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

INDEPENDENCE PLACE — Facility Name
0037994 — I.D. Number

1705 SOUTH PARK AVENUE, HERRIN, ILLINOIS 62948 — Address

Reviewed By

JULY 6, 2005 — Date of Survey

COMPLAINT 0552654 — Type of Survey

Surveyed By

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 of 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):

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The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:

The DON shall participate in periodic re-evaluation of the type, extent and quality of services and programming.

The DON shall participate in the development of a written plan for each resident to provide for nursing services as part of the total habilitation program.

Direct care personnel shall be trained in, but are not limited to, the following:

Detecting signs of illness, dysfunction or maladaptive behavior that warrants medical, nursing or psychosocial intervention.

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Basic skills required to meet the health needs and problems of the residents.

First aid for accident or illness.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

These regulations were not met as evidenced by the following:

1) Per review of R1's Physician's Order Sheet, R1 is a 48-year-old female that functions at a severe level of Mental Retardation. Other diagnoses' include Anemia, Seizure Disorder, PICA, Tardive Dyskinesia and Aggression. R1 is ambulatory and non-verbal.

Per review of facility's Tardive Dyskinesia Assessment, dated 03/05/05, documentation states that R1 has minimal facial tics, occurring only once or twice a week in a short non-repetitive manner.

Documentation also states that R1 has severe, abnormal movements occurring almost constantly in the upper extremities. Documentation states, "Athetoid/Myokymia movements of the finger, arm and wrist and pin rolling."

Per review of Physician's Order Sheet, R1 is currently taking Ability 10 milligrams every morning and Keppra 500 milligrams twice a day for symptoms of Tardive Dyskinesia.

Per interview with E1, (Direct Support Person), on 06/23/05, at 10:50 A.M., E1 stated that she has worked at this facility as a direct support person since 01/05/05.

E1 stated that she first noticed R1's hand tremors becoming worse on 06/17/05. E1 stated that there was a meeting on 06/17/05, at the facility, to discuss any of the clients' medical issues and that she reported the increased tremors to E2, (Registered Nurse Consultant). E1 stated that E2 told her that the tremors were due to the medications that R1 had taken in the past. E1 stated that there were no recommendations from E2 regarding R1's increased tremors.

Per review of R1's medical chart, there is no documentation of R1's increased tremors nor that E2 followed up on E1's observations of R1's increased tremors.

Per interview with E4 (Direct Support Person), on 06/23/05, at 12:35 P.M., E4 stated that on Saturday morning, (06-18-05), she first noticed that R1 was not feeling well. E4 stated that about 4:30 or 5:00 A.M., she went to get R1 up and that when she sat R1 up in her bed, R1

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leaned against the wall on her back. E4 stated that she again attempted to get R1 out of bed and she would return to the position of sitting on the bed with her back against the wall. E4 stated that E5, (Direct Support Person), came into the room and together both of them were unable to get her to stand up. E4 stated that this was unusual for R1.

E4 said that R1's vital signs were taken and that her temperature was, "102 or 103", axillary. E4 stated that she called E2 and informed her that R1 wouldn't sit up, get dressed and that they were unable to get her to walk. E4 stated that she also informed E2 of R1's increased temperature and vital signs. E4 stated that E2 told her to give R1 Ibuprofen and to retake her vital signs at 1:00 P.M., and if the temperature was still up, to send her to the emergency room.

E4 continued to say that she left at 10:00 A.M. that day, so she was not sure if R1's temperature had gone down or not, but that E5 was at the facility until 2:00 P.M. and that she had reported E2's orders to her.

E4 stated that she was not sure where she had documented the vital signs and temperature.

E4 stated that she did not write anything on the facility's, "Daily Shift Change Log", regarding R1's temperature or about her not being able to walk.

Per review of R1's medical file and all documentation provided when requested, there is no evidence that R1's vital signs were documented and no evidence of E2's follow up. There is also no evidence that R1 was taken to the emergency room for increased temperature as per E2's recommendation.

