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

BALLARD NURSING CENTER

0023093

Facility Name

I.D. Number

9300 BALLARD ROAD DES PLAINES, IL 60016

Address

Date of Survey: 3/24/04

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 shall provide the necessary care and services to attain or maintain the  
300.1210b)6) highest practicable physical, mental, and psychosocial well-being of the resident, in  
300.2210b)2) accordance with each resident's comprehensive assessment and plan of care.  
Adequate  
300.3100d)2) and properly supervised nursing care and personal care shall be provided to each  
300.3240a) resident to meet the total nursing and personal care needs of the resident.

All necessary precautions shall be taken to assure that the resident's environment remains 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.

Each facility shall:

Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

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- 300.1210a) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves
- 300.1210b)6) 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
- 300.2210b)2) the door, a signal is not required.
- 300.3100d)2) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident.
- 300.3240a)  
(Cont-d.)

Based on observation, staff and resident interviews, record review, the facility failed to supervise one resident (R1) who left the facility on 2/13/04 at approximately 3:30 AM through a back exit door that had a disabled alarm. The door locked behind the resident and the resident could not get back into the facility. R1 left the 3rd floor unit per elevator and was outside the facility during cold weather, until a staff heard R1 knocking on the back exit door. The facility was not aware that the alarm at the back exit door was disabled and was not functioning effectively to alert the facility that R1 had opened it and was locked-out outside.

**FINDINGS INCLUDE :**

Per record review, R1 has diagnoses of Alzheimer's Disease, Dementia, Hypertension, Anemia, Cataract, Diabetes Mellitus, history of Fractured Right Hip and has a Pacemaker.

Per Social History and Social Service Quarterly Reassessment dated 6/6/03, 9/5/03, and 12/5/03, "(R1) remains alert but confused." It was also documented that R1 wanders around the unit. Furthermore, the Social Service Assessment dated 3/8/04 noted that R1 is confused with non-intact short term and long term memory, and was identified as severely impaired in Decision - making ability. R1's nursing assessment dated 12/6/03 and 3/8/04 was consistently coded as per above assessment. Per MDS, R1 has a severe impairment in Cognitive Decision- making skills. Also, per interview of E8 (Certified Nurse Assistant / CNA) and E12 ( nurse ), R1 is confused.

Per Z1 (attending physician of R1), R1 can be deceiving because R1 can carry a normal conversation but if one digs deeper, there is severe cognitive impairment. Per R1's record, it also was documented in her Social History that R1's language poses a communication problem as she only speaks in Spanish and cannot read or write in English language.

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- 300.1210a) Per R1's incident report dated 2/13/04, at around 4:30 AM: R1 was " found at the back door  
300.1210b)6) of the facility, standing, and banging at the door." R1 was noted with "cold skin and shaky"  
300.2210b)2) during this time. Noted also were "2 bumps to both occipito-parietal area ( 1.5 x 1.5) and a "  
300.3100d)2) skin tear to right elbow." Added to this, R1's temperature at 5:00 AM was recorded per  
300.3240a) incident report and per nurses notes dated 2/13/04 as at 93.5 degrees Fahrenheit, well below  
(Cont-d.) normal. At 5:15 AM, R1's temperature was at 94.2 degrees and at 95.1 degrees Fahrenheit at 5:35 AM. At 6:45 AM, R1's temperature was noted per nurses notes to be at only 97 degrees.

When E6 (nurse) was interviewed over the phone on 3/22/04, E6 confirmed that R1's temperature was accurate as recorded on the nurses notes on 2/13/04. E6 also added that R1 was " kind of shivering", not wearing a coat, and was just wearing pants and shirt that is made of silky material. E5 (1st floor nurse) also confirmed that R1 was not wearing a coat and was shaking and was noted with cold skin. Furthermore, E6 said that R1 sustained 2 bumps on the head and a skin tear on R1's right elbow. E4 (CNA) and E7 (CNA) also said during interview that R1's skin felt cold after she was found outside.

Review of the local weather on 2/13/04 showed that at 2:53 AM, the temperature outside was at 16 degrees Fahrenheit. At 3:53 AM, the temperature dropped down to 15.1 degrees Fahrenheit and was further lower at 4:53 AM at 12.9 degrees Fahrenheit.

