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

FOREST HILL HEALTH AND REHAB	0042309
Facility Name	I.D. Number

4747 11TH STREET EAST MOLINE, IL 61244
Address

Date of Survey: 3/23/2004

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 needs 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.

300.1220b) The DON shall supervise and oversee the nursing services of the facility, including;

300.1220b)2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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300.1220b)3) Developing an up-to-date care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as are ordered be the physician shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Based on observation, interviews and record review, the facility failed to implement additional interventions to prevent one of one exit-seeking residents (R1) from leaving the facility unnoticed and unattended by staff. R1, wearing only a gown, was found barefoot in the snow covered parking lot on 02/08/2004. R1 was subsequently transferred and admitted to the hospital with frostbite and cellulitis of both lower extremities.

Findings include:

Admission records indicate R1 is a 76 year old resident admitted on 1/16/04 with diagnoses of: Post intra-cerebral hemorrhage, Cerebral Vascular Accident (stroke), Agitation and confusion. R1 was initially admitted to the main part of the facility.

Admission nursing note dated 1/16/04 by E13 (Licensed Practical Nurse/LPN) states,"Resident alert with confusion, has history of elopement." Nursing note on 1/17/04 at 6:00 a.m. states,"Resident exit seeking later in morning." At 9:45 a.m. on 1/17/04 nurses notes state,"Exit seeking behavior noted. Intervention per staff required X 3. Wife present and consulted related to moving (R1) to ..... for closer observation."

Social services notes dated 1/21/04 describe resident as,"(R1) is unable to express his wants/needs. Resident is dependent upon staff assist for all cares." The Resident Assessment Protocol dated 1/21/04 states,"Paces without awareness for his safety." The Mini Mental Examination completed on 1/23/04 shows scoring of 0-3 indicating severe cognitive impairment.

R1 was interviewed on 3/11/04 at 12:07 p.m. R1 was unable to state his name or identify family members. R1 was interviewed again on 3/16/04 at 10:00 a.m. R1 was unable to identify the weather or what to do when crossing the street. R1's speech was garbled and incoherent during both interviews.

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300.1210a) Nursing notes from 1/16/04 through 2/8/04 document agitation, pacing and at least 14
300.1210b)6) attempts to exit facility. Nurses notes on 1/16/04 state R1 was placed on 15 minute checks.
300.1220b) On 2/6/04 at 1:00 p.m., nurses notes by E20 (LPN) state,"Resident eloped X 2 today - first in
300.1220b)2) A.M. with 3 staff to retrieve. Very agitated and striking at staff. After much encouragement
300.1220b)3) came back."
(Cont-d.)

The care plan dated 2/5/04 does not address R1's elopement attempts, except for a notation on 2/8/04 of "wrist alarm to prevent elopement".

E20 was interviewed on 3/17/04 at 11:20 a.m. regarding R1 leaving the building on 2/6/04. E20 stated,"(R1) went out the side door to the sidewalk. The door (R1) left is in the TV room. Both times the alarms went off and staff answered the alarms. (R1) was dressed and had sandals with socks on." Nursing notes dated 1/16/04 note that R1 "has history of elopement, put on 15 minute checks..." No 15 minute monitoring sheets for R1 for 2/6/04 were available.

On 2/8/04, nursing notes state,"Resident found outside this A.M., fell in parking lot, scraped left knee, assisted back into building by staff. Wrapped in warm blankets, family and MD (doctor) notified, will continue to monitor." The 15 minute monitoring sheet for 2/8/04 is blank for 6:00 a.m. and 6:15 a.m.

Interviews were conducted with E1 (Administrator), E2 (Director of Nurses), E3 (Director of Operations), E5 (Certified Nursing Assistant/CNA), E6 (CNA), E7 (CNA), E8 (CNA), E9 (Licensed Practical Nurse/LPN) and E13 (LPN) on 3/11/04. Through these interviews, it was determined that R1 was last seen on the unit between 5:55 a.m - 6:00 a.m. on 2/8/04. E9 and E13 were informed by Z6 (spouse of E9) at approximately 6:15 a.m. - 6:20 a.m. that R1 was outside the facility wearing only a gown and no shoes.

