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

LAHARPE-DAVIER HEALTH CARE CENTER **0035741**

Facility Name **I.D. Number**

101 B STREET, P O BOX #547, LAHARPE, IL 61450
Address

Date of Survey: 07/08/2004

Incident Report Investigation of June 11, 2004 and 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):

300.1210a) **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 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 interviews, the facility failed to monitor 1 of 4 residents with electronic monitoring devices. R1, who is a known wanderer/exit seeker, exited the facility without staff's knowledge. R1 was seen walking 2-3 blocks from the facility near a busy highway. The facility was unaware of R1's whereabouts until notified by a local citizen.

Findings include:

R1 is an 84-year old female, who was admitted to the facility on 04/26/01. Among her diagnoses listed on her current admission face sheet is Dementia of Alzheimer's Type.

R1's current MDS (Minimum Data Set) dated 04/18/04 identifies her as being severely impaired for Cognitive Skills for Daily Decision Making with both short and long term memory problems. It also identifies R1 to have a behavior of wandering. R1's Exit-Seeking/Wandering Assessment dated 04/04/04 indicates that R1 has impaired safety awareness and is at High Risk of elopement. Review of R1's nurses notes from 01/31/04 to 06/11/04 identifies four incidents of R1 opening and/or exiting alarmed exit doors.

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300.1210b)6)
(Cont.)

On 06/23/04 at 10:05 A.M. during interview with R1, she was unable to answer questions regarding what season of the year it was or where she actually lives. She at times failed to complete her sentences when responding.

Incident report dated 06/14/04 indicated that the facility was notified between 7:15 P.M. and 7:30 P.M. by a member of the community that R1 was outside a local church. A staff member went to retrieve the resident who was initially unaccounted for.

The Midwest Regional Climate Center noted the temperature to be 81 degrees at 6:45 P.M. on 06/11/04.

During interview with E1 (Administrator) at 10:00 A.M., E1 stated that R1 was last seen around 6:00 P.M. on 06/11/04 by E8 (Certified Nurses Aide/CNA). E1 stated that R1 wears an electronic safety device, and that no one interviewed had heard any alarms go off that evening. E1 did state that he was recently made aware that R1 has been noted to pry on the hallway West side door with a spoon. E1 then demonstrated how the West side door could be pried open with your fingers.

Tour of the nursing unit on 06/22/04 at 10:00 A.M. reveals one door (the North door) which is equipped with an alarm for electronic monitoring devices. All other exit doors are equipped with keypad alarms. All alarms were functioning at this time. Observation of the hallway double doors reveals that they are located near the nurses station at the end of a hallway leading to the facility front office. The East door is noted to have a keypad alarm located on the door going out of the nursing unit. This door (the East door of the double doors) can only be opened to exit the nursing unit by putting in a code. The opposite door (the West side door of the double doors) is not equipped with a second alarm. Entry into the unit is made by only pushing on the West door. When leaving the unit one is supposed to use the East door, and the West door is not supposed to open out. The West door is equipped with a metal lip which is supposed to prevent it from opening unless the keypad East door is unlocked. E1 stated that they had this metal lip worked on in the past as it could be pried open. On the day of survey, it could still be pried open.

On 06/22/04 at 2:10 p.m., E8 was interviewed and stated, "I last saw R1 in the dining room at 6:00 P.M. as I was clocking out for supper break".

Z4 (a local citizen) was interviewed by telephone at 2:10 P.M. on 06/22/04. Z4 stated, "I had been driving down the highway on 06/11/04 around 7:15 P.M. when I saw R1 in front of a local church and headed down the main street. I noticed a lady walking somewhat unsteady on her feet and then I recognized R1, who I know to be a resident of the nursing home. I proceeded on about 3 blocks to the nursing facility to alert them".

Interview with E11 (CNA) at 10:20 A.M. on 06/24/04 indicates that E11 was notified by Z4 at the facility at approximately 7:30 P.M. that R1 was uptown. E11 stated, "I then went to find her. After driving around for some time I did find her inside of the church based on information provided by Z8, another passerby. R1 was dressed in a long sleeved shirt and was really sweating, but she acted all right. I returned R1 to the facility at approximately 7:45 P.M."

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The facility is located in the downtown area. The facility is surrounded by city streets with sidewalks on three sides. One of the streets is a state highway which has a constant flow of traffic. The speed limit on this street is 25 mph up to 35 mph at the location where she was found.

Interview with E7 (laundry aide) at 10:40 A.M. on 06/23/04 indicated that E7 has in the past observed R1 to try to open the double doors at the nurses station with her fingers.

Interview with E10 (Social Service Director) at 12:50 P.M. on 06/23/04 indicates that E10 had seen R1 pull the double door open last fall. E10 stated, "That time, R1 was headed down the hallway to the front office when I caught her and took her back".

E6 (CNA) was interviewed at 1:20 P.M. E6 stated, "We think R1 went through the double doors. She can pry them open".

E3 (Licensed Practical Nurse/LPN) was interviewed on 06/24/04 at 9:30 A.M. E3 stated, "I have seen R1 in the past pry open the West side door of the double doors."

During interview at 10:30 A.M. with Z3 (R1's daughter) Z3 stated, "I was aware of R1 going through the double doors in the past and getting as far as the front office near the exit doors".

The surveyor confirmed by demonstration at 10:10 A.M. on 06/22/04 that the West door of the double door can be opened from the nursing unit side by slipping the fingers under the lip of the door. Exit can then be undetected.

(A)