STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146052	A. BUILDING _____ B. WING _____	C 06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA CARE CENTER	**417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001**

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F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS 300.1210a) 300.3100d) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Section 300.3100 General Building Requirements d)2) 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 REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent the elopement of one (R2) of five sampled residents who had been assessed at risk for elopement. R2 left the facility on 6/28/06 without the knowledge of staff. R2 sustained abrasions to his face, right shoulder, and both knees during the elopement attempt.	F9999		

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Findings include:

R2 is an 80 year old man. His physician's order sheet, dated June 2006, indicated that he had a partial diagnosis of Alzheimer's Disease with Psychosis. R2 receives Risperdal (an anti-psychotic medication) 0.5 milligrams (mg) daily, Zyprexa (an anti-psychotic medication) 5mg at bedtime, and Remeron (an anti-depressant medication) 7.5 mg at bedtime.

R2's Minimum Data Set (MDS), dated 4/21/06, documented R2 had short and long-term memory problems. The MDS noted he wandered daily, had episodes of verbal and physical abusiveness, socially inappropriate behavior, and resisting care. The MDS identified R2 was easily distracted, had periods of altered perception, periods of restlessness, periods of lethargy, and his mental function varied over the course of day.

The MDS identified R2 had impaired vision, unsteady gait and had fallen in the last 30 days. R2's Delirium Rap Module, dated 4/22/06, documented the following:
"He is very anxious with repetitive movements, inability to sit still, difficult to involve in activities (and) re-direct away from door as he tries to elope @ (times). He also has trouble in late hrs (hours). Also can be up (and) mobile a lot @ night."

R2's care plan, dated 4/21/06, identified R2 had severe disorientation to time and place. The care plan noted that R2 believed he was in his work place and that the staff are all his employees. R2 wanders about the facility without regard to safety

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and is apt to attempt to leave the facility unattended. The goal for this problem identified " Continued safety of resident and no incidents of elopement thru next review, dated 7/20/06. The approaches were as follows:
"Make receptionist personnel aware of wander risk; elopement risk log at each nurses station-updated weekly; monitor resident's location frequently; re-direct away from exits to more appropriate area, i.e. activity or living room; evening door greeters to provide 1:1 re-direction; and frequent checks for location at least Q (every) 30 minutes."

R2's nurse's notes since his admission on 4/10/06 indicated that he had fallen five times. His nurse's note, dated 6/17/06, at 10:00 a.m., noted the following:
"Res (Resident) agitated, attempt to elope x 4, hard to re-direct, took res for walk outside, cont. to be agitated, verbally abuse to staff, will continue to monitor."

On 6/27/06, at 8:06 a.m., a telephone interview was conducted with Z1. Z1 said on 6/26/06, at around 5:50 a.m., she was getting ready for work and looked out her window. Z1 said she saw an elderly man walking down the main road. Z1 said the man was wearing a tank t-shirt and gray jogging pants. She could not re-call if he was wearing shoes. She said it was a cool morning. Z1 said this man was walking directly on the highway and was walking on the side of the road that did not have a sidewalk. She said the man was walking "hunched back." Z1 said the man fell onto the road directly onto his face. Z1 noted the man got up and was bleeding from his face. Z1 said by the time she got her shoes and out of

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her home, he had walked further down the road. Z1 said the man was near the elementary school. Z1 said another man in a truck stopped to assist her and the elderly man. Z1 said the elderly man was bleeding from his face and shoulders. Z1 said the elderly man did not know his name or where he lived. She said the gentleman in the truck assisted the elderly man into the truck, and they returned him to the nursing home. Z1 said when they returned the elderly man to the facility, two employees said they heard an alarm go off, looked around, but could find anyone, so they went back to work. Z1 said the entire episode lasted 10 to 12 minutes, from first seeing the elderly man to taking him back to the facility.

The facility's Report of Incident or Accident to State, dated 6/26/06, documented the following: "Resident sent to ER (Emergency Room) for sustained abrasions to face, R (Right) shoulder, R/L (Right and Left) knee after fall on sidewalk. Returned to facility - no fractures - upon investigation - this was elopement - had left facility's property. Nurse had given meds 5:20 a. m. - returned to facility 5:32 a.m. by 2 citizens of community - (was found walking on sidewalk 3 and 1/2 blocks from facility)."

E2, Director of Nurse's (DON), summary statement of R2's elopement investigation, dated 6/27/06, was reviewed. The statement noted: "Upon investigation with each night employee, 2 night CNA's were on C hall and 1 CNA (day) on A hall at 5 AM on 6/26/06. Charge nurse on A hall passing meds. Alarm sounding on employee entrance (#2 panel board) - new CNA turned off alarm - did go outside of premises to look but didn't see anything and came back in - unsure of

