STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145416	A. BUILDING _____ B. WING _____	C 08/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND MANOR NURSING CENTER	410 NORTHWEST THIRD CASEY, IL 62420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 323	Continued From page 6 Assistant station to identify R1 and any other residents who are at high risk for elopement and who may be on an elopement watch log. 2. Mandatory all staff inservicing was started on 8/1/08 and completed on 8/2/08 covering the following topics: Elopement Policy, Door Alarm Policy, and the Shift to Shift Resident Report Policy. No staff were allowed to work until their inservice was completed. This was done by the Administrator and the Director of Nurses. 3. Elopement logs have been changed and monitoring times have been changed to every fifteen minutes times forty-eight hours for those residents placed on the elopement watch log. This was done by the Administrator and the Director of Nurses on 8/1/08. 4. The Elopement Policy was changed by the Administrator on 8/1/08 to reflect a new order in notification after staff realize a resident is missing. The staff will now notify the local police first. 5. The Maintenance Director re-labeled all lights at the alarm control box to ensure accuracy of identifying an alarming door. This was done on 8/1/08.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.1210b)6) Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 7 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. Based on observation, interview and record review, the facility failed to supervise R1, a known high elopement risk. Staff failed to communicate the need for heightened supervision to the oncoming shift, incorrectly communicated which exit door was activated, and failed to account for all residents prior to resetting an unwitnessed, activated, door alarm. R1 exited the building without staff knowledge or supervision. R1, a demented resident with no safety awareness, was found lying in the road a number of blocks from the facility and was taken to the local police station by a passing motorist. R1 was one of two residents sampled for elopement.	F9999		

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F9999	Continued From page 8 Findings include: R1's most recent Physician's Orders dated July of 2008 indicates R1 has diagnoses of Alzheimer's Dementia and Osteoporosis. The assessment dated 4/11/2008 shows R1 is cognitively impaired, has periods of restlessness, does not always understand others, has sleep cycle issues, and has repetitive physical movements including pacing. The assessment also shows R1 has no Range of Motion problems and is ambulatory. Further, the assessment demonstrates R1 needs extensive to total assist for her activities of daily living. The Clinical Record Face Sheet demonstrates R1 was admitted to the facility on 4/4/08. Review of the Nurses Notes indicates that R1 tried to elope from the facility seven times on 4/5/08, the day after she was admitted. Further review of the notes indicates R1 was continually trying to leave the facility. She tried to leave twice on 4/8/08, and once on 4/15/08. She attempted elopement on 5/7/08 when R1 got to the parking lot. On 5/18/08 she was observed walking by an adjacent building, and on 6/13/08 she was noted to be outdoors. On 6/15/08 she got out twice, and on 7/3/08 she got to the parking lot. She made two more attempts to leave the building once on 7/7/08 and on 7/9/08. A Nurses Note dated 7/11/08 indicated R1 again tried to leave the facility and an elopement log was started at 4:00 PM on that date. In interview with E2, Director of Nurses (DON) on 7/31/08 at approximately 10:30 AM, E2 stated, "...we use the Elopement Log to increase supervision of residents who are at high risk for elopement..."	F9999		

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F9999	Continued From page 9 E7 Certified Nursing Assistant (CNA) is a day shift CNA. On 7/31/08 at approximately 2:00 PM, E7 indicated she was not aware R1 had tried to get out the previous afternoon (7/11/08), Nor was she aware R1 was to have heightened supervision. E7 stated, "...the night aide (CNA) did not tell me (R1) was on an elopement watch..." E4, CNA who works nights, stated on 8/1/08 at approximately 10:00 AM that she failed to report to the day shift crew that R1 was on an elopement watch. E4 stated, "...I did see the sheet and saw (evening CNA) sign off and I did know that (R1) was on the elopement watch sheet. It was my responsibility to watch (R1) that night and to sign off on the sheet. I failed to report to the oncoming CNA (E7) that R1 was on the elopement watch list. I should have reported that..." E9, Licensed Practical Nurse (LPN) stated on 7/31/08 at approximately 2:15 PM that she similarly did not report to her CNA's that R1 was on the elopement watch list. E9 stated, "... (E10) LPN (the night nurse) told me (R1) was on an elopement watch. The (Elopement Watch List) is a way to heighten our awareness about where (R1) is and what she is up to at any given time. She is to be checked every thirty minutes at a minimum. I didn't tell the girls (CNA's) that (R1) was on an elopement watch. I don't know why I didn't tell them...R1 has no safety awareness she would not be safe to be outside alone...." Review of an Elopement Watch List started 7/11/08 at 4:00 PM demonstrates that R1 was not accounted for after 6:00 AM on 7/12/08.	F9999		

