time, he hurt his left knee and shoulder. R1 stated he was "scared" and was "gone a long time". R1 was not aware of safety hazards such as ditches, but stated he would get out of the way of a car.<br><br>According to interview with E7 on 06-12-07 at 9:16AM, R1 would not be aware of safety hazards and would not be able to tell someone where he resides.<br><br>The Helia Healthcare of Energy is located at 210 East College Street in Energy, Illinois. The facility is 1 block east of the busy 4-lane road Route IL 148 (Pershing Street). College street is a busy 2-lane blacktop road with frequent car and truck traffic observed on 06-11 through 06-14-07. The road is narrow with no shoulder present on either side. A steep ditch is located across the street to the north of the facility on College Street, and a smaller ditch is in front of the facility. A large grass park is located past the ditch with a parking area.<br><br>R1 was found 0.8 mile from the facility in the street in a residential area, 1 block north of the park. In a wheelchair R1 would have traveled 1/2 block east on College Street, then north 4 blocks on Front Street. R1 then traveled west 1/2 block on Ford Street, then 1/2 block north on Tucker street, and back west on Brenda Lane past 3 houses. R1 was found in the middle of the street in front of the house at the address 303 Brenda Lane. Several steep ditches were noted bordering the College, Ford, and Taylor streets.<br><br>Z1 (physician) stated per phone conversation on 06-18-07 at 9:50AM, that R1 has a Dementia Diagnosis, is confused, and needs to be in a | F 324 | | |

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| F 324 | Continued From page 6 | F 324 | | |

nursing home. Z1 stated R1 would not know safety hazards nor be safe out of the facility unsupervised.

According to a previous incident report on 05-06-07 at 11:45AM, R1 walked outside the facility and fell in the grass on his knees. R1 hit his head and received several small abrasions to the nose and forehead as well as a busted lip. According to the nurses notes on this date, R1 exited out the west door without the alarm sounding. R1 was seen 10 minutes before in the dining room. The facility performed 15 minute location checks on R1 for 24 hours and changed his electronic monitoring bracelet on 05-07-07, according to interview with E1 on 06-13-07 at 11:40AM.

R1 also left the facility by the front door on 05-26-07 at 2:30PM according to the facility incident report and nurse's notes. R1 was seen running through the parking lot and fell with no apparent injuries (no mention if the door alarm or electronic monitoring device was working).

During the initial tour on 06-11-07 at 10:57AM with E3, the door buzzer alarm on the C Hall front door did not sound or light up at the nurse station when opened. According to interview with E5 (LPN on C hall) on 06-11-07 at 10:55AM, the alarm had not sounded or lit at the nurses station since she came in at 7:00AM.

All exit doors in the facility are equipped with an electronic monitoring alarm signal that must be coded off at the door with a keypad before it ceases to sound for residents wearing the electronic monitoring bracelets. All doors also have a low sounding buzzer alarm that sounds

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| F 324 | Continued From page 7<br>only when the door is opened and quits when the door is closed. This alarm does not require staff to turn off the alarm.<br><br>Per interview with E7 on 06-12-07 at 9:16AM per phone, E7 stated the open door buzzers are not always heard by staff when they are in resident's rooms as the buzz is a low frequency and sounds like the call light buzzer. Staff do not always respond to the door buzzer as it sounds often, stated by E7.<br><br>E11 (Certified Nursing Assistant) also agreed the door buzzer sounds when the exit doors are opened and the buzzer sounds are not always heard when staff are in a resident's room or in the break room according to interview on 06-13-07 at 10AM per phone.<br><br>The Immediate Jeopardy was presented to E1 (Administrator) on 06-12-07 at 1:00PM. The Immediate Jeopardy was determined to have begun on 06-05-07 when R1 left the facility without staff knowledge after 1:45AM and was found at 3:15AM by the local police 0.8 mile north of the facility. The Immediate Jeopardy was removed for R1 at the time he was returned to the facility at approximately 3:30AM by the ambulance service and police. R1 was assessed by staff and placed on 15 minute checks. The electronic monitoring system was checked and determined defective and replaced. E1 stated the door buzzer alarms were checked and determined to be in working order on 06-05-07 when R1 was returned to the facility.<br><br>The facility record indicates that the following corrective actions were initiated by the facility in response to R1's leaving the facility without staff | F 324 | | |