Though nowhere in R1's record was it documented that R1 attempted to elope or wander to another floor prior to 2/13/04, it was found out during interview of E7 that there was 1 time that R1 wandered to the 1st floor lobby without the 3rd floor staff knowledge. This was confirmed on 3/22/04 interview, when E8 (CNA) admitted that "2 - 3 months ago", R1 was observed by E9 (receptionist) on the 1st floor lobby. E9 said during 3/22/04 interview that when R1 was asked, R1 said in Spanish that she was going to the store. E9 called the 3rd floor unit and E8 came to the lobby and took R1 back to the 3rd floor. Though E11 ( MDS / Care Plan Coordinator ) was aware that R1 had previously wandered to the 1st floor, there was no evidence that this behavior was addressed or care planned. R1 was only placed on elopement risk after

R1 went outside of the facility on 2/13/04. There was no incident report to verify exact date of previous wandering for R1. Facility evaluated R1 upon return to floor and gave her first aid, gave her warming blanket and hot tea, changed her clothes and placed her next to a heater, and dressed her skin tear.

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- 300.1210a) During tour of the facility on 3/22/04, it was noted that R1's previous room (Room 326) was
- 300.1210b)6) next to the elevator when the incident happened on 2/13/04. In front of the elevator is a
- 300.2210b)2) nurses station that has not been used by the staff for awhile and also on 2/13/04 .
- 300.3100d)2) The 3<sup>rd</sup> floor nurses station currently being used by the staff is located at the west end of the unit and
- 300.3240a) if the staff is by that station, there is no way to monitor if R1 went downstairs using the
- (Cont-d.) elevator. Though the 2 exit doors on the 3rd floor unit are alarmed, the elevator is not, and a security code is not needed to get off the floor and to bring the elevator to 3rd floor. Per E10 (CNA), there was one instance months ago that she observed R1 pushing the elevator buttons while at the 3rd floor unit.

Per observation on 3/22/04, the back exit door (northeast exit/ employee exit door) alarm was noted as triggering the alarm when the exit door was opened without using the staff's ID badge. Per E3 (Clinical Administrator) and per Z2 (alarm system technician), prior to 2/14/04 (when a new alarm system was installed), the 1st floor exit door alarm had 2 reset buttons and was located at the 1st floor nurses' station. One for the Audio alarm and the other for light in the panel corresponding to the exit door opened. According to E3 and Z2, in order to reset or re-engage the back door exit alarm properly, both the Audio and Light reset button should be hit . Per E3 and Z2, the back exit door alarm was probably triggered prior to R1's incident on 2/13/04. E3 and Z2 added that the light bulb for the back exit door alarm had burnt out . E3 and Z2 further explained that when it triggered prior to the 2/13/04 incident involving R1, the staff must have hit the reset for the Audio Alarm but did not press the reset button for the light panel. This according to E3 and Z2 disabled the backdoor exit alarm. Both added that if the back door exit is opened, it will not trigger the alarm at the 1st floor nurses station, so on 2/13/04 the alarm did not trigger when R1 opened the back exit door between 3:30 AM and 4:30 AM .

Per interview of E4 and E5, it was confirmed that when R1 opened the back door exit and was locked out outside of the door afterwards, no alarm was triggered or heard, nor was the panel at the nurses station lighted to alert the staff that someone opened the back door exit. It was also confirmed per 3/23/04 interview with Z1, that R1 told Z1 that she did a wrong turn that early AM, found herself outside and realized she has to come back inside. Because R1 only speaks in Spanish and it is in early morning when R1 got locked-out outside of the facility's back exit door, it is hard for R1 to ask for help or assistance outside, due to the language barrier, her cognitive deficit and also because of the time of the day when this happened.

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- 300.1210a) When Z1 was asked on 3/23/04, Z1 said that when R1 was found outside of the facility on
- 300.1210b)6) 2/13/04, R1's temperature was below normal. Z1 added that because of R1's age (74 years
- 300.2210b)2) old) because R1 is thin, because the elderly do not have the ability to shiver well, because
- 300.3100d)2) the hypothalamus do not work well among the elderly, and in the absence of a coat / jacket,
- 300.3240a) R1 is prone to hypothermia if exposed in the cold outside. Furthermore, Z1 added that with
- (Cont-d.) the temperature at around 15 degrees Fahrenheit outside, an elderly without a coat can possibly develop hypothermia within 15 minutes. Z1 added that is why he sent R1 to the hospital emergency room for further evaluation. The hospital took R1's temp which was 100.5, evaluated bumps and skin tear and returned resident to facility same day.