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F9999	Continued From page 12 exact time - knows it was before 5:30 a.m. Charge nurse unaware of alarm sounding and didn't realize resident missing until returned with 2 citizens of community - injury apparent but not life threatening - abrasions cleansed, neuro checks implemented, MD and family notified - sent to ER for eval / tx (treatment) - returned to facility - no fractures - tx order for facial abrasions ." E3's, Certified Nurse's Aide (CNA), statement dated 6/26/06 documented "I (E3) heard the door alarm, went looking around building. I shut off the alarm and walked outside and looked in some of the different areas of the nursing home. I'm sorry I shut off the alarm." On 6/27/06, at 12:30 p.m., during a telephone interview with E3, E3 confirmed her statement. On 6/27/06, at 10:30 a.m., during an interview with E4, Certified Nurse's Aide (CNA), E4 said "(R2) ambulates all day long until exhaustion." E4 noted that R2 wanders down the hallways and into other rooms and is constantly trying to elope. E4 said R2 thinks he is working and looking for paperwork. E4 noted that R2 was not aware of his safety and won't sit down even when his is leaning. E4 noted she was working at the time R 2 eloped. E4 said "There was a new girl, only here 3 days. The new girl looked out and shut off the alarm." E4 said E3 should have told somebody, and the staff would have done a head count to see who was missing. On 6/27/06, the facility's elopement policy and procedures was reviewed. The policy noted " When a door alarm sounds, all employees are responsible to respond to the alarm, by checking	F9999		

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the panel to see what alarm sounded, then to check that door area to determine if indeed a resident did got out the door. In the event it cannot be determined who went out the door, then report to the Charge Nurse on duty who will then direct a head count of all residents, and direct a staff member to go out the door where the alarm sounded to begin conducted a search, while other staff, determines if residents who wander are still in the building, and determine who eloped. The alarm is not to be re-set until it is determined who went through the doors."

On 6/27/06, at 1:55 p.m., R2 was lying in his bed. R2 had multiple blood-reddened abrasions across his nose, cheeks, and chin. The surveyor questioned R2 regarding his injuries. R2 responded "Three times, three times I fell. I was walking but then decided to trot. He had some pretty good moves that I couldn't keep up with." The surveyor questioned R2 if he got into a fight. R2 responded "No, no. I didn't get into a fight. I fell on the street and I was alone. They say it was a miracle my doctor was there and I guess I had enough fluids."

On 6/27/06, at 4:00 p.m., the surveyor met with Z 1 in the area where R2 was found. R2 was found approximately 0.4 miles away from the facility. This road is a heavily traveled road. The speed limit in this area is 30 miles an hour. There is a sidewalk on the north side of the road; however, there is no sidewalk on the south side. Z1 said that R2 was walking down the side of the road without the sidewalk. There is a large ditch on the side of the road. Z1 said "It's amazing he didn't get hurt worse. People fly down this road."

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F9999	Continued From page 14 On 6/27/06, Z2, R2's physician, faxed a signed statement at 4:42 p.m. The statement noted R2 would not be capable of leaving the facility by himself with no staff/ family supervision. The statement noted R2 would not be capable of negotiating safely outside of the facility, such as knowing street signs, negotiating the terrain, crossing the street safely and ambulating independently. On 6/28/06, at 2:00 p.m., during an interview with E5, Licensed Practical Nurse (LPN), E5 said she gave R2 his medications at 5:20 a.m. on 6/26/06. She said he was located in the dining room. She said a little later she heard a door alarm go off. She was passing medications on A- hall. She said she went to the panel, and the employee entrance light was going off. However, the buzzer on the actual employee entrance door was not sounding. E5 said she thought one of the CNAs had "got whoever and shut it off." (A) 300.163 Section 300.163 Alzheimer's Special Care Disclosure A facility that offers to provide care for persons with Alzheimer's disease through an Alzheimer's special care unit or center shall disclose to the Department or to a potential or actual client of the facility the following information in writing on request of the Department or client: a) The form of care or treatment that distinguishes the facility as suitable for persons with Alzheimer's disease;	F9999		

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F9999	Continued From page 15 b) The philosophy of the facility concerning the care or treatment of persons with Alzheimer's disease; c) The facility's pre-admission, admission, and discharge procedures; d) The facility's assessment, care planning, and implementation guidelines in the care and treatment of persons with Alzheimer's disease; e) The facility's minimum and maximum staffing ratios, specifying the general licensed health care provider to client ratio and the trainee health care provider to client ratio; f) The facility's physical environment; g) Activities available to clients at the facility; h) The role of family members in the care of clients at the facility; and i) The costs of care and treatment under the program or at the center. (Section 15 of the Alzheimer's Special Care Disclosure Act) This REGULATION is not met as evidenced by: Based on record review and interview, the facility is providing information to the public that indicates that they are providing Alzheimers specific care, and that they have activities that are designed for Alzheimer/Dementia residents. The facility has failed to disclose the required information (items "a" through "i" as noted above) that are required to be disclosed when operating	F9999		

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F9999	Continued From page 16 a Alzheimer's Special Care Unit. Findings include: On 6/27/06 a review of the facility's brochure documented the facility provides "Alzheimer's Specific Care" and provided "Focused Activities Designed for Alzheimer/Dementia Residents". The facility has not provided the required information concerning the facility's Alzheimers program to prospective residents, current residents, nor to the Department. On 6/28/06, at 1:00 p.m., during an interview with E1 (Administrator), E1 verified that the brochure was the current brochure given to the public and residents. During an interview with Z1 on 6/27/06, Z1 stated that when R2 was returned to the facility on the morning of 6/26/06 after R2 had eloped, staff on duty stated R2 lived on the Alzheimer's unit. (B)	F9999		