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	145488	A. BUILDING ______ B. WING ______	C **01/07/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDERS-VAUGHN HAVEN	**135 SOUTH MORGAN STREET RUSHVILLE, IL 62681**

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F9999	FINAL OBSERVATIONS 300.1210(a) 300.1210(b)(6) 300.3100(d)(2) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F9999		

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F9999	Continued From page 10	F9999		

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.

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.

All exterior doors shall be 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.

These requirements were not met as evidenced by:

Based on observation, record review, and interview, the facility failed to reapply a personal alarm bracelet to 1 of 11 residents (R1) identified as wanderers, after R1 was readmitted from the hospital. The facility failed to have a system in place to monitor alarmed exit doors. R1 exited the building unattended and unnoticed by staff. R 1 was found approximately 105 feet beyond facility property and inside a parked vehicle.

Findings include:

R1 is a 82 year old male resident who was

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F9999	Continued From page 11 admitted to the facility on 12/31/03 and readmitted on 12/13/04 per review of the current admission sheet. Among R1's Diagnoses included on the face sheet are: Dementia with Behavioral Disturbance, Diabetes Mellitus and Coronary Atherosclerosis. R1's current MDS (Minimum Data Set) dated 12/17/04, identifies him as being moderately impaired for Cognitive Skills for Daily Decision Making and having both short and long term memory problems. It also identifies him as having a behavior of wandering and an unsteady gait. A Physical Therapy Evaluation dated 12/15/04 indicates that R1 is confused, impulsive, has poor safety awareness, is Ataxic (having an impaired ability to coordinate movement) and requires gait assistance that is to be provided by an ambulator (an enclosed rolling chair). R1's care plan dated 09/25/04 was reviewed. It indicates that R1 is to wear a personal alarm bracelet at all times. On 12/28/04 at 10:40 a.m., R1 was interviewed. R1 was asked what his name was. R1 stated, "I'll think of it pretty soon." R1 was asked what year it was. R1 stated "19, uh, 19, uh." R1 was asked when his birth date is. R1 responded, "I don't remember." He did not respond when asked what town he is in. At 10:58 a.m. he responded with "1918." When asked if that is his birth year, he stated, "Yeah." Review of record face sheet indicates his birthday to be 9/11/1922. R1 was asked if there are stop lights in this town R1 stated, "I don't remember." He was then asked if he knew what a green light or red light on a stop light meant. R1 stated, "I don't remember." During interview with Z2,(R1's spouse) at 9:00 a.m. on 12/29/04 regarding R1's cognition, Z2	F9999		

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F9999	Continued From page 12	F9999		

stated, "He talks to you but nothing registers."

The facility incident report dated 12/17/04 documents that at 5:45 p.m., " 'CNA' (Certified Nurse Aide), reported that ' res.' (resident's) supper was still in ' D/R' (dining room) untouched and wondered if (E4), LPN (Licensed Practical Nurse) had seen him. Resident was not located in his room. Staff searched facility and was unable to locate him. At this time notified Director of Nursing (D.O.N.) and the Sheriff's dept. to help look for him'. Incident report continues, "Family member found resident sitting in a parked car with door cracked. Ambulator was tipped over beside the car. The bar was still latched with seat belt locked around bar."

E2, (Administrator), was interviewed on 12/28/04 at 10:55 a.m. regarding how the facility determined which door R1 exited. E2 stated, "We think he exited the West entrance door because of interviews with (R4) and (R2's) wife, (Z1). They said they saw him going down the hall where that door is located and we think he was looking for his old room on that hall."

At 12:30 p.m. on 12/28/04, Z3 (a visitor) was interviewed regarding finding R1. Z3 stated, "I always come to feed my wife around 5:30 p.m. It was almost time for me to go when I noticed a lot of activity in the hall. I asked the girls, 'Is someone missing?'. They said yes and then they scattered to search. I looked out in this parking lot, not there, then I went West down the driveway to the front street. It was plenty dark, but I just happened to see something shining in front of the second house past the facility. It looked like a walker. It was tipped over, empty,

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F9999	Continued From page 13	F9999		

but the bar was locked. I looked on down the street. At the next residence, I saw a dome light on in a parked car. The door was cracked causing the dome light to come on or else I would have never seen it. He was lying on the front seat fiddling under the dash of the car. The keys were not in it. He said to me, 'Can't get the d--- thing started'. Z7, R6's daughter, who was also visiting at this time added, "That street intersects with the truck route. That's a very busy street." Z3 stated, "I know he was dressed, shoes, no jacket, and he didn't have a hat on."

The Midwest Regional Climate Center noted the temperature in the area on 12/17/04 to be 27 degrees at 5:42 p.m. and 25 degrees at 6:42 p.m ..

