STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

FRIENDSHIP MANOR — Facility Name
0024760 — I.D. Number

1209 21ST AVENUE, ROCK ISLAND, ILLINOIS 61201 — Address

11/04/2004 — Date of Survey

Incident report investigation — Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210a) The Facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial 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 that resident.

300.1210b)6) 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.

These REGULATIONS are not met as evidenced by:

Based on observation, record review, and interview, the facility failed to monitor 1 of 8 resident wearing an electric monitoring device. R1, who is a known wanderer/exit seeker, exited the facility without staff's knowledge. R1 was discovered lying in a flower bed approximately fifty yards from the entrance to the infirmary. The facility was unaware of R1's whereabouts until notified by a nursing student who was on her way home from the facility. The facility also failed to monitor one resident R9 who exhibited wandering tendencies, and was identified as being confused and at risk for lack of safety awareness. R9 exited the facility unattended and unknown by staff, being found wearing one slipper, in the facility parking lot, by a staff member.

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Findings include:

1. R1 is a 92-year old female, who was admitted to the facility on 03/09/01. Among her diagnoses listed on her current physicians order form, dated 10/01/04 through 10/31/04, is Dementia.

R1's current MDS (Minimum Data Set) dated 09/03/04 identifies her as being severely impaired for Cognitive Skills for Daily Decision Making with both short and long term memory problems and able to recall her room only. The MDS also listed R1 as having periods of altered perception or awareness of her surroundings and behaviors of wandering 1 to 3 times during the past 7 days which was not easily altered. R1's fall risk assessments for the past five quarters identifies R1 as at a high risk for falls. Nurses Notes indicate that R1 had one fall 04/04/04 and one 09/04/04. R1's interim resident status sheet dated 09/08/04 indicates that R1 wears an electronic monitoring device on her ankle. R1's monthly summary indicates that R1 ambulates independently and forgets to complete tasks due to Dementia with a safety note that R1 will occasionally walk out door. Nurses Notes dated 08/10/04 indicate that R1 left the facility, was found on 12th Street and returned by a dietary staff member at 8:00 P.M. on that date. On 08/24/04 at 5:00 P.M. R1 went up the elevator and was retrieved by staff.
R1's Resident Care Guide dated 09/08/04 indicated that R1 had poor decision making skills, poor long and short term memory, and attempts to go outside and would forget to get back in the facility if she left. R1 is not to leave the facility unattended and wears an electronic alarm on her ankle.

Interview at 9:00 A.M. on 10/21/04 with R1 was unable to answer questions regarding what season of year it was or where she actually lives. R1 at times failed to complete her sentences and mumbled unintelligible answers to questions. R1 did not recall the incident of 10/08/04.

Incident report dated 10/08/04 indicated that the facility was notified at 10:20 P.M. on 10/08/04 by Z1 (Nursing Student) calling on her cell phone that R1 was lying in the garden, next to the parking lot near the north-east corner of the facility. E3 (Registered Nurse) responded by asking two Certified Nurse Aids (CNA's) to go and retrieve R1. One of the CNA's returned to have E3 come out as R1 was lying on the ground.

Telephone contact at 3:15 P.M. on 10/28/04 with Z2 (The Midwest Regional Climate Center in Champaign) affirmed that the air temperature at the Moline Airport at 9:52 P.M.on 10/08/04 was 64 degrees Fahrenheit with humidity of 58 percent and clear conditions.

Interview at 10:30 A.M. on 10/21/04 with E3 indicated that R1 was last seen approximately 9:45 P.M. on 10/21/04 while two CNA's were taking R1 to her room. E3 stated that R1 wears an electronic monitoring device and that none of the staff working that evening had heard any alarms sounding between 9:00 P.M. and 10:00 P.M. E3 stated that R1 wanders all of the time and when she roams near the exit doors the alarm sounds and staff go to retrieve her. E3 said that she did not feel that R1 would be aware of her own safety if out of the facility on her own and added that though R1 knows the staff that she will slap at them and push them away, at

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times, during cares. E3 also said that when she brought R1 back in the building through the main entrance, which was closest to where R1 was found, the door signal did sound. E3 also said that R1 was wearing a front and a back patient gown and a pair of shoes when found. E3 said that R1 told her she was looking at the flowers when E3 asked her what she was doing out there.

