

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

WALNUT MANOR

0015784

Facility Name

T.D. Number

308 SOUTH SECOND STREET, WALNUT, IL 61376

Address

Date of Survey: 04/01/2004

Incident Report Investigation of February 28, 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) The facility must provide the necessary care and services to attain or maintain the highest practicable physical,
 300.1210b)6) mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive plan of
 300.3100d)2) 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.

These regulations are not met, as evidenced by the following:

Based on observation, interview and record review the facility failed to monitor all of the exit alarms and monitor the whereabouts of R1 after she exhibited exit seeking behavior. R1 is one of ten residents identified by the facility as having wandering and exit seeking behavior and wearing electronic monitoring bracelets.

R1 left the facility without staff knowledge and unattended by staff. R1 wandered one and one half miles from the facility and was missing for thirty minutes.

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"A" VIOLATION(S):

300.1210a) Findings include:

300.1210b)6)

300.3100d)2)

(Cont.)

R1 a seventy-three year old female resident, admitted to the facility on 01/28/04 and has a diagnosis of Alzheimer's Disease according to the Physicians Order Sheet dated 03/01/04 through 03/31/04. A review of R1's nursing assessment dated 02/07/04 indicated that R1 is moderately impaired at decision-making, has long and short-term memory problems, sometimes understands others and has daily wandering that is not easily redirected. A review of R1's Exit-seeking/Wandering Assessment dated 01/28/04 identified R1 as at risk for possible exit-seeking, to complete profile and place in exit-seeking book. Review of R1's assessment dated 02/10/04 indicated that R1 has had a deterioration of cognitive loss in the past ninety days, wanders halls, has tried to go home, does not understand to stay in facility, has been assessed to be at risk on exit seeking assessment and wears an electronic monitoring device. It further indicated that R1's husband reports that R1 was trying to leave home before coming to the facility. Review of R1's Care Plan for Cognitive Loss/Dementia dated 03/01/04 listed under approach/Interventions to attempt to be aware of R1's whereabouts at all times. Review of R13's Behavior Flow Sheets and Nurses Notes for the months of January and February 2004 documented that R1 has daily episodes of wandering and numerous unsuccessful attempts to exit the facility.

Incident report dated 02/28/04 indicated that R1 was found at (local repair shop) at 12:10 p.m. on 02/28/04. Interview at 1:50 p.m. on 03/29/04 with E6 (Licensed Practical Nurse, LPN), and observation generated from an automobile excursion directed by E6, demonstrated that R1 was found at local repair shop which is one and one half miles from the facility. The assumed route that R1 took between the facility and the location where she was found by E6 included one mile of paved farm roads which had no posted speed limits and open fields on both sides of the roads. E6 further indicated that when found, R1 was in the yard of the business talking to a man there.

During interview with Z2 (Business Owner) at 12:50 P.M. on 03/30/04, Z2 related that at approximately 12:10 p.m. on Saturday 02/28/04 he was working on machinery in the drive. He heard a woman ask him if the item he was working on was heavy, and he replied that it was. Z2 said that she then asked him if he would give her a ride back to her apartment. Z2 asked her where her apartment was and the answer that she gave him was not intelligible. Z2 said that at that moment a lady, identifying herself as an employee of the nursing home, arrived in a car and took the other lady away.

Interviews in the a.m. and p.m. of 03/29/04 with E3 (Certified Nurses Aide, CNA), E4 (CNA), E5 (LPN), and E6 (LPN), all working at the time R1 left the facility, show that none of them were aware that R1 had left the facility, nor had they heard any of the facility's five exit door alarms sound between 11:30 a.m. and 11:40 a.m. on 02/28/04.

Interview at 11:15 a.m. on 03/29/04 with E5 and review of the incident report dated 02/28/04 documents that at 11:30 a.m. on 02/28/04, E7 (CNA) told E5 that she had just observed R1 in the front lounge area near the front exit door. E5 said that the staff were keeping the usual ten to fifteen minute visual checks on R1 that morning, as coincides with the facility's Wandering Resident Elopement policy.

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300.1210a) Interview at 1:50 p.m. on 03/29/04 with E6 notes that at 11:40 a.m. on 02/28/04 she asked E4 if she
 300.1210b)6) had seen R1. E4 replied that she had not. E6 further stated that at that time all staff present began
 300.3100d)2) to search the facility and grounds for R1. E6 said that after searching the facility she took her
 (Cont.) automobile and began searching the streets north and west of the facility, eventually finding R1 at
 12:10 p.m.

Interview at 11:15 a.m. on 03/29/04 with E5 indicated that while the staff were looking for R1 at about
 11:45 p.m., Z4 (Visitor) told her that earlier she had seen R1 on the West Hall and a little later had
 heard some faint buzzing coming from the hall while she was in room 309. E5 said that at that time
 she went to the nurses station and discovered the wall light, indicating that the West Hall exit door
 had been opened, was lit. E5 also said that, at the time of the elopement, the exit doors, including
 the West Hall exit door, were affixed with an alarm that sounded only when the door was open and
 shut off when the door closed.

Observations between 8:30 a.m. and 9:00 a.m. on 03/29/04 revealed that the five exit doors in the
 facility are affixed with exit alarms that sound when the doors are opened and require someone to
 stop the audible alarm sound by entering a code on a key pad located on the wall at the door where
 the alarm is sounding. The front door is the only door that had a second alarm system that is
 triggered by an electrical monitoring bracelet worn by certain residents. This alarm also must be
 turned off at the door location when it is sounding. All of the alarms were working as designed at the
 time of the observation.

Interview at 10:00 a.m. on 03/29/04 with E2 (Director of Nurses, DON) and at 11:15 a.m. on 03/29/04
 with E5 showed that at the time of the incident all of the door alarms, with the exception of the
 electronically activated monitoring alarm on the front exit door, sounded only when the door was
 open and shut off when the door closed. Both verified that R1 was wearing an electric monitoring
 bracelet at the time of the incident on 02/28/04 and that upon R1's return to the building on that date
 all of the exit door alarms were tested and were working as designed.

Interview at 1:50 p.m. on 03/29/04 with E6 notes that at the time of the incident R1 was dressed
 appropriately for the weather which was mild. Review of the facility's Elopement Incident
 Investigation dated 02/28/04 revealed that the resident was wearing shoes, jogging pants, a
 sweatshirt and electronic monitoring bracelet at the time of the incident.

Telephone contact at 2:25 p.m. on 03/29/04 with Z3 (Weather person) revealed that at the Peru,
 Illinois Airport, at 11:45 a.m. on 02/28/04 the temperature was recorded at fifty degrees Fahrenheit
 with clear sky and a ten-mile-per-hour wind from the South West.

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"A" VIOLATION(S):

300.1210a) During interview at 11:30 a.m. on 03/29/04 with R1 revealed that R1 thought that she has lived in the
300.1210b)6) facility for ten years and that her apartment was in one of the other buildings. There is only one
300.3100d)2) building to the facility. She said that she likes to go around and around during the day and that she
(Cont.) likes music. R1 said that she remembered the day she took the walk by herself and that she was
"only gone for about fifteen minutes and was going to find some new personalities, you know." R1
also said, when asked, that she always looks both ways when she crosses the street, so she doesn't
get run over.

(A)