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

REGENCY NURSING CARE RESIDENCE — Facility Name
0036178 — I.D. Number

2120 WEST WASHINGTON, SPRINGFIELD, ILLINOIS 62702

Date of Survey: 09/01/2004

Complaint Investigation

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 by 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):

300.1210 General Requirements for Nursing and Personal Care
300.1210b)4)6

a) 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 the resident.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day-a-week basis:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis.

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.

This standard is NOT MET as evidenced by:

1) Based on record review, interview and observation, the facility failed to ensure that 1) residents with cognitive deficits do not leave the facility grounds unsupervised. This occurred in one resident (R5) out of ten sampled residents. In addition, the facility failed to ensure that 2) residents with cognitive deficits and sexually inappropriate behaviors are adequately supervised. This occurred with R3 and R4, R3 and R1, and R3 and R10.

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Findings include:

1) Review of R5's record reveals R5 was admitted to the facility on 08/21/03, with a diagnosis of Dementia. Review of R5's history and physical completed in the hospital by Z1 (physician) on 03/16/04 indicates that "…R5 is quite demented and history is not useful." Review of R5's Nurses' Admission Record indicates that R5 is alert with confusion. Review of nurses' notes dated 03/19/04, indicates that R5 is alert with much confusion. Nurses' notes of 05/03/04 also indicate that R5 is alert and oriented to person only. Review of incident reports reveal that at 7:00 a.m. on 05/09/04, R5 was found off facility grounds standing at a busy intersection at the corner of Chatham Road and Washington Street by a 3-11 staff person who was driving her daughter to work.

Review of R5's record indicates that R5 is alert and oriented to person only.

Interview with E1 (Administrator) and E2 (DON) on 07/15/04, confirms that the facility did not report R5's elopement incident to the Department. In addition, the facility did not send the Department a narrative summary of the incident within seven days of R5's elopement.

Further review of nurses' notes at 1945 (7:45 p.m.) on 04/05/04, indicates that R5 exited the west side door, setting off the alarm. When checked by staff, R5 was found sitting in an unlocked car in the west parking lot. R5 was brought back into the facility without difficulty. On 04/09/04 at 2005 (8:05 p.m.), R5 attempted to exit out the southwest door. At 2015 (8:15 p.m.), R5 exited out the northwest door. R5 was found walking down the ramp with his walker. R5 returned to the facility without resistance. In addition, review of R5's nurses' notes indicate at 0700 (7:00 a.m.) on 05/09/04, reveals E7 (certified nursing assistant – CNA) brought R5 back to the facility through the front lobby. E7 (CNA) said she was on her way to the facility to drop her daughter off at work when she spotted R5 standing at the corner of Chatham road and Washington street with his walker. Electronic monitoring device still in place on left wrist. E8 (Registered Nurse – RN) and another CNA assisted R5 to a wheelchair and taken to his room. Assisted R5 to his bed and assessed him for any bruising, skin tears or abrasions and none found. R5 stated, "I'm okay, I'm just tired now let me lay down." At 1045 (10:45 a.m.) per E8 (RN) "….R5 has new electronic monitoring device to left wrist and also to R5's walker".

Interview with E8 (RN) at 2:55 p.m. on 08/30/04 reveals that R5 has had an electronic monitoring device possibly since admission. In fact, R5's electronic monitoring device activated the alarm when R5 was brought back into the facility through the front entrance lobby doors. E8 (RN) also indicated that R5 had a jacket on when he returned. E8 (RN) said that the electronic monitoring device does not always activate the alarm when clothing covers the device. In addition, E8 (RN) indicated that if other objects are blocking the electronic monitoring device, or the door has not closed completely before a resident passes by the receiver, the electronic monitoring device may not activate the alarm. E8 (RN) also indicated that usually on weekends, the front entrance lobby doors are not unlocked until 8:00 a.m. or

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9:00 a.m. Telephone interview with E8 (RN) at 1:30 p.m. on 08/31/04, reveals E8 (RN) went back and checked her schedule and found that E9 (RN) was working the east hall the day of the incident.

Telephone interview with E7 (CNA) at 10:35 a.m. on 08/31/04, reveals that E7 (CNA) spotted R5 walking on the sidewalk with his walker unsupervised down Washington street a little before 7:00 a.m. on Sunday, 05/09/04. R5 was just a little past the east drive to the facility at the bottom of the hill before you get to Chatham road. E7 (CNA) indicated that she walked R5 back to the facility as she was unsure if R5 would have been able to get into her truck or be willing. In addition, E7 (CNA) indicated that she believes R5 had his blue and white striped pajamas on at the time of the 05/09/04 incident.

Interview with E2 (Director of Nursing – DON) on 08/30/04 reveals that E9 (RN) was a new nurse orienting on the east hall the day of R5's incident. Further facility investigation of R5's incident on 05/09/04 reveals that E9 (RN) had turned the lobby door alarm off when staff had entered and did not reset the alarm to keep the doors monitored. In addition, E2 (DON) watched the video tape of the front lobby for the date of R5's 05/09/04 incident and confirmed that R5 exited the facility through the front entrance lobby doors.

