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

GOOD SAMARITAN HOME	**0009258**
Facility Name	**I.D. Number**
2130 HARRISON STREET, QUINCY, ILLINOIS 62301	
Address	
Date of Survey: 04/13/2004	
Incident Report Investigation of March 23, 2004	

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) 300.1210b)6) 300.3100d)2) **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.**

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.

All exterior doors shall be equipped with a signal that will alert 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.

Based on record reviews, interviews and observations, the facility failed to implement interventions and monitor the whereabouts of one of three sampled residents (R1). R1 showed increased confusion in orientation, confusion as to his location within the facility and a decrease in ability to process information. R1 left the facility without staff knowledge on 03/23/04. R1 was approximately 200 feet from the facility entrance with the front wheels of his wheelchair on the street when staff stopped him.

Findings include:

Incident report dated 03/23/04 at 4:00 p.m. documents R1 exited the facility without visual control by staff and was found on the sidewalk by .... Street. This report states the staff were alerted by E5 (Admissions Director) by phone when she was leaving the facility to go home from work. At that time, E5 informed the staff that R1 was outside and heading down the sidewalk.

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The nursing assessment dated 02/26/04 identifies R1 as a 94-year-old resident of the facility since 09/05/97 with latest readmission on 04/09/02. The assessment dated 02/26/04 shows a decline in the cognitive functioning of R1 with decreased ability to understand and be understood as well as decreased ability to process information with short-term and long-term memory deficits. The assessment lists diagnoses as: Arteriosclerotic Heart Disease, Parkinsons, Chronic Obstructive Pulmonary Disease and additional diagnosis added on 02/26/04 (listed in nursing notes) of dementia. This assessment also identifies R1 as independently mobile in his wheelchair.

R1 was interviewed on 04/06/04 at 1:00 p.m. and 04/07/04 at approximately 11:15 a.m. During both interviews R1 showed vacillating ability to answer questions appropriately and consistently. R1 was asked what he would do when crossing the street. R1 replied, "You tell me." R1 was asked what he would do if he found an envelope on the ground with a stamp. R1 replied, "I would pick it up and find the owner." He incorrectly identified the year as 1997. He was unable to state what type of clothing to wear outside in the winter. He stated he misses his wife and, "If I could find the keys to my car I would go and see her at church." (R1 has been a widower for several years.) On 04/07/04, R1 stated it was 1998 and asked who this surveyor was.

The assessment dated 02/26/04 and completed by E15 (Social Services Assistant/SSA) states,"His (R1) decisions he does make are not safe. His mental function varies throughout the day." The quarterly social services assessment completed by E15 on 2/26/04 identifies R1 as "Wanders one to three times a week" with change in behavioral symptoms as "deteriorated." The additional comment section of this report states, "(R1) has had a decline in his behavior since last review. He wander(s) around the unit (unsecured unit) and at times off the unit 1 to 3 times weekly."

Nurses notes dated 02/23/04 through 04/06/04 document increasing confusion, speech slurred with difficulty understanding verbalizations by R1 to staff. These notes also document R1 "interrupting others conversations, being rude to staff and peers, coming out of his room with his pants down and this behavior not typical of (R1)." Nursing notes dated 03/07/04 at 8:45 a.m. state, "Repeatedly failing to pull up pants and reminded to call for assist with clothes while in room. Pleasant and agrees but soon 'forgets' and repeats behavior."

Social services notes dated 03/04/04 through 04/06/04 confirm the increase in confusion by R1. Social service notes dated 03/03/04 state, "Staff visited with (R1) today. He was kick(ing) his foot on the RNCC (Resident Nurse Care Coordinator) door. Staff asked (R1) what he needed. (R1) stated 'I've got to get out of here. I've got to leave'." On 03/11/04, social services notes state, "(R1) was noted going off the unit today after lunch. He was trying to go out the west exit doors that lead outside the building. He was setting off the alarms." E15 stated R1 was trying to get to accounting to get money for a movie and got "mixed up as to where he was at."

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Nursing notes on 03/17/04 at 10:00 p.m. state, "Very restless, confused this eve. Wandered into several other residents rooms this eve. Wandering around circle with pants at knees. CNA (Certified Nursing Assistant) reported resident was taking a sock, wetting it in the sink and wringing it out on his bed, floor X 2. When questioned resident stated,'I'm playing a game.' CNA reported resident stated, 'I can too, I've already made $7,500' when reminded inappropriate to travel in hall with pants down."

Nursing notes on 03/18/04 at 9:30 a.m. state, "Resident had hat on and was heading out door into west parking lot. Tried to reorient to time and resident says,'Do you think you know everything?' Noticed residents pants were down around knees." At 3:00 p.m. on 03/18/04 nursing notes document, "CNA reported resident has been going into other residents rooms."

