

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 9/9/04
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 7/8/04
NAME OF PROVIDER OR SUPPLIER EDEN VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTH STATION ROAD GLEN CARBON, IL 62034		
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F9999	<p>FINAL OBSERVATIONS</p> <p>Surveyor: 02470 300.1210(a)</p> <p>The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to provide adequate supervision</p>	F9999			

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F9999	<p>Continued From page 6</p> <p>to prevent an elopement incident, for one of ten residents in the sample (R1). This incident resulted in R2 eloping from the facility without staff knowledge on 06/25/04 at about 7:45 PM. Staff last reported seeing R1 about 7:40 PM. At 8:05 PM, Z1 called the facility saying Z3 had R1 with him at a neighborhood location about 0.25 miles from the facility.</p> <p>Findings include:</p> <p>On 06/29/04 the facility notified the Department that R1 had eloped from the facility on 06/25/04. The facility provided a report to the Department.</p> <p>The facility's incident report and investigation documentation was reviewed on 07/02/04. It indicates the that on 06/25/04 Hall 6 personal-alert, door alarm was "cancelled" around the time when R1 was last reported being seen, which was about 7:40 PM. Staff who responded to the alarm conducted only a brief and cursory look in that exit area, for any resident who may have triggered the personal-alert door alarm system. No staff member proceeded with a head count verification of any kind in response to this Hall 6 door alarm. It was noted that Z3 found R1 noted R1's I.D. bracelet and called the 800 number on this Alzheimer Association wrist I.D. bracelet to get positive identification. The Alzheimer Association called Z1. Z1 then informed the facility by a phone call at about 8:05 PM of the elopement and of R1's pending return by Z3.</p> <p>On 07/02/04, R1's medical record was reviewed. R1's Admission Face Sheet indicates she is 82 years old and admitted to the facility on 06/24/04. R1 has diagnoses which include Alzheimer's</p>	F9999		

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F9999	<p>Continued From page 7</p> <p>Disease, Syncope & Collapse, and Osteoarthritis. R1's Minimum Data Set, dated 06/28/04, indicates she has short-term memory problems and has moderately impaired decision-making skills. R1's initial admission "Level of Care Assessment" form indicates she triggered with behaviors under "wanders, oblivious to needs/safety." This sheet also indicates she can ambulate on her own without assistance.</p> <p>R1's clinical record indicates she has a history of confused wandering. Hospital record dated 05/23/04 indicates R1 was admitted to a hospital on 05/21/04 due to "she was confused and wandering on the street."</p> <p>Z4's (R1's Physician) progress notes dated 06/15/04 (also previous to admission), state 'her memory and judgement are somewhat impaired. She does not seem to understand the situation as it presents today. She has no memory of her hospitalization....recent downturn would suggest vascular dementia. also osteoarthritis of the knees." Z4 was interviewed on 07/06/04 at about 11:15 AM. Z4 indicated that R1 is confused, that she could avoid dangers like ditches, curbs and cars, but she has no clue as to where she is going or how to get there.</p> <p>R1 was interviewed on 07/06/04 at about 1:30 PM. R1 did not remember the incident of being found and brought back by Z3 on 06/25/04. R1 talked a lot about going home during the interview. R1 talked about her home being only 2 blocks away when in reality it is at least 5 miles away.</p> <p>R1's nurse notes dated 06/24/04: 1:00 AM "Res. woke up from room, lying in bed;</p>	F9999		

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F9999	<p>Continued From page 8</p> <p>Inquiring over & over where she is, that she needs to go home. Walking up & down the halls & tries to open doors @ end of halls. Staff /c elder constantly 1-1. Given explanation many x's where she is & reoriented to time, but elder repeats questions & insists she needs to leave...."</p> <p>7:00 AM "Up this AM & 1-1 needed to supervise for poss. flight risk. Elder continues to verbalize her need to leave this place. Taken to Alz. unit for close monitoring. Wanderguard applied also."</p> <p>R1's nurse notes dated 06/25/04: "2105 Received call from [Z1] stating Alz. Assoc. had called and pt. was down the street with [Z3] and would be returning to facility....All alarms and gate alarms on unit armed and had not alarmed. Will assess other doors. "2110 [Z3] escorted pt to facility. 2 staff assisted R1 to unit....No S/S of injury noted. Watchmate intact."</p> <p>E4 (Licensed Practical Nurse) was interviewed on 07/02/04 at about 2:10 PM. E4 indicated E7 and E8 responded to the Hall 6 alarm. He indicated E8 looked for residents in that area by looking out the windows and did not see any, but E8 did not go outside to look. The alarm was reset or cancelled. They did not do a resident head count of any kind and they did not inform the Alzheimer unit of the alarm. On 07/06/04, E4 was interviewed about the Hall 6 alarm sounding loud enough for staff to hear in that dedicated unit. E4 indicated the Hall 6 alarm was not heard by any Alzheimer unit staff at the time of the incident. No notice was given to the Alzheimer unit staff that the personal-alert exit alarm at Hall 6.</p> <p>On the survey it was noted that 10 residents in the</p>	F9999		

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F9999	<p>Continued From page 9</p> <p>facility are outfitted with a personal-alert exit alarm due to potential wandering and/or elopment behaviors. Eight of these ten residents reside on the Alzheimer unit.</p> <p>E7 (Certified Nurses Aide - CNA) was interviewed on 07/06/04 upon her arrival for her 3:00 PM shift. E7 indicated that she and E8 responded to the alarm. They were both working on the non-Alzheimer side of the building where Hall 6 is located. E7 indicated E8 went down to check the area for residents who may have triggered the alarm and did not see any, so E7 reset the alarm. They both assumed it was R10 who set the alarm off and R10 was found so nothing else was done.</p> <p>E8 (CNA) was interviewed on 07/06/04 upon her arrival for her 3:00 PM shift. E8 indicated that she responded to the Hall 6 alarm and looked in the area by looking out windows. E8 indicated she did not go outside to look. E8 indicated she and E7 started looking for R10 and when they found R10 they assumed it was R10 who had set off the alarm. E8 did not recall where R10 was found but indicated R10 resides on the non-Alzheimers side and sets off alarms frequently. He has a personal-alert exit device on, but never leaves the building. He just gets near the doors and they "always find him."</p> <p>On 07/07/04, the surveyor observed the grounds of the facility and the surrounding area up to the spot where R1 was found. There are no side walks in this residential neighborhood. The speed limit is 30 miles per hour. The distance from the facility to the spot where R1 was found is about 0.25 miles.</p>	F9999			