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| F 324 | Continued From page 8<br>knowledge on 06-05-07:<br><br>1. On 06-05-07, the facility staff reviewed the alarm systems to verify that all door alarms and electronic monitoring devices were functioning properly. It was determined that R1's electronic monitoring device was not functioning properly and was replaced.<br><br>2. On 06-05-07, R1 was returned to the facility, was assessed and 15 minute checks were initiated, and an additional electronic monitoring device was applied to R1's wheelchair.<br><br>3. On 06-14-07, R1's care plan was updated and approaches revised to include R1's past lifestyle patterns, added a wheelchair alarm on R1's chair, and 15 minute checks.<br><br>4. On 06-05-07 at 11:00PM and on 06-08-07 at 11:45AM, all staff were inserviced on "Code Yellow" to include the monitoring of door alarms.<br><br>5. On 06-12-07 the facility policy was updated to include the use of a hand held monitoring device to check all resident's electronic monitoring devices every shift and staff were re-inserviced on 06-14-07 of this change. Staff were also inserviced on the documentation of 15 minute checks for elopement risk residents instead of just visual checks.<br><br>6. All residents that are identified to be a wandering risk will be monitored for location every 15 minutes until they are re-evaluated and no longer be found to be at risk.<br><br>7. On 06-15-07 an electrician will evaluate the possibility to increase the volume/tone on facility | F 324 | | |

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| F 324 | Continued From page 9<br>door buzzers.<br><br>8. On 06-11-07 at 2PM, the C Hall front door alarm was repaired to sound and light at the nurses station when the door is opened. | F 324 | | |
| F 441 SS=E | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, interviews, and review of the infection control log for the past six months, the facility failed to maintain an effective infection control program and an accurate infection control log to prevent the transmission of communicable diseases (rashes) for R11, R5, R12, and R13 from the sample.<br><br>Findings include:<br><br>1. Review of the infection control logs for the past 6 months reveal the facility treated 5 residents for a rash with Elimite on May 4, 2007 (R11, R14, R15, R16, and R17) No isolation precautions were documented for these residents. The infections were not nosocomial | F 441 | | 7/19/07 |

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| F 441 | Continued From page 10<br>and all were resolved on 05-25-07 according to the facility's Infection Control Log for May. No follow-up documentation regarding the rash was found in the clinical record for R11, confirmed by interview with E15 (Licensed Practical Nurse) on 06-21-07 at 10:40AM.<br><br>2. According to the nurses notes in R5's record on 04-02-07 and 04-26-07, R 5 had a skin rash and skin scrapings were done (negative results). Elimite cream was applied to R5 on 05-04-07, one time only with no follow-up to the status of the rash or need for re-treatment. This was not included on the April or May 2007 infection control log, confirmed by interview with E1 (Administrator) on 06-21-07 at 1:30PM. R5 currently has a red raised rash on his arms, abdomen, back, and buttocks and was observed scratching himself on 6-21-07. Per interview with E15 on 06-21-07 at 10:40AM, R5 has had the same type rash since April 2007. It cleared some on 05-04-07 then returned on 06-15-07. R5 was treated with Permethrin 5% on 06-16-07. R5's rash has been treated with Hydrocortisone cream on 04-10-07 and 04-27-07.<br><br>3. R12's and R13's (roommates) record review revealed a red skin rash documented on 05-03-07 with the physician ordering a skin scraping to be done. No lab results were in the record, verified with E5 (Registered Nurse). Results were obtained per fax on 06-21-07 at 1:00PM by E5 stating both were negative. Both R12 and R13 were treated with Permethrin 5% cream one time only on 05-05-07. This was not included on the facility's May 2007 Infection Control Log, confirmed with interview with E3 (Licensed Practical Nurse) on 06-21-07 at | F 441 | | |