The nursing care plan dated 03/02/04 does not address the diagnosis of dementia or the increasing confusion displayed by the R1. The care plan does not address R1's elopement on 03/23/04 nor does it identify R1 as an elopement risk.

E5 was interviewed on 04/06/04 at 12:15 p.m. E5 stated, "I was leaving from work (on 03/23/04 at approximately 4:00 p.m.) for the day. As I was pulling out on .... Street, I turned left and looked back and I saw (R1) there -- on the sidewalk, past the bench. As I got a few feet down the road I realized he was having some behavior problems so I called, turned around and came back. When I got back he was on the sidewalk near .... Street. I had been told by staff that in the last couple of days, (R1) had been more confused and was wandering more. They were watching him and trying to decide if we needed to do anything. That incident told us we needed to put an elopement band on."

E6 (Licensed Practical Nurse/LPN/Resident Nurse Care Coordinator) was interviewed on 04/06/04 at 1:10 p.m. E6 stated, "(R1) got out around 4:00 p.m. (R1) went out the front door. The door alarms for (residents wearing a code alarm bracelet). There is someone at the desk to monitor. I don't think the receptionist saw him go out. Lately (R1) makes derogatory remarks to staff/residents. (R1) comes out of his room with his pants down. I don't know if he would find his way back if he went a block or so away from facility."

E12 (receptionist/front door and shelter care door monitor-evening shift) was interviewed on 04/07/04 at 9:37 a.m. E12 stated, "I did not see him go out that night. I don't know if he went out the front door. I could have been in the back room making copies or doing some work at the desk and since he did not have a code alarm bracelet on, I would not have heard him. I had not been told he was having any problems until the nurse came back in and told me to put him on the elopement list--so I did that right away. There is no one to cover for me when I go on break."

E9 (CNA) was the staff assigned to R1 on the evening of 03/23/04 from 2:30 - 11:00 p.m. E9 was interviewed on 04/06/04 at 3:25 p.m. E9 stated, "I didn't see (R1) when I first came on shift. He goes to activity. He is not supposed to now but if our attention is somewhere else he may leave the unit. We try to remember to ask if someone is off the unit but some days it is too busy. I don't know if he would find his way back if he left. I was at supper at the time he left."

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E7 (CNA) stated in interview on 04/06/04 at 1:28 p.m.,"I don't know if he would know what to do when crossing the street. I don't think he could find his way back. His mental function can vary over the day."

E11 (Maintenance Supervisor) was interviewed on 04/07/04 on 8:30 a.m. and a tour of the facility doors was conducted. The alarm system within the facility was explained by E11. All exterior doors are alarmed for anyone leaving the facility unless a code is entered with the exception of the main front door and the shelter care door to the right of the receptionists' desk. These two doors only alarm when a resident wearing a code alarm bracelet attempts to exit. The receptionist at the front desk monitors these two doors. While on tour with E11, the front door was tested for difficulty in opening. This door required an initial push of approximately two inches at which time the door continued to swing open with no additional pressure required.

E10 (Maintenance) was interviewed on 04/07/04 at 8:10 a.m. E10 stated, "I was leaving to go home (on 03/23/04), turned east on .... Street. I saw (R1) and (E5). (R1) was on the main sidewalk by the drive. They (facility) have a code alert alarm system that makes a high pitched noise if someone with a code bracelet leaves. All exterior and some interior doors have code alarms. You need to know the code to reset all exterior doors and some interior doors have a button to push. The front door is the only one I think that is unalarmed unless wearing a code alarm bracelet. All the other doors you have to push the code to exit. There is someone at the front desk so that is not alarmed except for the code bracelet alarm."

E11 calculated the distance with surveyor from the front door to the sidewalk at approximately 200 feet sloping downward from the facility to .... Street. The curb is approximately 5.5 inches in height. The posted speed limit is 30 miles per hour.

Z1 (Midwest Climate Control Center) was interviewed on 04/09/04 at 11:00 a.m. The weather on 03/23/04 at 3:54 p.m. for the city was cloudy and overcast with intermittent showers. The air temperature was 47 degrees Farenheit with a 13 mile per hour wind. Humidity was 97 percent.

On 03/23/04, Social Services notes state, "Staff in admissions reported to nursing staff on 03/23/04 that (R1) had wandered outside the building and was found on the corner stepping off the curb heading to .... Street. When staff asked (R1) where he was trying to go, (R1) stated, 'I was trying to go to my folks on Grandview." RNCC (Resident Nurse Care Coordinator) placed code alert bracelet on (R1) right wrist."

Nursing notes dated 03/23/04 at 4:00 p.m. confirm this and state, "Admissions Director called and reported resident at the end of sidewalk at .... street in front of the building. Admissions reported 2 front wheels (of wheelchair) in street. Resident stated,'I was going to my folks home on Grandview.' Placed code alert bracelet on right wrist."

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SAMARITAN VIOLATION.WPD