STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(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) COMPLETE DATE
S 000	Initial Comments Incident Report Investigation for Incident of 7/25/15/IL79755 Clark-Lindsey Village is in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities for this survey.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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. d) Pursuant to subsection (a), 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident This requirement is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to provide supervision for R1 to prevent exiting the building without staff knowledge, and by failing to to respond to a sounding door alarm. This failure resulted in R1 leaving the building unnoticed, crossing a two lane city street, and being discovered in a nearby residential area, uninjured. This failure affects one of three residents (R1) reviewed for wandering behavior on the sample of three. Findings include: According to the electronic record and the Minimum Data Set dated 6/2/2015, R1 has	S9999		

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communication problems, is severely cognitively impaired, requires supervision only for ambulation in and out of the unit, and has behaviors of wandering. On 9/1/15 at 10:30am, E2 (Assistant Administrator) stated that R1 is independent with ambulation and is "very fast," and is known to challenge closed doors. The Physician Order dated 7/10/15 states that R1 receives Seroquel (antipsychotic) twice daily.

R1's careplan dated 6/2/15 identifies a problem of "potential for wandering due to her dementia and not understanding her environment. She has the potential for elopement (leaving the building unnoticed). " Approaches include an electronic monitoring bracelet and to "monitor for proper function and placement. . . .Monitor for exit-seeking behaviors/triggers. Accompany {R1} on a walk to redirect, expend excess energy and to calm down when needed. . ." Elopement Risk and Safety Risk Assessments dated 7/9/15 and 4/17/15 assess R1 as an elopement and safety risk. E6, Registered Nurse stated on 9-2-15 at 12:30 p.m. that R1 has no personal safety awareness when independently out in the community.

The facility Incident Report Follow-Up dated 7/26/15 states that R1 "was returned to the facility by {city} police officers at approximately 8 pm on Saturday, July 25, 2015, approximately 40 minutes after leaving facility. She was returned without incident and there are no injuries. . . " The undated Statement of Events states that upon R1's return to the facility, E1 (Administrator), E2, and E3 (Director of Nursing) were notified and were onsite at the facility within the hour, when the investigation was initiated. This statement states, "The door alarm report was reviewed to determine if the {electronic

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monitoring system} alerted staff to {R1} leaving the building - it did not. . . .Tapes of the door cameras were reviewed to determine the exact time that {R1} exited the building (entered office and closed the door at 1922 (7:22pm). Returned to facility by {city} police at 2010 (8:10pm)." The statement continues with doing the head count, staff interviews, verifying monitoring tags, testing door alarms, contacting monitoring device company, and inservicing of staff.

On 9/1/15 at 10:45am, E2 and E4 (Director of Health Services) confirmed information in the Incident Report Follow-up and the Statement of events for R1. E2 and E4 stated that the door that R1 initially went through was a newly created office door off the Skilled Care dining room. When returned by police, it was determined that R1 had crossed the street into a residential area, where the police were called by a citizen. E2 stated that R1 could not state her name to the police. Reviewing the door alarm records and the cameras, E2 determined that the regular door alarm did sound approximately 7:25pm. E2 stated that E6 RN (Registered Nurse) turned off the alarm at the door alarm control panel, and did not check the door to see if a resident went out the door, as she thought it was the courtyard door. E2 stated that another nurse, E5 RN (Registered Nurse) was also present and did not check the doors after alarms sounded. E2 and E4 both stated that door alarms should be responded to even if it is a courtyard door.

On 9/1/15 at 1:00pm, E16 (Maintenance Director) confirmed that all doors are alarmed to prevent residents exiting without staff knowledge. E16 stated that the control panel lights up to indicate location of the alarming door, and that all door alarms are checked monthly.

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On 9/1/15 at 2:10pm, E6 RN confirmed that she did not go to the alarming door and stated that she thought the door alarm she silenced on the panel was a courtyard door. E6 also stated that she had seen R1 walking around about 15 minutes prior to the door alarm. E6 stated she did not know that the office door off the dining room was unlocked.

On 9/1/15 at 3:45pm, E5 RN stated that R1 had gone through that office door and activated the exterior door alarm earlier in the day around noon. E5 stated that the alarm did not sound on the panel but did sound at the door. E5 did not report that to anyone. E5 stated that when the alarm sounded in the evening after 7pm, the other nurse (E6) thought the alarm was for the courtyard door, and that she had just seen R1. E5 confirmed that she did not go to the door to look for any residents who may have exited.

According to a web-based city weather report, the temperature at 7:18pm on 7/25/15 was 80.1 degrees Fahrenhiet (F.); the relative humidity was 74 per cent, for a heat index of 83.6 degrees F. ; sunset was 8:13pm on 7/25/15, R1 was returned to the facility at dusk (8:10 p.m.) according to the 7-26-15 facility incident report.

Interdisciplinary Notes by E7 (Registered Nurse) dated 7/25/15 at 8:13pm state, "Resident returned to facility by {city} police. . . .Resident is alert and responsive, walking without difficulty. . . .Noted resident's clothes to have areas of perspiration on the chest and back. . . .had two. . . reddened areas on upper chest and back. . . . While washing reddened areas began to fade. . . .Resident remained alert, whistling entire time. . .No distress noted. . . . "

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S9999	Continued From page 5 On 9/2/15 at 10:30am. E7 confirmed information in nurses notes. E7 confirmed that she was not aware that R1 was absent from the facility until the police called and then returned R1 to the facility. E7 stated she was aware that R1 tends to wander and attempt to go outside, but E7 was not aware that an alarm had sounded earlier or that R1 had attempted to go out earlier in the day. R1 was observed at intervals throughout the day on 9/1/15 and 9/2/15 in activities and at meals. On 9/1/15 at 2:45pm, R1 ambulated to the bathroom and back into halls and activities. R1 ambulates without difficulty. On 9/2/15 at 9:30am, R1 was wandering through the activity room, occasionally picking up magazines or rearranging items. Attempts to interview R1 were not successful due to cognitive impairment. The facility policy for Lost or Missing {healthcare center} Residents dated September 1, 2011, states "When a door alarm is activated, all available staff members should respond promptly to the audible alarm and make a determination of who exited out of the door." (B)	S9999		