STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	C 5/5/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSONIAN CARE CENTER	**1700 WHITE STREET MOUNT VERNON, IL 62864**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	FINAL OBSERVATIONS Licensure Findings for Incident Report Investigations of 4-15-04 & Incident Report Investigations of 4-21-04 300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. 300.3100d)2) All exterior doors shall be	F9999		

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F9999	Continued From page 9 equipped with a signal that will alert the 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 constant 24-hour-a-day supervision of the door, a signal is not required. 300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT.(sections 2-107 of the Act) Based on medical record review, facility observation, staff, resident and family interviews and facility policy and procedures, the facility failed to provide adequate supervision to prevent the elopement of one resident (R1), from the sample of 7. The facility identified seven residents at risk for elopement that were wearing electronic wandering devices, these residents did not have elopement assessments with care plan approaches to prevent elopement (R1, R3, R4, R5, R6, R7. R9). R1 who is cognitively impaired and at risk for elopement, left the facility on 04-21-04 without staff knowledge. Findings include: 1. R1 is a 90 year old resident admitted on 8-28-03 with diagnoses including Alzheimer's Disease, Dementia and Macular Degeneration. The most recent quarterly Minimum Data Set Assessment (MDS) completed 2-12-04 states R1 has short and long term memory problems and is severely impaired for cognitive skills for daily decision making. R1 also was identified to have wandering behavior that occurs 1 to 3 times in the past 7 days. A history of wandering was noted per	F9999		

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F9999	Continued From page 10 interview with E6 (CNA) on 5-3-04 at 3:05pm, stating R1 had gotten out of the facility to the parking lot sometime in February 2004. Nurses notes state R1 wanders around the facility and often goes to the doors setting off alarms. Per interview with R1 on 5-3-04 at 1:20pm, R1 was aware of her name and recognized family members but was not aware of where she was, the date, or time of year. R1 was observed ambulating unassisted aimlessly during the survey on 5-3-04 and 5-5-04. According to the facility incident report, investigation report, and nurses notes in the clinical record review all dated 4-21-04, R1 eloped from the facility at 5:30am. R1 was last observed by staff wandering east on the West hall at 5:20am. At 5:30am E9 and E10 (CNAs) entered R1's room to dress the resident for the day. They discovered R1 was missing. A facility wide search was conducted inside then outside on the facility premises. R1 was found at 5:35am sitting under a tree on the facility grounds approximately 150 feet from the building dressed only in a cotton facility nightgown and slipper grip socks. The outside temperature was 62 degrees F. Two .5cm skin tears were noted on R1's right forearm. These areas were cleansed and a dressing applied. R1 was returned to the facility by 2 staff members. R1 was ambulatory with a steady gait and the electronic monitoring bracelet in place. This electronic monitoring bracelet only works at the front door. R1 was confused and did not know where she was. No periodic location checks for this resident are in place or were done prior to or after the elopement. The facility staff was unsure as to how the resident left the building. According to nurses notes dated 4-21-04 and interview with	F9999		

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F9999	Continued From page 11 E4 (LPN), R1 was very agitated prior to the elopement wandering up and down the halls, this behavior was unusual for R1. The Administrator and Director of Nurses were not made aware of R1's elopement until they arrived at work at approximately 8:15am on 4-21-04. Facility policy and procedure for "Elopement of a Resident" states the administrator and director of nurses should be notified immediately. The family was not notified of the elopement until 10:15am on the 4-21-04, and the administrator and Director of nurses were not notified when the resident was found. Facility policy states "once the resident is found notify the administrator, regional director, police and family/guardian at this time." According to interview with Z1 (physician) on 5-3-04 at 1:45pm, he was not made aware of R1's elopement. Z1 stated R1 would not be aware of safety hazards and would not be safe to be outside alone. Z1 stated R1 had severe Alzheimer's disease scoring less that 10 on a mini mental exam. According to staff interviews conducted on 5-3-04 with E1 (Adm), E2 (DON), E4 (LPN), all stated R1 was confused and not oriented to time and place and would not be aware of safety hazards. When R1 was questioned about safety hazards on 5-3-04 at 1:20pm, she stated she would cross a creek if needed to get to the other side. Z2 and Z3 (family) stated R1 crossed the street at home without looking for cars prior to admission to the nursing home. According to phone interview with E4 (LPN-charge nurse) on 5-3-04 at 3:20pm, she was not aware which door R1 exited. R1 had an electronic monitoring bracelet on and the alarm sounded at	F9999		

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F9999	Continued From page 12 the front door when R1 reentered. E4 stated the East hall door was also checked and was working at that time. The other door alarms were not checked at that time. E2 (DON) stated she checked all exit door alarms when she was made aware of the elopement at 8:15am on 4-21-04 and all were working. R1 was found approximately 150 feet west of the building on the facility's property sitting under a tree on the grass. R1 would have crossed a small ditch and uneven terrain to reach the tree where she was found. Hazards in the vicinity include a small wooded area to the north with rough and rugged terrain and a busy residential road named Deadman's Street to the west with a large ditch on the other side of the road. A hospital is located 1 block south of the facility. F324 was cited for Incident Report Investigation dated 4-21-04. F157 was cited for Incident Report Investigation dated 4-15-04.	F9999		