E13 (LPN) was interviewed on 3/11/04 at 2:40 p.m. E13 stated,"I got on the unit about
5:55 a.m. (R1) was sitting in a recliner in front of the big TV. I went to the nurses station to get report, count narcotics and check assignments with (E9). (Z6) came in the building and told us there was someone outside in a gown. We both went out to

get him. (E7) and E21 (Unit Assistant/UA) went as well."

E9 (Licensed Practical Nurse/LPN) was interviewed on 3/11/04 at 12:12 p.m. E9 stated,"Report ended a little after 6:00 a.m. I went to clock out around 6:15 a.m. and (Z6 - spouse of E9) was coming in to get me. We discovered (R1) was outside. I went out to retrieve (R1) and called his name and he bolted. (R1) was wearing a gown and like a shawl.

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300.1210a) (R1) didn't have shoes on or anything. It was cold. He was by the house next door when I
300.1210b)6) caught him."
300.1220b)
300.1220b)2) E13 stated she completed an incident report regarding R1 leaving the facility and the
300.1220b)3) condition of R1 upon return noting the cuts on his feet. E13 stated,"(R1) had a scraped left
(Cont=d.) knee and some cuts on the top of his toes. (R1) toes were bright pink and cold. I checked the bottom and they were cold and dark pink."

E13 stated in interview on 3/11/04 at 2:40 p.m.,"I am not sure exactly how long he was out." Nurses notes by E13 dated 2/8/04 at 7:20 a.m. record body temperature at 94.3 degrees. Prior temperature recordings in the nurses notes for R1 are documented ranging from 97.0 degrees to 98.4 degrees Farenheit.

Z5 (Climate Control representative) was interviewed on 3/17/04 regarding the weather on 2/8/04 at 6:00 a.m. Z5 stated,"On 2/8/04 at 5:52 a.m. the weather is recorded at 15 degrees Farenheit (F). With the wind chill factored in it would be approximately 3 degrees F. The skies were overcast. The temperature is based on where a persons face would be (about five foot above the ground). This would be assuming all other body parts are covered. If uncovered it would be much more dangerous to exposed flesh."

E7 (CNA) was interviewed on 3/11/04 at 11:24 a.m. E7 stated,"When I first came in around 5:55 a.m. - 6:00 a.m. (R1) was in the TV area. I went to the clean utility to get my cart together around 6:05 a.m. I heard (R1) was outside. I went out the front door. When I got outside, he was at the house next door with (E9) and (E21). He had a gown and blanket on. I ran across the parking lot and through the snow. (E9) told me to get his coat and shoes. When I was coming back (E5) was at the door and I told her to get (R1)'s coat and shoes. (E21) and I brought him back in. (R1) tried to stop a couple of times outside but I told him we had to go inside because it was freezing. (E13) told me to put on lots of blankets and socks. Before I put

slipper socks on him I told (E13) his feet were beet red on the top. I went and got the slipper socks and put them on."

E6 (CNA) was interviewed on 3/11/04 at 11:23 a.m. E6 stated,"When I first came in at around 6:00 a.m, (R1) was sitting in a recliner. I went to the clean utility on hall one. When I came back to the dining room he was still outside with staff. They were bringing him back in and were in the parking lot. He was wearing a gown and maybe a blanket. He was out of breath and sat down when he got in here. They tried to keep him warm with blankets. They didn't want to mess with his feet because they were frozen. It was very cold."

300.1210a) E5 (CNA) was interviewed on 3/11/04 at 11:05 a.m. E5 stated,"I clocked in about 6:00 am. I
300.1210b)6) was going to get linen supplies at around 6:15 a.m - 6:20 am. I heard a scream and came back
300.1220b) to the dining room. I think (E7) said (R1) got out. By the time I got outside, (E7), (E21) and
300.1220b)2) (E9) were holding him. (R1) was sitting on the ground fighting to get away. I came back in
300.1220b)3) the building to find a coat because he only had a gown on. We found his coat and shoes and
(Cont-d.) took them out to the parking lot. About 5 to 10 minutes later I came back in. (E7) and (E21) brought him back in around 6:25 a.m. - 6:30 a.m. We checked him over for wounds, feet had scratches on them and I reported it to (E9) and (E13). His feet were cold so we kept putting towels on them until after breakfast."