Tour of the facility at 9:45 A.M. on 10/21/04 confirmed that exit doors number 1 at the main entrance, 3 near the elevator, 4 at the elevator, 7 at the west side of the dining room, 8 at the west side of the other dining room and 9 to the dining room in the apartment side of the complex all have alarm signals that are activated by the electronic sensing bracelets worn by certain residents. All of the alarms functioned as designed with the exception of door alarm number 9. This door alarm did not sound during five attempts to pass through it. The code alert transmitter tester was checked and found to be working properly. The exit doors number 2, 5, and 6 have an alarm that sounds whenever the door is opened without the need of an electrotonic sensing device. These three door alarms were working as designed. All of the alarms have to be shut off manually when sounding by the use of a code punched into a key pad mounted on the wall at each door location. At 10:10 A.M. on 10/21/04, E4 (Maintenance Person) notified this surveyor that he had corrected the malfunction on door number 9. E4 said that he had adjusted the wall wand that senses the signal emitted by the electronic monitoring bracelets worn by certain residents. This was re-tested by the surveyor and found to be working properly at that time. E4 said that the wall wand was pushed off center and that he felt it may have been done by being hit by a wheelchair. Observation during the tour revealed that R1's room is located nearest to the number 9 door. As you pass through the number 9 door you enter the dining room for the apartment dwellers. When you go through the apartment dining room you enter a lobby which has an exit door to the outside going into the parking lot where R1 was found.

When interviewed by E3 all of the staff working on the evening shift, to include E5, E6, E7, E8, E9, E10 and E11, indicated that they were doing cares in resident rooms, or other duties in rooms, and did not see R1 exit the building and did not hear any alarms sound on that shift.

Interview at 1:00 P.M. of 10/21/04 with E12 (CNA) indicated that R1 would not be aware of her own safety in traffic when out of the facility by herself.

Interview at 1:15 P.M. on 10/21/04 with E13 (CNA) revealed that R1 would not be aware of her own safety if out alone and might get in a car for a ride with a stranger. E13 said R1 is in and out of it at times.

Interview at 1:25 P.M. on 10/21/04 with E14 (Licensed Practical Nurse LPN) revealed that R1 on a good day can be your best friend and on a bad day not and your worst enemy.

Interview at 1:30 P.M. on 10/21/04 with E15 (CNA) revealed that R1 would not be aware of her own safety if outside alone and that she would probably get in a car with a stranger if one stopped to ask her if she wanted a ride. E15 said that R1 wanders all of the time and says that

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she is going to church or to get her mother.

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The facility is located in a downtown area and is surrounded by city streets with sidewalks and very little traffic. The speed limit on the streets surrounding the facility is 25 miles per hour.

2. R9 is an 84-year-old female who was admitted to the facility's Shelter Care Unit on 08/13/04 and transferred to the Health Care Unit on 09/27/04 because of declining health. Among her diagnoses listed on her current Physicians Order Sheet dated 11/01/04 through 11/30/04 were Insulin Dependent Diabetes Mellitis, Blindness, Chronic Anxiety and Depression. Nurses Notes dated 09/07/04 indicate that R9 was reluctant about her transfer from the Shelter Care Unit to the Health Care Unit.

R9's Admission Nursing Assessment dated 09/27/04 identifies R9 as Anxious, Agitated, Depressed, Confused, with Poor Coordination, Poor Balance and Ambulates with a wheeled walker or wheelchair. R9's Activities of Daily Living Function/ Rehab Potential Assessment dated 10/11/04 identifies R9 as requiring supervision while ambulating due to unsteady gait and poor safety awareness. R9's Medical Social Services Assessment dated 10/14/04 identifies R9 as confused to time and place and not understanding the need for staff assist. R9's Interim Resident Status Sheet dated 10/15/04 identifies R9 as blind, using a walker with one assist, and forgetful. R9's Interim Resident Status Sheet dated 08/17/04 identifies R9 as needing an escort while out on a pass. R9's Fall Assessment dated 10/10/04 identified R9 as being at a High Risk for falls by scoring an eighteen, with ten and over being at high risk. Review of R9's Nurses Notes dated from 09/27/04 through 10/23/04 identify R9 as being confused on eleven occasions.