Per interview with E4, as above, E4 continued to say that when she came back to work at midnight on 06/18/05, when she did her bed checks, she noticed R1 was sitting on her bed with her back leaned against the wall again. E4 stated that she got R1 some liquids, which she drank, and assisted her to lie down. E4 stated that when she did her 2:00 A.M. bed checks, R1 was again sitting on the bed with her back against the wall. E4 assisted her back to bed. E4 stated that she did not take R1's vital signs because R1 kept falling back against the wall, and she was unable to do so.

There is no evidence that E4 notified E2 of R1's change in health at this time.

E4 said that when she did her 4:00 A.M., bed checks she found R1 lying in the floor, drying. E4 also said that R1's bed was wet and that R1 had never wet the bed before. E4 said that she took R1's vital signs and that they were, "okay" and that there was no apparent injury.

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E4 assisted R1 back to bed. E4 stated that she documented the vital signs on an incident report. E4 stated that R1 did not have an increased temperature at this time.

E4 stated that she called E2 on her cell phone with no answer. E4 then said she called the local hospital (where E2 works as an Emergency Room Nurse), and was told that E2 was not there. E4 stated that she then called E2's home and informed her that R1, "Wasn't acting right", that she had fallen, wouldn't get dressed, wouldn't sit up and wouldn't eat and was having frequent urination. E4 stated that E2 told her to keep R1 home from work, keep an eye on her and to elevate her feet.

Per E4, E2 also stated that R1 might have a Urinary Tract Infection or Constipation. E4 said that she told E2 that R1 was not constipated but that she got no further orders from E2.

Per review of R1's file there is no evidence that E2 came to the facility to assess R1 or follow up after she thought that R1 might have a urinary tract infection.

E4 continued to say that information is usually put on the shift change check list that informs all the staff of any changes or new orders on clients. E4 stated that she did not document this information on the shift change log after R1 fell and had an increased temperature, that she just verbally informed the next shift.

When asked where vital signs and temperature are supposed to be documented, E4 replied, "I have no idea".

Per review of Incident report dated 06/21/05, at 4:00 A.M., documentation stated, "Found resident on floor in her room. Informed the nurse, has scrape on right knee, & (and) has a scrape and bruise on left leg". Documentation of vital signs at this time is blood pressure 130/70 pulse 68, respiration 18. No further documentation.

When asked if she had recorded R1's temperature, E4 stated that she had documented it somewhere, but that she could not remember where.

E4 stated that when E1 came to work Monday morning, E4 informed her of R1's condition over the weekend.

Per interview with E5, (Direct Support Person), on 06/24/05, at 8:46 A.M., E5 stated that she was working with E4, on 06/18/05, when E4 told her that R1 "Wasn't acting right and seemed not herself". E5 stated that R1 refused breakfast and only drank her liquids. E5 stated that after breakfast, she gave R1 her medications and took her vital signs. At this time, R1's temperature

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was 102.7 axillary. E5 said that E4 called E2 at home and got orders to give her Ibuprofen, which she did.

There is no evidence that the nurse followed up to direct care staff's continued reports regarding R1's deteriorating health condition.

Per review of R1's Medication Administration Record, dated 06/19/05, documentation states, "6/19 GA (staff initials) Ibuprofen Fever/Pain". No actual temperature was documented.

Per review of R1's files there is no documentation to show that any other Ibuprofen was given.

E5 said that the rest of the day R1 acted like she needed to go to the bathroom about every 10 minutes. E5 stated that she went into the bathroom with R1 twice and she was actually urinating every time.

There is no evidence of assessment of the actual number of times that R1 urinated, the amounts, color and odor of the urine.

When asked if the nurse was contacted regarding R1's frequent urination, E5 said that she was not contacted. E5 continued to say that she did not do a Nurse Consultant form (that is to be completed with each incident for the Nurse Consultant to follow up with), because she had not actually talked to the nurse.