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| F 441 | Continued From page 11<br>1:30PM. No follow-up was found in the clinical record to determine the rashes had cleared. R12 was observed on 06-21-07 at 1:10pm to have a slight red rash on her right lower arm with scabbed areas noted. R12 complained during an interview on 06-21-07 at 1:10PM that the rash itches and that she has had the rash for 2 to 3 months.<br><br>4. On 06-20-07 the facility identified 30 residents and 7 staff to have a red raised rash with complaints of itching. Twenty-Seven resident rashes were treated between 06-15-07 and 06-19-07 with Permethrin 5% cream and included on a June Infection Control Log. No positive scrapings were obtained but a physician confirmed the rash was scabies on R11's physician's progress note dated 06-19-07. The other 47 residents had not been treated as of 06-20-07. The facility plans to treat all residents and staff on 06-21-07 PM.<br><br>Seven staff members were identified to have a red rash with itching. Two staff members had positive diagnoses from the physician of scabies with treatments ordered on 06-15-07 through 06-19-07. All staff will be treated on 06-21-07.<br><br>The facility does not have a tracking system to identify rashes and follow-up to the rashes and treatment, confirmed by interview with E1 on 06-21-07 at 1:30PM. | F 441 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.1210a)<br>300.1210b)6) | F9999 | | |

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| F9999 | Continued From page 12<br>300.3100d)2)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br><br>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.<br><br>Section 300.3100 General Building Requirements<br><br>d) Doors and Windows<br><br>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.<br><br>These REGULATIONS are not met as evidenced | F9999 | | |

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| F9999 | Continued From page 13 | F9999 | | |

by:

Based on observation, record review, and interviews, the facility failed to provide adequate supervision for 1 of 2 sampled residents identified as a wander-risk for elopement and with previous attempts to elope from the facility (R1).

The facility identified 18 current residents at risk for elopement that wear an electronic monitoring device. R1, who is cognitively impaired for decision making, at risk for elopement, and who requires staff assistance with ambulation due to an unsteady gait, left the facility on 06-05-07 without staff's knowledge. R1 was found lying in the street of a residential area. R1 sustained abrasions to both knees from a fall.

The facility failed to implement a system that assures supervision of the exit doors when the door alarm sounds and assures that all door alarms are operational. The front door alarm on C hall was not operational when checked on 06-11-07 at 10:57AM.

The findings include:

R1 is a 64 year old resident admitted to the facility on 03-16-07 with diagnoses that include: Lung Mass, Weight Loss, Dementia, Depressive Disease, and Alcohol Abuse according to the Nursing Admission History and Physical dated 03-29-07. A psychiatric assessment dated 06-10-07 states R1 has Severe Dementia with impairment of memory, judgement, executive function, and attention.

R1's Minimum Data Set (MDS) dated 03-30-07 states R1 is moderately impaired for daily

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| F9999 | Continued From page 14<br>decision making (decision poor cues/supervision required). R1 was also assessed to require limited assistance of two-plus person physical assistance for transfers and total dependence with one person assistance for locomotion on and off the unit. The MDS and facility's initial Elopement Assessment dated 03-16-07 did not identify R1 as an elopement risk.<br><br>R1 was observed on 06-11-07 at 11:40AM propelling himself in a wheelchair with his feet. On 06-12-07 at 3:15PM, R1 was ambulating with a walker with assistance; his ambulation was unsteady. R1 was observed to have an electronic monitoring device on his right wrist and another on his wheelchair. An electronic monitoring device was ordered by the physician and placed on R1 after an attempted elopement on 05-04-07 according to the facility incident report dated 05-04-07. An elopement re-assessment was completed on 05-04-07 identifying R1 as an elopement risk. R1's care plan was updated on 05-04-07 with approaches for R1's risk for elopement.<br><br>The facility incident report dated 06-05-07 and interviews with E7 (Registered Nurse) on 06-13-07 at 9:16AM confirmed that R1 was last seen in the facility going into his room in a wheelchair at 1:45AM on 06-05-07 by E7.<br><br>E6 (Licensed Practical Nurse) was interviewed on 06-13-07 at 10:25AM. E6 stated on 06-05-07 at 3:15AM the local police department called the facility and asked if they were missing R1. The police found R1 at 303 Brenda Lane lying in the street. The police requested E6 send someone to pick up R1. Before other facility staff could be located to go get R1, the police and ambulance | F9999 | | |