During an interview at 10:30 A.M. on 11/03/04 with R9, she was oriented to time, date and place. R9 was also able to describe the treatments to the pressure sores on both of her heels and indicate that she would not go outside until they are healed and because she is blind in her left eye and cannot see very well from her right eye. Observation during interview was that R9 had large white bandages on both feet and was wearing slip-in bedroom slippers. R9 did not remember exiting the building on 10/23/04, eleven days previous. R9 also said that it hurts her feet too much to go to the dining room from her room without a wheelchair. This distance is approximately fifteen yards.

Incident report dated 10/23/04 indicated that at 11:00 A.M. on that date R9 was discovered by E20 (Assistant Director of Nursing, ADON) in the parking lot of the facility ambulating with her walker and one slipper on.

Telephone contact at 9:30 A.M. on 11/04/04 with Z2 (Midwest Climate Center, Champaign) confirmed that at the Moline Airport, at 10:52 A.M. on 10/13/04 the air temperature was 71 degrees Fahrenheit, the humidity was 73 percent and it was mostly cloudy.

During interview at 9:10 A.M. on 11/04/04 with E20 (Assistant Director of Nursing, ADON) indicated that an unidentified bystander came to her office at 11:00 A. M. on 10/23/04 and

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notified her that a resident was outside the facility in the parking lot. R9 was found in the turnaround circle of the driveway which is within twenty feet of the entrance door to the reception area of the apartments, attached to the Health Care Unit by the dining rooms for both units. This location is approximately sixty feet from the entrance door to the Health Care Unit. E20 also said that R9 was wearing street clothes and only one bedroom slipper. E20 said that R9 was waving at traffic moving in the parking lot and said she wanted them to stop. E20 said that when she came up to R9 she seemed very confused, did not recognize her and started to yell for the police. E20 said that she felt that R9 would not be aware of her own safety when she was out of the facility alone. E20 said she last saw R9 at 10:30 A.M. on 10/23/04 in the day room watching television. E20 said that R9 did not wear an electronic monitoring bracelet before the incident as she had not exhibited exit seeking behavior up to that time. E20 indicated that immediately after the incident an electronic monitoring bracelet was placed on R9's ankle and she was identified to be evaluated for possible placement in an Alzheimer's Unit. This was also confirmed in the facility's incident report. E20 also confirmed that R9 was blind, had pressure sores on both heels and had her good and bad days with confusion.

Tour of the facility found all of the exit door alarms in good working order. R9's electronic monitoring bracelet was also working as designed.

Interview at 10:10 A.M. on 11/03/04 with E16 (CNA who worked first shift 10/23/04) identified that she was not aware of R9's being outside the facility on 10/23/04 as she was at lunch during that time. E16 did say that R9 wanders in the halls a lot but does not try to go outside. E16 also said that she feels that R9 would not be aware of her own safety when outside the facility and may get in the car with a stranger since she is confused a lot.

Interview at 10:15 A.M. on 11/03/04 with E17 (CNA who worked first shift 10/23/04) identified that she was at lunch when R9 exited the facility and when she came back to the unit R9 was in a wheelchair with E20 and that R9 was confused, agitated and hard to calm down that time. E17 said that R9 is confused much of the time, wanders the halls a lot and some times sets off a door alarm. E17 also said that she feels that R9 would not be aware of her own safety and would probably get in the car with a stranger if she would be out of the facility alone.

Interview at 10:20 A.M. on 11/03/04 with E18 (CNA who worked first shift 10/23/04) identified that she was at lunch when R9 went out on 10/23/04 and that she only heard about the incident later that day. E18 also said that R9 was confused a lot of the time and that she wandered in the halls a lot and some times went out the door but that there was always someone after her to bring her back in. E18 said that she felt that R9 would not be aware of her own safety and would probably get in the car with a stranger if she were out of the facility alone.

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Interview at 10:25 A.M. on 11/03/04 with E19 (CNA Rehabilitation Aide) identified that this was the first that she heard about R9's incident of 10/23/04. E19 said that R9 is confused much of the time but that she was much better this week. E19 also said that R9 uses her walker when she walks in the halls with her help. E19 said that she feels that R9 would not be aware of her own safety if she were out of the facility alone.

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DB:jb/Friendship Manor (11-22-04)

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