E5 stated that she could not remember if she documented R1's illness/increased temperature on the daily shift change log or not.

Per review of facility's, "Shift Change Checklist", surveyor noted no documentation regarding R1 and her medical status, until Sunday, 06/19/05, 4:00 P.M. until 12:00 A.M. shift. Documentation states, "Keep an eye on (R1) she hasn't been eating and has been in bed all night. Check B/P (blood pressure) Pulse/Temp. (Temperature)". No signature on the shift change checklist. There is no documentation of what the vital signs were, or if they were actually done.

On Monday, 06/20/05, 12:00 A.M. until 8:00 A.M., documentation on the shift change checklist states, "Kept (R1) home - she seems to be ill. Constantly going to the bathroom, refusing meals, (increased) temperature needs to go to the doctor. No signature of writer.

There is no documentation of what the vital signs actually were.

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On Monday, 06/20/05, 8:00 A.M. until 4:00 P.M., documentation on the shift change checklist states, "(R1) is home today - did not eat much lunch - has a Dr. Appt. for 4:15 P.M., w/ (with) (Z1)". No signature of writer.

No documentation was found by surveyor regarding the vital signs; nurse notification and nursing follow-up.

Per interview with E5, on 06/24/05, at 8:46 A.M., E5 stated that there is no chain of Command at this facility, "No one in charge to make sure that the DSP's (Direct Support Staff) do their jobs, and some of them don't".

Per interview with E1, on 06-23-05, at 10:50 A.M., E1 said that she does not work on weekends and that when she came back to work on Monday (06-20-05), direct care staff reported to her that R1 had been having frequent urination throughout the weekend and that they thought she might possibly have a Urinary Tract Infection.

E1 stated that she did not contact the Nurse Consultant, but instead, called the doctor's office and made an appointment for R1 at 4:30 P.M. that day. E1 also said that she noticed that

R1’s right ankle and foot were swollen.

E1 said that she kept R1 home from day training due to her not feeling well and the swelling in the right ankle/foot. E1 stated that before her doctor's appointment, R1's appetite decreased and she was not eating well. E1 said that she kept R1's legs elevated and gave her plenty of fluids.

There is no evidence in R1's Nurses Notes to indicate that the nurse evaluated R1.

E1 stated that she took R1 to the doctor's office for her appointment and that Z1; (R1's Physician) told her that he thought R1 had cellulitis in her foot. E1 said that Z1 ordered Amoxicillin 500 milligrams to be given three times a day and urinalysis to be done.

E1 stated that they were unable to get the urine specimen at that time, so R1 was taken home.

E1 said that she didn't get the prescription for Amoxicillin 500 milligrams filled after the doctor's appointment because it was 7:00 P.M. when they arrived back at the facility.

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When asked what the facility's procedure was as to getting medication prescriptions filled after hours, E1 stated that she did not know, that the prescription is usually faxed to the pharmacy during the day.

Per review of facility's, "Nursing Protocol", documentation states, "MNC (Medical Needs Coordinator" will fill out new medication notification form with order and call RN (Registered Nurse) consultant for direction on what to put under monitoring section..."

Documentation continues to say, "Medication will be started when it arrives from the pharmacy as prescribed. Staff will put MAR (Medication Administration Record) in book. Staff will call QMRP (Qualified Mental Retardation Professional) or RN (Registered Nurse) when medications arrive to make sure correct med was sent".

Documentation also states, "If after office hours, staff will notify RN consultant and let her know of a new medication order. She will call ER (Emergency Room) or DR (Physician) and get order. RN will call in order to the pharmacy after hour's number. RN will also tell staff what to put on medications notification sheet. This sheet will be signed by authorized staff before starting the med. Pharmacy will deliver and medication will be started..."

There is no evidence that this protocol was followed.