During interview on 3/11/04 at 1:35 p.m., Z1(R1's physician) stated,"R1 had frostbite and cellulitis. I don't know but think it would take over 10 - 12 minutes for frostbite (depending on weather). I don't remember staff telling me of the cuts on (R1) feet."

On 2/10/04 nurses notes at 6:00 a.m. state,"Third shift nurse reported to this writer (R1) had large blisters on feet and toes. Both feet are red and warm to the touch. Abrasions noted to several top aspects of toes. Residents socks are wet with liquid drainage - some blisters remain intact. Will notify skin nurse that resident in need of assessment at this time and treatment." A called was placed to Z1 (physician of R1) at 10:30 am. At 1:00 p.m. no return call had been received. At 9:30 p.m. on 2/10/04, Z1 returned the call and ordered treatment for the feet of R1.

Nurses notes on 2/11/04 at 9:30 a.m. show an assessment done by E4 (LPN/skin

nurse) on the blistered areas. R1 was sent to the hospital at 10:25 a.m. on 2/11/04 for evaluation.

Nurses notes dated 2/11/04 at 6:00 p.m. state,"Resident admitted to (hospital) with frostbite and cellulitis of the feet".

The hospital emergency room record for R1 on 2/11/04 was reviewed and lists admission diagnoses for R1 as: Frostbite and Cellulitis of feet.

Physician's note on 2/13/04 state,"Eloped barefoot." On 2/24/04 physician's notes state,"Second degree frostbite both feet."

The current care plan for R1 shows a "wrist alarm to prevent elopement" was initiated on 2/8/04. E2 (Director of Nurses) confirmed this on 3/10/04 at 9:30 a.m. during interview.

E1 (Administrator) was interviewed on 3/11/04 at 3:48 p.m.and again on 3/17/04 at 10:17 am.

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300.1210a) E1 stated,"The (electronic monitoring bracelet) alarm is on the unit door. On day mode
300.1210b)6) from 8:00 a.m. to 8:00 p.m. if you walk up to the door and punch in the code you can exit
300.1220b) with no alarm chiming for the next 15 seconds. This was changed to 8 seconds on 3/11/04.
300.1220b)2) If someone with an (electronic monitoring bracelet) pushes on the door, the alarm will sound
300.1220b)3) and the door will not open for 15 seconds. After (R1) left on 2/8/04, the night alarms were
(Cont=d.) changed- so from 8:00 p.m. to 8:00 a.m., the screamer alarm is now on. The (electronic monitoring bracelet) alarm does not mean much at night unless a person with the (electronic monitoring bracelet) attempts to open the door. The screamer alarm will sound if someone with a (electronic monitoring bracelet) pushes on the door and the door will lock them out for 15 seconds." E1 stated this was to allow staff time to respond before a resident would exit the facility.

R1 again left the facility unnoticed by staff on 2/19/04 at 8:45 p.m., after the initiation of the policy on 2/9/04 requiring alarms be on "scream mode" from 8:00 p.m. - 8:00 a.m. E10 (CNA), E11(CNA), E12 (CNA) and E14 were on duty the night of 2/19/04 and were interviewed in regard to this incident.

E14 (LPN) was interviewed on on 3/11/04 at 3:07 p.m. E14 stated , on 2/19/04,"(R1) went out the front door. I heard the (electronic monitoring bracelet) alarm go off and got to him while he was on the sidewalk just past the canopy. The bracelet alarm went off. I don't remember where I was when I heard the alarm go off. I didn't see any staff in the dining or TV area."

E10 (CNA) was interviewed on 3/11/04 at 2:20 p.m. E4 stated,"As far as I know, he only got to the sidewalk. The nurse told us he had gone out and we needed to try and be in the dining room. I don't know if (R1) had a electronic monitoring bracelet. I was in hall two and didn't hear an alarm."

During daily status meeting with E2 and E3 on 3/11/04 at 12:50 p.m. both denied knowledge that R1 actually exited the facility on 2/19/04 until informed by surveyor. E1 also stated on 3/16/04 at 10:30 a.m. that he was unaware R1 actually exited the facility on 2/19/04 until informed by E2 and E3 after daily status meeting on 3/11/04.

(A)