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| F9999 | Continued From page 15<br>returned R1 to the facility according to E6.<br><br>According to E7's interview, an assessment was completed when R1 returned. Abrasions were noted on both of R1's knees. E7 stated R1's electronic monitoring device was in place on his right wrist and sounded when he returned through the front door on A Wing. An assessment with neurological checks was done on R1 by E7.<br><br>All door alarms were checked upon R1's return, and R1 was placed on 15 minute location checks by staff. R1's electronic device failed to sound 3 out of 5 times when tried at the door according to interview with E7 on 06-13-07 at 9:16AM. A new electronic device was placed on R1 by E7.<br><br>According to the 06-05-07 police report and interview with Z2 (police officer) on 06-12-07 at 2:35PM, the dispatcher received a phone call at approximately 3:16AM that a man was laying in the street at 303 Brenda Lane calling for help. Upon Z2's arrival an elderly black man was lying flat in the street in some apparent distress. R1 responded to Z2 that he had leg injuries and could not walk. An ambulance was requested. R1 told Z2 that he had been riding a bicycle from Chicago to Alabama and had fallen off the bicycle. R1 knew his name and date of birth but was not aware of his location or his current residence.<br><br>A search of the area discovered a wheelchair approximately 100 yards away from R1 in a driveway on Ford street. Z2 stated it was obvious that R1 had crawled across 2 residential lawns in the grass. Z2 stated R1 had dried blood on both knees, and it looked as if R1 had fallen on his knees several times. Z2 stated R1 was | F9999 | | |

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| F9999 | Continued From page 16<br>appropriately dressed in pants, shirt, and shoes and had an electronic monitoring device on his right wrist. Z2 had the police dispatcher call the facility and ask if they were missing R1. The facility was unaware R1 was missing from the facility at that time. R1 was returned to the facility per ambulance, and the electronic monitoring alarm sounded when R1 was brought back in the facility.<br><br>E7 was interviewed on 06-12-07 at 9:16AM. E7 stated R1 was up and dressed the night he eloped. He talked to her about going to see his sick wife. This was not unusual for R1 to be up and dressed at night and to wander in the halls.<br><br>E9 stated on 06-12-07 at 3:03PM that R1 often wanders in the halls and tries to get out the exit doors frequently setting off the door alarms. Per interview with R1 on 06-11-07 at 11:40AM, he worked the night shift for 10 years on the transit system and usually eats at 1:30AM.<br><br>E3 (Licensed Practical Nurse-Care Plan Coordinator) was interviewed on 06-13-07 at 11:40AM. The facility was unaware of R1's past history of night shift work and eating patterns. This was not included in R1's care plan to help identify times and approaches to prevent elopement, which was confirmed with E3.<br><br>R1's care plan dated 03-29-07 identifies elopement and wandering as a problem with approaches but does not identify changes in approaches as R1 continued to attempt elopement. The current care plan did not identify the 15 minute whereabouts checks and the extra monitoring device applied to R1's wheelchair after the 06-05-07 elopement. This was | F9999 | | |