Per fax, sent to surveyor, by E2 on 06-28-05, E2 states, "When a resident is put on any new medication--staff must be trained--all meds are resident specific".

E1 said that the next morning (06/21/05) she had direct care staff get a urine sample from R1.

E1 also said that she went to the pharmacy and got the prescription filled and gave R1 her first dose, at approximately 9:15 A.M. E1 then took the urine specimen to the physician's office. E1 stated that the urine was tested and had blood in it. She was informed by the physician to keep her on the antibiotics and that he wanted to see R1 again in his office on Thursday (06/23/05).

E1 stated that at this time, the physician also ordered, "a series of blood work".

Per review of Physician's Order's, orders state, "Keep foot elevated - Stay off feet for 3 days".

Per review of Physician's Order sheet, labs that were to be drawn were: Complete Blood Count, Comprehensive Metabolic Profile, Depicted level. T3, Thyroid Sensitizing Hormone, Bill Rubin and Foliate level.

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E1 stated that Z1 had said that it would be okay to wait and get the blood work drawn on Thursday (06-23-05), when the visiting phlebotomist from the local hospital came to the facility.

E1 stated that the Nurse Consultant was not contacted before or after the Doctor's appointment.

Surveyor found no documentation to inform direct care staff, working with R1, that she was to have her feet elevated and to stay off them for 3 days.

There is no evidence of monitoring vital signs and signs and symptoms of illness.

E1 stated on 06/21/05, R1's condition began deteriorating and that R1 began having trouble walking and that staff were having to hold her up to walk.

E1 reported to surveyor that R1 was crying and having frequent urination. E1 stated that R1 normally has a good gait, and that she has never known her to fall before. E1 stated that she paged E2, waited 10 minutes with no response and paged her again. E1 stated that, after waiting another 10 minutes, with no response from E2, she called Z1 and informed him that she needed a prescription to take R1 to the local hospital. E1 stated that this prescription was immediately faxed to her.

E1 continued to say that E2 never called back after being paged twice, and that she (E1) called E3, (President of the Corporation that owns the facility), and was instructed by him to send R1 to the emergency room.

E1 stated that R1 was taken, by ambulance, to the local emergency room, around noon, on 06/21/05. E1 stated that at the hospital, a Physician's Assistant examined R1. E1 stated that she relayed all of R1's symptoms to the Physician's Assistant.

E1 stated that the staff at the local hospital came into R1's room and attempted to draw blood 3 times and were unsuccessful.

E1 then said that R1 was taken for a Venous Doppler Study, and X-Rays of her Right leg, hip, pelvis and foot.

Per review of Emergency Room Records, when R1 arrived at the emergency room she had 1+ pitting edema to the Right foot. The Venous Doppler Study and all X-Rays were negative. The Physician's Assistant had ordered blood to be drawn for a Complete Blood Count.

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Per interview with E1, on above date and time, E1 stated that when R1 was being taken back to the emergency room after having the Doppler study done, at approximately 3:00 P.M., they ran into E2, who works at the hospital as an emergency room nurse. E1 said that E2 was not aware that R1 was at the hospital until this time. E1 reported to surveyor that E2 asked what they (R1 and E1) were doing at the hospital. E1 stated that she told E2 that R1 was sick and that they were coming back from a Doppler study. E1 said that E2 made no comment and she took R1 back to her room.

E1 continued to say that while they were in the emergency room, a tetanus shot was given to R1.

E1 said that, at approximately 4:20 P.M., E2 came into the room and picked up the lab tray that had previously been used in the attempts to draw R1's blood. E2 asked E1 if they were doing okay. E1 stated that she told E2 they were fine, because R1 had fallen asleep.

E1 stated that she waited at the nurse's desk until E2 came up and E1 told her that she was going to step right outside the back door, by the emergency room entrance, for 5 to 10 minutes, and that if they needed her, to come and get her. E1 stated that E2 said, "Okay".