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F9999	Continued From page 10 Facility policy titled "Elopement" and identified by the Administrator as the policy in effect at the time of the elopement states, "When any door alarm sounds the staff shall: ...check the exit door for any exiting resident by means of a visual check. Visual check means observing any area around the exit and may require leaving the building...Reset the door alarm after it is determined by visual check that no resident has exited the facility inappropriately...If an alarm is discovered de-activated, staff will perform an immediate head count to ensure all residents are accounted for..." An untitled facility document indicated R1 left the facility without staff knowledge or supervision on 7/12/08. The report states, "On July 12, 2008 three door alarms sounded at approximately (9:20 AM) alerting staff that someone had either entered or exited without entering our code on 2 sets of doors...Our policy is that when a door alarm sounds the closest staff member to the alarm board will go to the telephone and page for alarming doors to be checked. Then the closest staff member to those doors are to check the doors and if they are clear then they are to page that the door is ok. On this day when the three alarms were sounding, (E6), Housekeeper paged the wrong door. (E6) paged that the (west dining room door), (front door), and (east dining room door) be checked instead of stating (east exit door)..." The report goes on to say this error resulted in confusion; after the confusion was resolved the (east exit door) was checked but nothing was seen. According to interview with E7, CNA a head count was not done at this time. E7, CNA, on 7/31/08 at approximately 2:00 PM stated, "... I was working the day (R1) got out and	F9999		

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F9999	Continued From page 11 I was working the hallway her room is on...there was confusion earlier (in the day) about an alarm going off. About 9:00 AM to 9:30 AM, I was giving showers and someone called (on the public address system) to check the west dining room door (we don't have a west dining room door). There was not a head count done at that time, there should have been... I went about my business... I believe (R1) got out then. When I went up front to clock out for lunch - the alarm went off (again). This was a little before 10:00 AM. I asked (E8 Unit Aide) if she would go check the door. She didn't see anyone (we think a family member set it off, but we didn't see them set it off) so we started the head count then. I asked (E9) Licensed Practical Nurse (LPN) to make sure all wings called back clear and I went to lunch. I was in the breakroom for about seven minutes (I clocked back in at 10:13 AM). (E9) said they could not find (R1) and so I got in my van and went to look for her." A local police report shows that R1 was found away from the facility by a passerby. The report states, "...On Saturday 7/12/08 I reporting officer (Z1) was on patrol for (the local) police department. At 10:08 AM I was requested to meet with a subject at the police department. The caller (Z2) had found an elderly lady lying in the street and did not know where she belonged...At 10:20 AM dispatch advised that (the facility) had called looking for a patient who had walked out (R1). I called (the facility) and advised the nurse that I had (R1). A nurses aide arrived at the department and picked (R1) up and took her back..." Observation shows that R1 was found a short distance from the facility (within a quarter mile) in	F9999		

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F9999	Continued From page 12 a residential area with gullys on both sides of the road. The area has a speed limit of 25 - 30 miles per hour. It is unknown of R1's exact location because the passer-by could not be contacted. Observation further shows the facility is within one-tenth of a mile of a state highway with a speed limit of 55 miles per hour. The exact route R1 took is unknown. Elopement Incident Investigation dated 7/12/08 stated "...grass stains noted on knees of blue jeans she (R1) had on..." An attempt was made to interview R1 on 7/31/08 at approximately 2:00 PM, about the incident and to gauge her safety awareness. R1 was totally nonsensical in her replies to questions, didn't seem to remember the incident, and was judged to be uninterviewable. R1 was deemed to have minimal if any safety awareness. (A)	F9999		