

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS

Asta Care Center of Rockford <u>Facility Name</u>	0041772 <u>I.D. Number</u>
707 West Riverside Boulevard Rockford, IL 61103 <u>Address</u>	
	01/28/04 <u>Date of Survey</u>
Incident Report Investigation of 11/05/03 <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. Prevent the elopement of R6: <ol style="list-style-type: none"> a. Closely monitor R6's whereabouts on 11/5/03 after R6 displayed increased agitation and confusion throughout the day; b. Assess and intervene after R6 displayed increased confusion on 11/5/03; c. Develop a plan to prevent R6 from eloping; d. Keep the door alarm access code to the front exit door confidential from residents with confusion; e. Follow the facility's policy and procedure for elopement;
300.1210 a)	

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300.1210 b)6)
(cont.)

- f. Ensure that residents are properly dressed when going outside of the building.
- 2. Maintain the safety of at least 3 other residents:
 - a. Ensure that call light is accessible and can be utilized by the resident.
 - b. Maintain an electronic monitoring device on a resident with a diagnosis of altered mental status;
 - c. Ensure that a resident going outside to smoke wears a coat during sub-zero temperatures.

These failures resulted in:

- 1. R6 leaving the facility, undetected by staff, on 11/05/03 at approximately 8:00PM. Forty minutes later, a concerned citizen found R6 in a mall parking lot approximately 2/10 of mile away from the facility lot trying to get into parked cars. E13 and E17 walked R6 back to the facility after a concerned citizen made them aware of R6's location.
- 2. The safety and well being of R1, R8, & R25 being potentially compromised.

The findings include:

- 1. R6 has the following diagnoses: Depression with Psychotic Features, Alzheimer's Disease, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary, and Osteoporosis per physician's orders for January 2004. The resident assessment tool, dated 8/19/03, documents R6 as having short-term memory problems. The resident assessment tool dated 11/6/03 documents that R6 continues to have short-term memory problems, is moderately impaired in her decision-making skills and requires supervision. These failures resulted in R6 leaving the facility, undetected by staff, on 11/05/03 at approximately 8:00PM. Forty minutes later, a concerned citizen found R6 in a mall parking lot approximately 2/10 of mile away from the facility lot trying to get into parked cars. E13 and E17 walked R6 back to the facility after a concerned citizen made them aware of R6's location.

The facility's investigation report dated 11/12/03, documents that R6 was upset (on 11/5/03) because physical therapy requested that she use a hemi-walker when she ambulates. R6 was walking very fast and not using her hemi walker. R6 was also not wearing her arm sling related to an injury she sustained during a previous fall (10/19/03). On 11/5/03, staff administered Ativan to R6 at approximately 7:00PM because of her increased agitation and then assisted R6 back to her room at approximately 8:00PM. E15 stated that R6 came to the receptionist desk sometime between 8:15PM and 8:30PM asking for a telephone book. E12 received a call from the 911-operator shortly after 8:30PM stating that someone had called 911 from the facility.

During interviews conducted on 1/21/04 with E1, E9, E11, E12, E13 and E15 surveyors learned that the facility could not determine the exact time R6 left the building unattended on 11/5/03. All staff interviewed verified that R6 left the facility wearing two hospital gowns, sweater & socks and shoes. None of the staff

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300.1210 a)	There was no documentation in R6's clinical record verifying that R6 was wearing an	

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electronic monitoring device on 11/5/03. The facility's electronic monitoring device log sheet documents that staff applied a monitoring bracelet to R6 after she returned to the facility on 11/5/03.

Review of the facility's policy and procedure for Elopement states, "Any staff member should promptly report the suspected absence of a resident to the licensed nurse. Once the resident has been located, the nurse will assess the resident's condition and, if indicated, send her/him for further evaluation and/or treatment."

Review of R6's care plan dated 11/13/03 identifies that R6 has a potential for increased injury risk related to a history of falls. R6 is to have her picture at the front office to alert staff of resident's wandering behavior and increased safety risk. The facility did not address R6's altered thought processes in her plan of care.

