

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

PINCKNEYVILLE HEALTH CARE CENTER 0045260  
\_\_\_\_ Facility Name I.D. Number

708 VIRGINIA COURT, PINCKNEYVILLE, IL 62274  
\_\_\_\_ Address

Date of Survey: 6/24/2004

Incident Report Investigation of 6/9/04

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):**

**300.1210a) 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 the resident.**

**300.1210b)6) All necessary precautions shall be taken to assure that the resident's 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.**

**300.3100d)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 record review, observations, and interviews, the facility failed to provide adequate supervision to prevent the elopement of one resident (R1) from the sample of seven. The facility had identified 10 residents at high risk for elopement. R1, who is cognitively impaired and at risk for elopement, left the facility on 6/9/04 without staff's knowledge.**

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**300.1210a) The findings include:**

**300.1210b)6)**

**300.3100d)2) R1 is a 78 year old female who was admitted to the facility on 11/13/03. R1 was admitted with**

**(Cont'd.) the diagnosis of Alzheimers, Dementia, Hypertension, and Hypercholesterolemia. R1's assessment of 5/21/04 indicated that R1 has short and long term memory loss and is moderately impaired for making daily decisions. The assessment of 2/20/04 indicated that R1 scored a 13 "high risk" when evaluated for elopement risk. The same assessment showed that R1 attempted to leave unattended 1-2 times weekly.**

**The plan of care for R1 identified that R1 was at risk for wandering prior to the elopement, and at risk for falls. The approach to this problem included to encourage R1 to get involved in activities and to keep the environment safe. R1's tracking behavior sheet showed that R1 attempted to elope several times on 6/7/04, 6/8/04, and on 6/9/04 with staff interventions of re-direction and one-to-one. The nurses notes of 6/9/04 at 1845, read: "Has attempted to leave building many times. In Activity room hitting windows." Neither the nurses notes nor the tracking sheet that monitors hitting indicated staffs interventions for these behaviors. The nurses notes of 6/9/04 at 1915 read: "Out of facility. No alarms went off . Walked to corner. Fell in ditch. No apparent injury."**

**Per interview on 6/18/04 at 1:00 p.m., Z1 stated she first saw R1 outside by the front doors around 6:30 p.m. on 6/9/04. Z1 stated R1 was not accompanied by staff so she summoned another neighbor to go tell the facility staff that R1 was out of the facility. By the time Z1 got to R1, R1 had fallen in the shallow ditch by the "for rent" sign in the yard of the facility's adjoining property. At the time of the incident R1 was wearing a sweat outfit and shoes. Z1 noted that R1 was sweating at the time of her arrival but appeared unhurt. R1 told Z1 that she was going home. Z1 used to work at the facility and knows that R1's previous address was St. Louis. R1's previous residence in St. Louis was later confirmed by the record review. Z1 did not feel like R1 knew her surroundings at the time of the incident.**

**An interview with E4 (direct care staff) on 6/18/04 at 2:30 p.m. and incident report review identified that E4 went to retrieve R1 from outside the building on 6/9/04 around 7:15 p.m. E4 confirmed that R1 was completely dressed and without injury; and that R1 stated she was going home. E4 stated that there was no rain nor water in the shallow ditch in which R1 fell. E4 and E3 (direct care staff) both stated that the alarm did not sound to indicate that R1 had left the facility. E3 and E4 also stated that they had just seen R1 five to ten minutes prior to being notified that R1 had left the building. E3 and E4 stated that R1 will frequently attempt to leave the building and at times will wait until staff turn their back before she attempts to open a door.**

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**300.1210a) E3 and E4 both believe that R1 exited the east end door which has a 13 second delay once it is**

**300.1210b)6) originally activated.**

**300.3100d)2)**

**(Cont'd.)**

**An interview with the maintenance man (E6) on 6/18/04 showed that the east end door does not reactivate for 13 seconds once the door is opened from the outside or inside of the building. E6 stated that he checks the alarms daily on Monday thru Friday and had found all the doors to be functioning appropriately before and after the incident. E6 identified that since the incident was believed to be caused from a visitor entering the east end door, the facility now has a lock on the door so no one can enter the door from the outside unless they have the key. E6 also commented that the door is not locked on the inside but is not to be used unless there is a delivery or emergency.**

**Observation of functioning of the east end door on 6/18/04 confirmed that the door could be reopened without alarming after the alarm sounded and was reset. The testing of the door showed that the alarm would only sound if the door was again reopened after the 13 second delay had surpassed. A testing of all the doors on 6/22/04 showed that only the east end door and the door to the court yard had the 13 second delay. All other door alarms sounded immediately after the doors were opened.**

**An interview with R1 on 6/22/04 showed that she knew to stop if she saw a stop sign. R1 stated that she would stop if she saw cars while she was crossing the road. However, R1 did not remember the incident of 6/9/04, did not know that she was in a nursing home, and did not know the day or the time. The record did not indicate that R1 would be able to recognize other dangers. A phone interview with the physician (Z2) on 6/22/04 confirmed that R1 could not be out of the facility without staff members assistance as she is lucid one moment and confused the next.**

**Observation of the site at which R1 was found showed that it was approximately 20 feet from the facility's property line on the west end of the building. The area did have a metal grate in the ditch. However E4 stated on 6/22/04 that R1 fell before she got to the metal grate. An interview per phone with Southern Illinois University Weather Center staff showed that on 6/9/04 at 7:15 p.m., the temperature was 77 degrees Fahrenheit, and the dew point was 68 percent.**

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- 300.1210a) A review of the facility's nursing policy and procedure for "Elopement or Wandering/Missing**
- 300.1210b)6) Resident" showed that the facility failed to follow their own policy and procedure. The policy**
- 300.3100d)2) and procedure stated that the facility will assess all residents for elopement. If the resident scored**
- (Cont'd.) a 9 or higher, the resident would be considered to be at risk for elopement with the staff intervention of placing a red-colored identification bracelet on the resident per physician's orders. Observation of R1 at 11:22 a.m. showed that R1 was not wearing a red identification bracelet. At 1:10 p.m., R2, R3, and R4 also were observed to not have a red identification bracelet despite scoring 9 or higher on the elopement assessments. R5 was identified by E1 (administrator) to be an elopement risk. However, R5's record failed to show that R5 had been evaluated for elopement. At 1:15 p.m. on 6/22/04, R5 was observed to not have a red identification bracelet on.**

(A)