E1 said that she had been sitting at the picnic table, right outside the emergency room entrance, approximately 5 minutes, when R1 was brought out of the emergency room on a stretcher and was being loaded into the ambulance.

E1 said that she went back inside the emergency room and asked E2 where R1 went. E1 stated that E2 informed her that R1 had been discharged. E1 asked E2 where her discharge papers were and E1 stated that E2 said that she did not know where they were. E1 said that she asked another person in the emergency room where R1's discharge papers were and she said that the discharge papers had been put in the ambulance with her and sent back to the facility.

E1 said that when she returned to the facility, the ambulance crew was placing R1 into her bed at the facility. E1 stated that she got the discharge papers and the diagnosis was, "Contusion L. (left) Leg". Orders were to give her Motrin 800 milligrams three times a day, which she was already on. E1 stated that it was after 5:00 P.M., and there was nothing more she could do that day, so she told the staff at the facility to keep fluids in her, keep her leg up and to assist her in whatever way they could.

There is no evidence that the direct care staff notified the attending physician, facility's nurse consultant or the president of the corporation that owns the facility of R1's ongoing health status.

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When asked if R1's vital signs were taken and documented after R1 returned home from the local hospital emergency room on 06-21-05, E1 stated that it never occurred to her to take the vital signs.

E1 continued to say that E2 was aware of R1's emergency room visit and discharge and gave no orders other than to keep an eye on her.

Per interview with E2, on 06/23/05, at 6:07 P.M., E2 stated that she is the Nurse Consultant at this facility, another facility in the region and also works full time as an emergency room nurse at the local hospital.

When asked how she could work 3 jobs and still be available 24 hours a day, to go into the facility and assess clients as necessary, E2 stated that if she was working at the local hospital, she could probably leave if she had to, but that she couldn't do it very often.

E2 continued to say that she was not aware of R1 falling on 06/20/05 until 11:00 A.M., the next day.

E2 continued to say that she was not aware that R1 had been taken to the doctor's office and was not aware of his orders for blood work to be done.

E2 stated that she was at the hospital when R1 was brought in by ambulance, assessed and discharged.

E2 stated that R1 was only seen by a Physician's Assistant, and not by a Physician. E2 also stated that she was upset when R1 was discharged from the emergency room without having her blood work done. E2 stated, "They could have done a femoral stick, they do it all the time".

E2 stated that she had questioned the Physician's Assistant about not doing a femoral stick on R1 after R1 had been discharged and that the Physician's Assistant had taken offense to her questions. E2 stated that she had stopped questioning the Physician's Assistant because, "I have to work with them".

When asked about vital signs not being taken over the weekend, while R1 was ill, E2 said that she takes each client's vital signs monthly, but if they are ill then vital signs are taken before staff calls her. E2 stated that vital signs should have been taken and documented regarding R1.

E2 continued to say that the direct care staff is not knowledgeable about medical issues.

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E1 stated that when she arrived to work at 8:00 A.M., Wednesday morning (06/22/05), R1 was really ill. E1 said that she did not know what to do, since she had taken R1 to the emergency room the day before, and they had, "Brushed her off".

E1 stated that she was really worried about R1, and that she checked on her often, that morning, to see if she was still breathing.

Per review of R1's medical file, there is no evidence that E1 notified the facility's nurse regarding R1's deteriorating health status nor evidence that R1's vital signs were taken.

E1 stated that she called E3, (Qualified Mental Retardation Professional), (E3 works at another facility owned by the same persons that own this facility and does the monthly reports for this facility), and explained the situation to her. E1 stated that E3 told her to contact R1's guardian and get permission to take her to another local hospital and to do it today, not to wait until Thursday for R1's doctor's appointment.

E1 stated that she called the Office of State Guardianship, (OSG) and was unable to talk to R1's guardian, but the supervisor at OSG listened to E1's concerns and gave his permission to take R1 to another hospital.

