STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146124	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARMI MANOR REHAB & NRSG CTR	**615 WEST WEBB STREET, PO BOX 133 CARMI, IL 62821**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide supervision for 1 (R2) of 3 residents reviewed for behaviors of wandering/elopement risk. The Findings Include: The facility policy and procedure titled Elopement Prevention with an effective date of 12/4/15 states that .it is the policy of Carmi Manor to maintain the safety of our residents by regularly assessing our residents for elopement risk and ensuring a multi-faceted approach to preventing undetected exit from the facility. Environmental controls, such as but not limited to: alarmed doors, visual cues. Communication, such as, but not limited to: use of an elopement risk assessment tool, resident elopement risk list, visual checks log. A score of 0-8 on the elopement assessment is a low risk. If an elopement attempt occurs: .In the event an exit door alarm is sounded, or a resident is reported missing, the following procedure is to be followed: all personnel hearing alarm are to immediately respond to the site, if initial investigation does not immediately reveal the cause of the alarm, proceed as follow 1 open door and search immediate perimeter of door, if no one is found secure door, report event to charge nurse who will notify DON, charge nurse is to initiate a head count of each resident to be directly visualized by a staff member and signed off for accounted census, if all residents are accounted for end the search, if not initiate a code green or code butterfly. This code includes the following steps: 1. the floor nurse is to announce over the loud speaker three times. 2. Nursing supervisor to be stationed at the front lobby with the resident picture identification available. 3. Response team members will obtain a visual description of the individual missing 7. at the conclusion of the internal and external building search, if the resident is not found then the police department must be notified Review of the facility's investigation on this incident shows that on 7/19/20 R2 was last seen at 3:50 AM near the nurses station. The front door alarm was going off at 4:00 AM. V5 (Certified Nurse Assistant)(CNA) and V15 (CNA) walked out the front door and around the patio and didn't see anyone, so they determined it was someone trying to break into the building. R2 has an admission date of [DATE] and date of birth of 6/7/42. R2's medical [DIAGNOSES REDACTED]. R2's most recent Quarterly Minimum Data Set ((MDS) dated [DATE] Section C for cognitive level is a 3, which indicates that the resident has impaired cognition. R2's Wandering/Elopement Risk assessment dated [DATE] has a score of 7= High Risk. The previous assessment dated [DATE] has the same score of 7, indicating a high risk for elopement. The same MDS has the resident assessed as independent with walking and transferring. R2's nursing progress note dated 7/19/20 at 6:30AM states Sheriff's Dept called to inform this nurse that resident was at(NAME)apartments across the field from Nursing home. This nurse went to pick up resident. Upon arrival ambulance was present and resident had been fully assessed with [REDACTED]. Upon return to the facility res was assisted to her room and oxygen applied. Vitals within normal limits. Head to toe assessment performed with no new injuries noted. Denies active pain or distress at this time. Resident placed on 15 min checks and wanderguard applied to right ankle. Physician, Administrator, Director Of Nursing and Power Of Attorney notified of situation. On 8/18/20 at 9:00 AM, V1 (Administrator) stated that V16 (Registered Nurse)(RN) was on shift that morning the elopement happened as well, but did not assist in looking for the resident. V1 went on to state that V5 has domestic issues at home and that is why she thought someone attempted to break-in to the facility, and that none of the three employees on shift that evening followed the facility's policy on wandering/elopement. V2 stated at this same time that all staff have been re-educated on the wandering and elopement policy since this occurred. On 8/18/20 at 2:00 PM, V5 stated that she was working the night that R2 eloped out of the facility. She last seen the resident at 3:50 AM up by the nurses' station. She asked R2 to go back to bed, but R2 refused. At 4 AM she heard the front door alarm sound. She told V16, who didn't hear it, and went outside with V15. They looked out the front and, on the patio, and didn't see anyone. They then determined someone tried to break in and didn't do anything else. V15 did not do anything else with the door alarm either. V5 states that she now knows that she needs to do a head count of all residents if that happens again. They have all be in-serviced on the policy should this happen again. On 8/18/20 at 11:00 AM, V10 (RN) stated that she was working the day the police called stating that they found R2. She had just clocked in at 6 AM and they called at 6:15 AM. No one knew that she was missing. She (V10) went to the apartment complex behind the nursing home to meet with paramedics and police. The resident was not harmed/injured so they let her come back to the home with her. R2 is a confused resident that now is placed on 15 min checks and has a wander guard. The facility administration re educated everyone on the elopement policy after this happened. But it has always been that you look out the door that is alarming to see if any resident is out there and if not then you do a facility head count to ensure safety. They are supposed to do bed checks every 2 hours, but that is not recorded anywhere. V10 stated that up until the point of the sheriff calling the facility, no one knew the resident was missing.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.