During interview on 1/20/04, at approximately 10:00AM, E19 verified that R6 did not have a photo posted at the front desk.

Environmental hazards in the area of the facility include a bridge and a river located less than one block away. A four lane major road is located in the front of the facility; vehicles routinely travel at speeds of 30 miles per hour or more on this road. Traffic is moderate to heavy in the late afternoon and evening. R6 had to cross this street to get to the location where she was found.

2. R1 expressed concerns, in interviews on 1/20/04, 1/21/04 and 1/22/04, about his call light. R1 stated that it was difficult to use his call light since he has little use in both of his hands. Surveyors observed R1 attempting to turn on his call light (pushing the top of the light down) using his mouth and both hands with extreme difficulty. R1 further related that the call light was rarely in reach and often falls short (the cord being too short) of his recliner or electric wheelchair resulting in R1 being unable to reach the light at all. R1 has a tracheostomy, and is unable to call out. Review of R1's resident assessment dated 11/05/03 reveals R1 as being dependent on staff for all ADLs. This assessment lists R1 as having functional limitation in range of motion affecting his arm, hand, and leg with partial loss of voluntary movement. During interview, R1 stated that one night his trach tie came loose and he was frightened. R1 stated his call light was not in reach, and he was unable to contact staff for several hours.

E2 was interviewed 1/22/03 and stated that the facility is acquiring a touch call light for R1 and it should arrive in several days. There is no safety assessment in R1's record, and review of R1's plan of care reveals interventions for injury risk such as keep call light within reach.

3. R8 has diagnoses including Renal Failure and Altered Mental State. Review of the Social Service notes dated 9/12/03 documents "He wears an electronic monitoring device for safety as he attempts to leave the building." A Social Service entry dated 12/3/03 documents "He continues to wear an electronic monitoring device as he has

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300.1210 b)6 (cont.)	<p>made past attempts to leave the building." Review of R8's current care plan with intervention of an electronic monitoring device was discontinued on 12/31/03, and wander photo at desk. The diagnosis of Altered Mental Status has not changed. On 1/22/04, E11 documented R8 is alert to name only and has a history of unescorted exiting of building. Interview with R8 on 1/22/04 reveals that R8 is confused and not a good historian. Surveyors observed R8 during the survey wandering about the facility. Interview with E11, on 1/21/04 at approximately 2:10PM, revealed that E11 was unable to state why the electronic monitoring device was removed and no reason was documented in any records.</p> <p>4. Review of R25's resident assessment dated 12/3/03 reveals R25 as moderately cognitive impaired. R25 has functional limitation in range of motion on one side, the arm, hand, leg and foot. Diagnoses included Congestive Heart Failure and Hemiplegia/Hemiparesis. Surveyors observed R25, numerous times on 1/20/04, 1/21/04 and 1/22/04, out of the facility near the front door smoking cigarettes. R25 was not wearing a winter coat, hat or gloves. The temperature/weather data obtained reveals that temperatures ranged:</p> <p style="padding-left: 40px;">1/20/04 - 10.0° F at 6:54AM with 10 mile MPH wind NNE 12° F at 9:54AM with light snow and 5.8 MPH wind NNE 15.1° F at 12:54PM light snow 16° F at 3:54PM with light snow. On 1/21/04 - 21.9° F at 7:54AM 26.1° F at 9:54AM with wind ranging from 17.3 - 23 MPH SW. 12:54PM the temperature was 32° F 35.1° F at 3:54 PM with 13.8 MPH winds WNW. On 1/22/03 - 7:54AM 0.0° F (not including wind chill factor) with 10 MPH winds. 8:54AM 0.0° F with 10 MPH wind (not including with wind chill factor). On 1/22/04 during interview approximately 9AM on 1/22/03, E1 stated he just goes out and won't listen to you when you ask him to put a coat on.</p> <p style="text-align: center;">“A”</p>