

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

PRINTED: 11/4/04
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E888	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 8/19/04
NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE WILLOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3520 NORTH ROCHELLE PEORIA, IL 61604		
(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	
F9999	<p>FINAL OBSERVATIONS</p> <p>Surveyor: 02619 Licensure findings:</p> <p>300.1210a) 300.1210b)6) 300.3100d)2)</p> <p>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>All necessary precautions shall be taken to assure that the residents' environment remains as free of accidents as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p>	F9999			

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F9999	<p>Continued From page 8</p> <p>All exterior doors shall be equipped with a signal that will alert 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 24 hour a day supervision of the door, a signal is not required.</p> <p>These regulations are not met, as evidence by the following:</p> <p>Based on observation, interview and record review the facility failed to monitor whereabouts of R1 and monitor the locking device on one exit through which R1 had previously exited the facility. R1 is one of twenty- one residents identified by the facility as having exit seeking behavior and wearing electric monitoring bracelets.</p> <p>R1 left the facility without staff knowledge and unattended by staff. R1 was absent from the facility for twenty-five hours being discovered by off duty staff eight blocks from the facility.</p> <p>Findings include:</p> <p>R1 is a fifty-nine year old male resident, admitted to the facility on 03/15/04 and has diagnoses of Schizophrenia and Alzheimer's Dementia, according to Psychiatric Social Service Assessment dated 02/19/04. A review of R1's assessment dated 06/15/04 indicated that R1 is moderately impaired at decision making, has long and short term memory problems, episodes of disorganized speech, mental function varies over the course of the day, and wandering episodes one to three days a week.</p> <p>Review of the Psychosocial Assessment dated</p>	F9999		

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F9999	<p>Continued From page 9</p> <p>03/15/04, for R1, identifies R1 as in need of constant supervision and is delusional. Psychiatric Progress Note, dated 06/07/04 indicates that R1 continues to go out windows and is on elopement precautions, has delusions, hallucinations, impaired judgement, impaired memory and is disoriented and wears an electronic monitoring device. Elopement precautions included R1 being on an hourly watch program with documentation of the hourly checks by staff.</p> <p>Review of R1's Care Plan dated 03/31/04 indicates that R1 attempts to exit the front door, becomes aggressive with redirection, wears an electric monitoring device, needs documentation of pass policy violations. Care Plan update on 06/15/04 indicates that R1 has had episodes of elopement climbing out of room window and jumping over patio fence.</p> <p>Interview at 10:00 A.M. on 08/12/04 with E1 (Administrator) indicated that R1 was on a Red Pass status. According to review of the facility's Resident Pass Policy this allows the resident to only to leave the facility grounds under supervision of staff or family.</p> <p>Review of Nurses Notes for R1 indicate four elopements between 06/08/04 and 08/05/04 during which R1 was returned to the facility between ten minutes and four hours on each occasion. One of which was through a room window and one over the patio fence.</p> <p>Review of the incident report dated 08/09/04 and associated interviews with facility staff dated 08/05/04, indicate that R1 was discovered missing from the facility at 4:45 A.M. on 08/05/04 by E9</p>	F9999		

