

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS

Prairie City Health Care Center <u>Facility Name</u>	0045377 <u>I.D. Number</u>
121 West Elm Street RR#2 Box #97, Prairie City, IL 61470 <u>Address</u>	
	02/05/04 <u>Date of Survey</u>
Incident Report Investigation of 01/22/04 <u>Type of Survey</u>	

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 a) 300.1210 b)6)	<p>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.</p> <p style="padding-left: 40px;"><i>Personal Care, as defined in section 300.330 is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act).</i></p> <p>General nursing care shall be practiced on a 24-hour per day, 7-day per week basis and shall include, at a minimum:</p> <p style="padding-left: 40px;">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.</p> <p>These requirements are not met based on observations, record reviews and interviews, wherein it was determined that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that all residents with electronic monitoring devices were in the facility once the door alarm and electronic monitoring device sounded. 2. The facility failed to monitor 1 of 5 residents at risk for elopement. R1 left the facility unattended and without staff knowledge.
300.1210 a)	Findings include:

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300.1210 b)6
(Cont.)

R1 is a 76 year old resident who was admitted on 4/11/02. Her diagnosis, as listed on the current physicians order sheet (POS), is Alzheimer’s Disease with Psychosis and Depression.

The current resident assessment, dated 10/28/03, identifies R1 as being moderately cognitively impaired with short term memory problems. This also indicates that R1 has a behavior of wandering daily and is independently ambulatory requiring only supervision from the facility staff. The "Resident Tracking Mood And Behavior" form, dated January 2004, verifies that R1 exhibits behaviors of wandering daily. A history and physical done at a hospital just prior to R1's admission at this facility reads, "She had been having marked agitation and increased confusion in the nursing home. She had eloped from the home repeatedly."

R1's current care plan, dated 11/04/03, verifies that R1 is at risk for wandering from the facility unattended due to her confusion. R1's care plan also indicates that R1 wears an electronic monitoring device due to her elopement risk.

The facility's exit doors are alarmed when opened and sound at the door only. They require a key from the charge nurse to turn off at the specific door that sounds. The exit doors are also alarmed with electronic monitoring device units; residents assessed to be an elopement risk wear transmitters. These electronic monitoring device sounds at the door and at the nurse’s station. A push button pad located at the door deactivates them.

On 1/28/04 at 11:13 A.M. R1 was observed to be ambulating independently with staff providing directions on which way to go. R1 had a slight shuffle to her gait. On 1/28/04 at 11:15 A.M., during interview, R1 was unable to answer questions regarding what season of year it was or where she lives. When asked if it was hot or cold outside on the evening of 1/22/04, she was unable to answer. R1 mumbled and refused to answer any more questions.

In a telephone interview at 1:40 P.M. on 1/28/04 Z1 provided the following information: On the evening of 1/22/04 he was driving back from a nearby city on a two-lane highway when he noticed a person (R1) walking right at him in the middle of his lane. Z1 stated that the speed limit was 55 miles per hour where (R1) was and that he had to swerve out of the way in order to miss hitting her. Z1 turned around in a park and went back to check on (R1). Z1 stated that (R1) was between a quarter of a mile to a half of a mile from the facility. When Z1 got back to (R1), Z1 noticed that (R1) was only wearing a sweatshirt, pants and shoes. Z1 stated that (R1) was not wearing a coat and it was "Freezing outside", so he thought something was wrong. Z1 then convinced (R1) to get into his car. Once in the car Z1 attempted to ask (R1) if she was ‘OK’ and where she lived. Z1 stated that (R1) was unable to answer any questions, so he called 911 for some help. During his call to 911, Z1 proceeded to take (R1) to a local gas station to see if any

300.1210 a)

of the employees there knew where (R1) was from. Z1 was told by Z3 that maybe (R1)

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300.1210 b)6 (Cont.)	<p>was from the nursing home down the street. Z1 then drove (R1) down the street to the nursing home, while the county sheriffs department called the nursing home.</p> <p>According to the county sheriff's department, this 911 call came in at 6:44 P.M. On 2/4/04 at 9:45 A.M. Z2 was interviewed by phone. According to Z2 the county sheriff's department called the nursing home at 6:52 P.M. on 1/22/04 to ask if they would check a car outside to see if they were missing a resident. The nursing home staff said they did not think they were missing anyone, but they would check the car anyway. (R1) was in this car.</p> <p>Z3 was interviewed by phone at 7:50 P.M. on 1/29/04; the information given by Z1 was confirmed by Z3. .</p> <p>The Midwestern Regional Climate Center noted the temperature to be 10 degrees Fahrenheit at 6:54 P.M. on 1/22/04.</p> <p>E6, was interviewed on 1/29/04 at 2:10 P.M. by phone. E6 provided the following information: The nursing home staff did not know (R1) was gone until a little after 6:45 P.M. when the county sheriff's department called saying there was a car outside with a person (R1) that might be one of the nursing home residents. The staff went outside and realized it was (R1) that had gotten out. E6 stated that earlier, at approximately 6:30 P.M. on 1/22/04, she went out back of the facility to take a break. As E6 walked back inside, she heard the alarm going off. E5, CNA, met E6 and told E6 that (R2) had set off the door alarm. E6 stated that she then gave E5 the key to shut off the door alarm.</p> <p>E5 was interviewed on 1/29/04 at 10:00 A.M. by phone. E5 provided the following information: E5 was in a resident's room down the east hallway at approximately 6:30 P.M., when she heard the west door alarm going off. When E5 looked out she saw (R2) sitting by the west door with his hand on the door bar. E5 stated that she assumed it was (R2) who set the alarm off. E5 then went to get the key from the nurse to shut the door alarm off. E5 stated when she went to the west hallway door to shut the door alarm off, that she noticed the personal alarm system was also going off. When E5 was asked if (R2) wore a personal alarm system, E5 stated "No". E5 stated that after she turned off both the west door alarm and the personal alarm system, she then gave E6 back the key and went on her break. E5 stated that no one checked the outside perimeter of the facility, nor was a head count done to make sure all of the residents were present.</p> <p>E4 was interviewed on 1/28/04 at 2:33 P.M. in the therapy room. E4 provided the following information: At approximately 6:30 P.M. she was in the shower room at the beginning of west hallway, when she heard the door alarm sound. E4 stated that she leaned out and asked E5 to take care of the alarm because she was busy bathing a resident. E4 stated the alarm was sounding for approximately five minutes before it stopped. E4 stated it then took her another ten to fifteen minutes to finish the bath and when she came out of the shower room E7 told her that they needed help getting (R1) out of Z1's car. E4 stated that (R1) has always tried to get out, but this was the first time</p>	
300.1210 a)		

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300.1210 b)6 (Cont.)	<p>(R1) had gotten out of the facility without any staff realizing it.</p> <p>The facility's "Elopement/Missing Resident Policy And Procedure" at the time of this incident did not inform staff on what steps to take in order to determine if a resident was missing.</p> <p>According to E1's investigation report, facility staff last saw R1 at 6:25 P.M. on 1/22/04. R1 at that time was sitting in the dining room.</p> <p>During an interview with E2, on 1/28/04 at 1:57 P.M., E2 stated that E5 should have realized it was not (R2) that triggered the alarms since E5 had to turn off the personal alarm system and (R2) did not wear an electronic monitoring device.</p> <p style="text-align: center;">“A”</p>