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| F9999 | Continued From page 17<br>confirmed with E3 on 06-13-07 at 11:40AM during the daily status meeting.<br><br>According to the website accuweather.com, on 06-05-07 the weather for Energy, IL ranged from a high of 82 degrees to a low of 72 degrees with no precipitation.<br><br>R1 was interviewed on 06-11-07 at 11:40AM, and was oriented to person but thought he was in a facility in Chicago, IL. R1 did not know the date or current residence. R1 recalled leaving the facility at night recently and stated he went out to get something to eat. R1 stated he fell out of the wheelchair when he came to a ditch. He said the grass was slippery. He fell and crawled up the street to get help. R1 stated when he fell the 2nd time, he hurt his left knee and shoulder. R1 stated he was "scared" and was "gone a long time." R1 was not aware of safety hazards such as ditches, but stated he would get out of the way of a car.<br><br>According to interview with E7 on 06-12-07 at 9:16AM, R1 would not be aware of safety hazards and would not be able to tell someone where he resides.<br><br>The Helia Healthcare of Energy is located at 210 East College Street in Energy, Illinois. The facility is one block east of the busy four-lane road Route IL 148 (Pershing Street). College street is a busy two-lane blacktop road with frequent car and truck traffic observed on 06-11 through 06-14-07. The road is narrow with no shoulder present on either side. A steep ditch is located across the street to the north of the facility on College Street, and a smaller ditch is in front of the facility. A large grass park is located past the | F9999 | | |

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| F9999 | Continued From page 18<br>ditch with a parking area.<br><br>R1 was found 0.8 mile from the facility in the street in a residential area, one block north of the park. In a wheelchair R1 would have traveled 1/2 block east on College Street, then north four blocks on Front Street. R1 then traveled west 1/2 block on Ford Street, then 1/2 block north on Tucker street, and back west on Brenda Lane past three houses. R1 was found in the middle of the street in front of the house at the address 303 Brenda Lane. Several steep ditches were noted bordering College, Ford, and Taylor streets.<br><br>Z1 (physician) stated per phone conversation on 06-18-07 at 9:50AM, that R1 has a Dementia Diagnosis, is confused, and needs to be in a nursing home. Z1 stated R1 would not know safety hazards nor be safe out of the facility unsupervised.<br><br>According to a previous incident report on 05-06-07 at 11:45AM, R1 walked outside the facility and fell in the grass on his knees. R1 hit his head and received several small abrasions to the nose and forehead as well as a busted lip. According to the nurses notes on this date, R1 exited out the west door without the alarm sounding. R1 was seen 10 minutes before in the dining room. The facility performed 15 minute location checks on R1 for 24 hours and changed his electronic monitoring bracelet on 05-07-07, according to interview with E1 on 06-13-07 at 11:40AM.<br><br>R1 also left the facility by the front door on 05-26-07 at 2:30PM according to the facility incident report and nurse's notes. R1 was seen running through the parking lot and fell with no | F9999 | | |

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| F9999 | Continued From page 19<br>apparent injuries (no mention if the door alarm or electronic monitoring device was working).<br><br>During the initial tour on 06-11-07 at 10:57AM with E3, the door buzzer alarm on the C Hall front door did not sound or light up at the nurses station when opened. According to interview with E5 (LPN on C hall) on 06-11-07 at 10:55AM, the alarm had not sounded or lit at the nurses station since she came in at 7:00AM.<br><br>All exit doors in the facility are equipped with an electronic monitoring alarm signal that must be coded off at the door with a keypad before it ceases to sound for residents wearing the electronic monitoring bracelets. All doors also have a low sounding buzzer alarm that sounds only when the door is opened and quits when the door is closed. This alarm does not require staff to turn off the alarm.<br><br>Per interview with E7 on 06-12-07 at 9:16AM per phone, E7 stated the open door buzzers are not always heard by staff when they are in residents' rooms as the buzz is a low frequency and sounds like the call light buzzer. Staff do not always respond to the door buzzer as it sounds often, stated by E7.<br><br>E11 (Certified Nursing Assistant) also agreed the door buzzer sounds when the exit doors are opened and the buzzer sounds are not always heard when staff are in a resident's room or in the break room according to interview on 06-13-07 at 10:00AM per phone.<br><br>(A) | F9999 | | |