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F9999	<p>Continued From page 10</p> <p>(Certified Nurses Aide, CNA). Interview at 10:00 A.M. on 08/12/04 with E1, indicated that R1 was discovered by E10 (Certified Nurse Aide, CNA), off duty staff, at approximately 7:30 A.M. on 08/06/04, two blocks east of Sterling Avenue, walking west on Forest Hill Avenue, which is twelve blocks from the facility by review of the City of Peoria Street Map.</p> <p>During interview at 8:45 A.M. on 08/19/04, E9 stated that she last saw R1 in the television common area at a table with some books and papers and the television on, at 3:30 A.M. on 08/05/04. When E9 completed her room check at 4:30 A.M. she noticed that R1 was no longer at the table where he was at 3:30 A.M. and she began a room search for R1. R1 was on an elopement precaution hourly observation by staff at that time. At 4:45 A.M. E9 notified E11 (Licensed Practical Nurse, LPN) that she could not find R1 in the facility. E11 told E9 to conduct a more thorough search for R1 which E9 did without finding R1. E9 further stated that she had not heard any of the facility's exit alarms sound during her shift. At 5:00 A.M. E11 notified E1 and the facility's Missing Resident Procedure was begun, which involved the notification of other facility staff to search the grounds and immediate neighborhood, notify the Police and notify pertinent family members and the resident's doctor.</p> <p>Interview at 10:00 A.M. on 08/12/04 with E1 documents that R1 was returned to the facility at 7:30 A.M. on 08/06/04 approximately twenty-seven hours after it was discovered that R1 was not in the facility. Review of the nurses notes for R1 and interview at 10:45 A.M. on 08/18/04 with E7 (LPN), show that during assistance with a shower, upon</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>R1's return, it was discovered that there was a fresh abrasion to R1's left knee. All other vital signs were normal. Interview also noted that R1 was wearing an electronic monitoring device when he was returned to the facility and that the device was tested and was working as designed. E7 also said that R1 was dressed in slacks, a shirt and socks and shoes when he was returned to the facility.</p> <p>Telephone contact at 2:45 P.M. on 08/12/04 with Z1 (Weather Person) at the Midwest Climate Center in Champaign, Illinois, showed that the temperature on 08/05/04 and 08/06/04, at the airport in Peoria, Illinois, recorded a high of seventy-five degrees Fahrenheit and a low of fifty-six degrees Fahrenheit between the two days and that the weather conditions were fair.</p> <p>Interviews in the morning of 08/18/04 with facility staff E5 (Psychiatric Rehab Service Coordinator, PRSC), E6 (LPN), E7 (LPN), E8 (CNA), E9 (CNA) and E12 (CNA) revealed that R1 would not be aware of his own safety regarding traffic and accepting rides from strangers, when out in the community alone and unattended by staff. E8 said that R1 had told her that he had hitchhiked with strangers when he has been out of the facility by himself. During interview at 10:30 A.M. on 08/12/04, E1 said that he sometimes hitches rides with people that he does not know. E8 said that R1 told her that he went to a policeman's house on 08/06/04 and asked for a drink and the person gave him a Pepsi Cola. R1 had an empty Pepsi bottle when he was returned to the facility.</p> <p>During interview at 10:30 A.M. on 08/12/04, R1 was not sure of the time, day of the week or month and thought that he had lived at the facility for a</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>long time. When asked about the incident of 08/05/04 R1 said that he was just going to get out of here, that he stayed with friends overnight at a location that he could not identify and that he ate a Taco Bell. He said he would cross the road at the corner and that he did not want to get run over. R1 then got up and walked out. During interview at 2:25 P.M. on 08/12/04 with R1 he said he did not know where he was going on 08/05/04 and that he stayed with friends. He then got up and walked off. When interviewed at 4:10 P.M. he said he stays with friends and that he would get out of the way of cars and that to get around while he is out he hitches. Again R1 got up and left.</p> <p>Observations between 1:30 P.M. and 2:15 P.M. on 08/12/04 revealed that all of the alarms on the facility's eight exit doors were working and that they required a key to reset them at the exit. The smoking lounge at the head of the B Wing has a sliding door that exits on to a patio area that has a six foot tall wood fence at its outer parameter, separating the patio from the outside. This door has an alarm that is turned off at the nurses station because of the fence, as learned in an interview at 2:00 P.M. on 08/12/04 with E4 (Maintenance Supervisor). There is a slide bar latch at the top edge of the door that is locked with a key at night. At the time of the observation there was also a small pad lock on the door near the handle that E4 said was placed there after the 08/05/04 incident.</p> <p>During interview with E1 and E9, they stated that the smoking lounge exit door was believed to be the means of exit used by R1 on 08/05/04 because the lock on the door was found to be not locked when checked around 5:00 A.M. on 08/05/04. E9 said she observed E11 locking this</p>	F9999			

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F9999	Continued From page 13 door at the beginning of the shift and that she found the lock not locked during the search for R1 in the A.M. of 08/05/04. The fence at the parameter of the patio was the one that R1 went over to elope on 06/09/04. Complaint No. 0423649: No Findings. Incident of 08/05/04: Tag F324 Cited.	F9999		