

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

PRINTED: 08/15/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2006
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF ENERGY			STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933		
(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	
F 324	Continued From page 3 The facility took the following steps to correct the deficient practice: 1. Facility staff checked all facility exit door alarms to be certain they were in working order on 04-21-06 after notification that R-1 was missing. 2. The resident was re-assessed for elopement risk, and a electronic monitoring device was applied. Resident was placed on every 15 minute visual checks by staff. These steps were completed after R-1 was returned from the hospital on 04-22-06. 3. Resident was moved to a room closer to the nurses desk on 04-22-06. 4. After a thorough investigation the facility concluded that the resident left the facility by the North West door across from the kitchen. 5. The facility completed inservice training for all staff regarding Code Yellow /elopement policies and procedures. The in-service training was completed on 04-24-06.	F 324			
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.1210a) 300.3100d)2) Section 300.1210 General Requirements for Nursing and Personal Care	F9999			

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F9999	<p>Continued From page 4</p> <p>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.</p> <p>Section 300.3100 General Building Requirements</p> <p>d) Doors and Windows</p> <p>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.</p> <p>These REGULATIONS are not met as evidenced by:</p> <p>Based on record review, interviews, and observations, the facility failed to provide adequate supervision to prevent the elopement of 1 resident (R-1) from the sample of 4. R-1 eloped from the facility without staff's knowledge on 04-21-06 at approximately 9:45 PM.</p> <p>Findings Include:</p> <p>R-1 was admitted to the facility on 04-20-06 from a sheltered care facility. Per review of staff written statements dated 04-22-06, E-5 (Certified Nurse Aide) saw R-1 sitting at the nurses station</p>	F9999			

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F9999	<p>Continued From page 5</p> <p>on A-wing at approximately 9:15 PM on 04-21-06 . E-5 left the area to wash out dirty linen. When E-5 returned to the nursing station area at approximately 9:30 PM, R-1 was not there. E-5 said she started to look for R-1. When she could not find her, she notified the Licensed Practical Nurse (LPN) that was passing medication on C-wing (E-7).</p> <p>Per written statement by E-7 (LPN), dated 04-21-06, a CNA told her that staff could not find R-1 at 10PM. After she was notified, a full search of the facility and notification of required staff was begun. The notification included the local police department.</p> <p>Per interviews done with E-4 (CNA) and E-5 (CNA) on 05-01-06 at approximately 2:30 PM, both were assigned to work on A-wing the night of 04-21-06. Neither of the staff heard a door alarm go off while R-1 was out of their visual range. E-4 and E-5 also said during the interview that R-1 was not able to make sound decisions regarding safety issues due to her confusion. E-6 (Licensed Practical Nurse) was interviewed on 05-01-06 at 3:PM. E-6 stated that R-1 could not make good safety decisions because of her confused state.</p> <p>Facility staff and local police searched for R-1 until approximately 1:30 AM, when Z-1 (police officer) found R-1. Per Z-1's written report dated 04-21-06, R-1 was observed lying on the grass beside the foundation of a house located at 106 Madison St. (this home is approximately 90 to 100 yards from the facility, depending on which exit R-1 used to leave the facility.)</p>	F9999			

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F9999	<p>Continued From page 6</p> <p>R-1 had to navigate a gravel driveway and walk across an uneven grass covered lot if she took a direct route from the facility to the area where she was found. R-1 was asleep when found and seemed confused when she awoke. R-1 thought she was at a friends house in Benton IL. Per the report, R-1 was shaking uncontrollably. Per interview with Z-1 by phone on 05-01-06 at 3:05 PM, R-1 was wearing a short sleeved top, pants, and shoes without socks. Per Z-1, he did not touch R-1, but knew that the grass was wet with dew, and said that he would think that R-1's clothing was wet due to the wet grass she was lying on.</p> <p>Per review of an Internet weather web site, the temperature at 9:25 PM in Energy was 59 degrees. At 10:05 PM the temperature was 57. At 11:25 PM the temperature remained at 57 degrees. When R-1 was found at 1:30 AM, the temperature was 55 degrees.</p> <p>R-1 was transferred to a local hospital for evaluation and returned to the facility at 4:05 AM with orders for triple antibiotic ointment and a band aide to be applied to her right knee for a scrape she had suffered while out of the facility.</p> <p>(A)</p>	F9999			