E1 said that she called Z1 and had him fax a prescription to her for her to send R1 to another local emergency room.

E1 stated that when she arrived at the emergency room, R1's blood pressure was very low. E1 said that blood work was done, chest x-rays taken, an intravenous line started and a urine specimen obtained.

E1 said that all the results were back within 20 to 25 minutes. E1 reported that the doctor informed her that R1 had, "A host of problems, and the main problem being Septicemia". E1 stated that R1 was admitted to the Intensive Care Unit.

Per review of R1's hospital records, dated 06/22/05, R1 arrived at the emergency room at 1:50 P.M. Blood pressure at that time is documented as being 77/41. Other vital signs were documented as being; pulse 92, respirations 18, temperature 97. Documentation continues to state, "She was also noted to have a white count of 24,000 (normal white count is 4.5 thousand to 11.0 thousand). Furthermore, she was also noted to have elevated BUN and creatinine. Due to multiple medical problems, she was admitted to intensive care unit".

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Documentation also states, "I suspect she probably has pre-renal azotemia and with this clinical severe hypotension with the sepsis, the patient may quickly go into acute tubular necrosis if her blood pressure cannot be maintained well for sufficient renal perfusion pressure..."

Condition at the time of admission to the intensive care unit is documented as, "Guarded".

Diagnoses' at the time of admission to the intensive care unit are documented as being: Acute Renal failure, Hyponatremia, Sepsis, Multiple falls, Hypokalemia, Mental Retardation and Thrombocytopenia.

Per observation of R1, on 06/23/05, at approximately 3:00 P.M., in the Intensive Care Unit, of the local hospital, R1 appeared to be asleep. Her skin was cool to touch. R1 had an Intravenous Line in her left arm, heart monitors and a urinary catheter.

Per interview with Z2, (Physician at the local hospital where R1 is admitted), on 06/23/05, at approximately 3:50 P.M., Z2 informed surveyor that the Sepsis had originated from R1s bladder. Z2 also informed surveyor that Central Intravenous Line was being put in R1 that afternoon. Z2 reported R1's condition as being, "Serious", at that time.

Per interview with E1, on 06/24/05, at 9:15 A.M., E1 informed surveyor that she had provided the surveyor with all the documentation available in regards to R1's recent illness and hospitalization.

Per interview with E2, on 06/30/05, at approximately 10:35 A.M., E2 stated that she had not been notified of R1 being taken to the Physician's office on 06/20/05, his recommendations to keep her off her feet and for the blood work to be done.

E2 stated that if she were aware of the Physician's orders, she would have had the blood work done at that time, that all labs should be done as soon as they are written. E2 continued to say that by delaying the blood testing on R1, this may have had an impact on her medical condition. E2 said that she should have been contacted so she could get the antibiotic after hours and start it immediately. E2 stated, "We do it all the time".

Per fax sent to surveyor, on 06/28/05 by E2, E2 states, "I expect to be called when there is any change in a resident's medical condition. I have a beeper, cell phone and home phone both with voice mail".

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Fax continues to state, "I was not called when (R1) went to see (Z1), I was not called to train staff on the antibiotic that was to be administered to her, I was not called that she was going to (local hospital) ER (emergency room) nor was I informed that she was going to (another local hospital) ER...".

The facility's failure to provide appropriate health care, monitoring and follow up on medical issues also has the potential to affect R2 through R15 whose ages ranging from 20 to 82 years and diagnoses including: Asthma, Anemia, Functional constipation, Chronic Conjunctivitis, Spina Bifida, Bladder spasms, Virginities, Peri-anal dermatitis, Seizure disorder, Degenerative Joint Disorder, Gastroesophageal Reflux Disorder, Chronic Obstructive Pulmonary Disease, Colitis, Osteoporosis, Hepatitis B carrier and Alzheimers Disease.

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