On 12/28/04 at 10:20, E2 was asked to see the facility policy for identifying and monitoring wandering residents. E2 said she would look for one. At 2:50 p.m. E2 returned and stated, "We do not have a policy a procedure for identifying wanderers." At 12:40 p.m. on 12/28/04, E2 was asked for a wandering assessment for R1 to explain why R1 had worn a personal alarm bracelet before going to the hospital on 12/09/04. E2 stated, "We don't use a wandering assessment form. The care plan team discusses the risk and determines if an alarm bracelet is needed." E2 was asked if R1 had exited the building previous to the 12/17/04 incident. E2 replied, "I guess there was one time a year ago." Review of R1's nurse's notes for 1/7/04 at 6:45 p. m., documents the following: R1 went out door and down to sidewalk. Brought back by staff. Review of R1's RAPs (Resident Assessment Protocol) dated 1/4/04, indicates in the RAP

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F9999	Continued From page 14 summary statement that during the admission process, R1's wife had informed the facility of wandering behavior at home. It also indicates that R1 had exited the facility on 1/7/04. On 12/29/04, E2 provided surveyor with a policy on wandering residents. The policy was not dated as to its implementation. Review of the policy identifies that residents at risk for harm because of wandering (elopement) will be assessed by the care planning team. E2 was asked for the facility door alarm policy and procedure on 12/29/04 at 2:10 p.m. E2 stated, "We don't have it written, it is just understood." E2 was asked how new hires are instructed on the door alarm monitoring and procedure. E2 stated, "We explain it to them during orientation. It has always been just understood." Employees 2,4,5,11,13 and 15 were interviewed regarding R1 wearing a personal alarm bracelet. All stated that he was not wearing one on the day of the incident. All stated that he had worn it before he went to the hospital on 12/09/04 but did not have it when readmitted on 12/13/04 and that it was reapplied after the incident occurred on 12/17/04. E2 was asked in an interview on 12/28/04 at 10:55 a.m., why R1 was not wearing a personal alarm bracelet at the time of the incident. E2 stated, "We took the personal alarm bracelet off him when he went to the hospital because we never get them back." At 11:25 a.m. on 12/28/04, E3, (Maintenance Supervisor), explained and demonstrated the alarm system including two light panels. These panels were noted to have each door designated	F9999		

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F9999	Continued From page 15 with a number and a light which lights in red when any of the doors are opened. These are associated with the main alarm system. The main alarms are turned off by using the reset button on the light panels. E3 explained that door #2 and door #10 are equipped with alarms that are activated by personal alarm bracelets. He demonstrated another alarm on all exit doors as motion detector alarms which alert when approached. They must be reset at the door after being activated. The facility was observed to be a multi level facility. Offices, laundry, and dietary are located on the lower level. The upper level houses the residents on two separate wings. One is located on the North end of the property. The other wing is on the East end of the property and extends into the South end of the property. Each exit door is numbered from 1 to 10 on the upper level. R1 has resided since readmission on the East side wing within close proximity of the South end entrance designated as door #10. The door R1 is assumed to have exited from is on the North end wing and is designated as #2. Door #10 is in visual contact with the Nurses station when staff are present. Door #2 is only in direct visual contact of the business office which is staffed on weekdays during business hours only. Staff must physically walk to this door to check is someone has exited it. On 12/28/04 at 11:15 a.m., the surveyor walked down the West wing and turned left into the foyer to door #2,(the door that the facility assumes R1 exited). The surveyor approached the door to determine if the alarm was functioning. Alarms sounded. E7 (housekeeper) was over heard to	F9999		

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F9999	Continued From page 16 say, "Is that an alarm going off. Would you turn it off?" A male voice responded "Yes, I can do that ." At this time a man came down the hall and into the foyer to door #2 where the alarm was sounding. He reset the alarm and then left the facility. E7 was working in the hallway. E7 was asked if she heard someone tell the man going down the hall to get the alarm. E7 stated, "Yes, that was me. Am I in trouble? He was a visitor." No staff were in visual contact with the door and no staff were observed to come into the area to check the door. E12, (LPN) was interviewed on 12/29/04 at 2:15 p.m. E12 was asked how the door alarms and panels are monitored. E12 stated, "One staff member has to be on the hall at all times. If the alarm sounds, no matter what I am doing, I am to first look at the panel to determine which door it is . If the door is on the other wing, I have to call that hall to check and then I can reset the panel. If it is on this wing, I must visually check the door before I reset the alarm on the panel. On 12/30/04 at 10:06 a.m., a door alarm sounded on the North end wing. E12 walked up the North side hall with another staff member. They turned right off the hall in the direction of the dining room. E 12 then returned alone. She went into the second room on the left. The door alarm then ceased. E 12 did not check the light panel and did not visually check any exit doors. No other staff were observed to check the light panel or the exit doors on this wing at this time. E12 was later informed of this observation. E12 stated, "Oh, I went into a residents room. No, I did not check the panel or the doors."	F9999		