Observation made of door alarm panel and electronic monitoring device panel made with E2 (DON) on 08/34/04.

Observation of R5 at 3:15 p.m. on 08/30/04 reveals R5 to be laying on his bed in his room and complaining of shortness of breath. This information was relayed to the facility nurse.

Interview with R5 at 3:20 p.m. on 08/30/04 reveals that R5 responds appropriately when asked his name. When asked if he knows what it is, R5 indicates that he does not know.

2) Review of R3's record reveals that R3 was admitted to the facility on 05/26/04 with a diagnosis of Alzheimer's Dementia. Review of R3's hospital Psychiatric Social Service Assessment dated 04/28/04 indicates that R3 was admitted to the hospital due to inappropriate aggressive sexual behavior. In addition, R3 is not considered to be a reliable source of information. Review of R3's Nurses' Admission Record assessment indicates that R3 is alert with confusion on day of admission 05/26/04. Review of R3's nurses notes indicate that R3 is alert and oriented to person only.

Review of R4's record reveals that R4 was admitted to the facility on 11/22/99 with a diagnosis of Alzheimer's Type Dementia. Review of Nursing Monthly Summary reveals that R4 is alert and oriented to person only. Review of nurses' notes dated 01/05/04 indicate that R4 is alert and oriented to person only.

Review of R1's record reveals that R1 was admitted to the facility on 03/15/04 with a diagnosis of Alzheimer's – Advanced with combativeness. Review of the Nurses' Admission Record assessment indicates that R1 is alert with confusion. Review of R1's nurses' notes indicate that R1 is alert and oriented to person only on 03/16/04, 05/06/04, 05/15/04 and 06/05/04.

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Review of 06/11/04 Nursing Monthly Summary indicates that R1 is alert and oriented to person only.

Telephone interview with E2 (DON) at 1:30 p.m. on 08/31/04, reveals that R10 is alert and oriented to person only. R10 is totally dependent on nursing staff for activities of daily living.

A) Review of R3's nurses' notes at 1645 (4:45 p.m.) on 05/30/04, indicate that a visitor reported inappropriate behavior between R3 and R4 in sunroom. R3 noted to be sitting on the couch in the sunroom with pants down to knees. R4 was sitting next to R3 with her hand on his penis with hand movement noted. R3 and R4 were separated.

B) Further review of R3's notes at 2015 (8:15 p.m.) on 06/19/04, indicate that R3 was sitting on a chair by the nurses' station and had R1 sitting on his lap with his hands up R1's disposable incontinent brief, between R1's legs and thighs. Staff immediately separated R3 and R1.

C) Review of R3's nurses' notes at 1100 (11:00 a.m.) on 06/24/04 reveals R3 sitting in chair with hands on R1's lap, playing with her bottom. One-to-one given about inappropriate behavior.

Interview with E2 (DON) at 11:15 a.m. on 09/01/04, reveals that R3 actually had his hand on R1's knee and that R3 touched a female staff person on the bottom as she walked by R3.

D) Review of R3's nurses' notes at 2000 (8:00 p.m.) on 06/27/04 reveals that R3 was sitting on a love seat with pants and underwear down to his knees and had his hand on his penis. Unknown female resident sitting next to R3. R3 removed from area. R3 returned and attempted to fondle unknown female resident. R3 requiring constant supervision.

Telephone interview with E2 (DON) at 1:30 p.m. on 08/31/04 reveals that she believes that the above unknown female was R1. Unable to confirm as no incident report completed.

Further review of R3's nurses' notes indicate that at 2020 (8:20 p.m.) on 06/27/04, R3 approaches E10 (RN) with his pants on and his hand over penis stating, "I've got a present for you." R3 was taken to his room and redirected per CNA.

E) Review of R3's nurses' notes indicate that at 2000 (8:00 p.m.) on 08/14/04, R3 was found in R10's room standing over R10 while she is in bed. R3 had his hands inside R10's disposable incontinent brief fondling R10's genitals. R3 removed and one-to-one about inappropriate behavior given.

At 2020 (8:20 p.m.) on 08/14/04, R3 was found back in R10's room with his hands in between R10's legs fondling R10 over her clothes. One-to-one given again about inappropriate behavior.

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Review of R3's care plan identifies the following nursing problem, "Potential for injury related to decreased mobility and confusion." Evaluation on 05/30/04, "inappropriate behavior with a female resident, both family's notified of episode watch closely for inappropriate behavior." The following interventions are "call light within reach; area free from obstruction; side rails up if requested; assist with ambulating/transferring; assist with activities of daily living (ADL's); allow resident to do for self; always assure residents' safety; develop a realistic plan with ADL's; emotional support as needed and electronic monitoring device."

(A)