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| **LIVINGSTON MANOR** | **RURAL ROUTE 1 PONTIAC, IL 61764** |

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| F 324 | Continued From page 14<br>reflect individualized information to prevent elopement. | F 324 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.610a)<br>300.690a)<br>300.1210a)<br>300.1210b)4)<br>300.1210b)6)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.690 Serious Incidents and Accidents<br>a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis | F9999 | | |

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| F9999 | Continued From page 15<br>shall be reported to the Department.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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.<br>b)4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following:<br>b)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.<br><br>These regulations are not met, as evidenced by the following:<br><br>Based on observation, record review and interview the facility staff failed to supervise one of 11 residents (R1) assessed at high risk of elopement every 30 minutes per R1's plan of care which allowed R1 to leave the wing and exit the building on the midnight shift without staff knowledge. Staff failed to immediately respond to the activated door alarm on A wing by not immediately thoroughly searching outside of the building at the activated doors per their elopement policy before starting a head count indoors on that wing. This delay allowed R1 to gain access to a two lane highway, where a | F9999 | | |

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| F9999 | Continued From page 16<br>motorist almost hit the resident.<br><br>The findings include:<br><br>On 7/24/06 at 8:45 am the Activity Director of Nurse's, E2, and Social Service Director, E12, were questioned about any incidents with residents that have been assessed at high risk for elopement (leaving the building unnoticed). E 2 stated that (R1) had recently gotten out of the exit door and had gotten all the way out to the road. E2 stated that staff were responding to the alarm. E2 indicated R1 had severe behaviors of hitting, kicking and verbally threatening staff and refusing medications and that R1's family would not allow the use of psychotropic medications. E 2 stated that R1 has Parkinson's and walks with a rolling walker, but she didn't believe he took it with him when he left the building.<br><br>The facility's Unusual Incident Report dated 7/08/ 06, 11:50 pm, stated "Resident (R1) went out A wing exit door - located by staff on side of road on (Route) 66 -returned to facility (without ) incident- appeared to have no apparent injuries." The names and titles of staff who were involved included Licensed Practical Nurse (LPN) E6, LPN E10, Certified Nurse Aide (CNA) E4, CNA E8, CNA E9, CNA E7, and CNA E5. Follow up action included resident placed on 10 minute checks with (one:one supervision) as needed and "Stop" sign mesh coverings for doors ordered.<br><br>R1 was admitted to the facility on 6/01/05 per review of admission sheet. The Physician's Order Sheet (POS) dated 7/16/06 lists diagnoses which included Cerebral Vascular Accident (CVA ), Parkinson's, Atrial Fibrillation, Dysphagia, Depression, and Organic Mental Syndrome with | F9999 | | |

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| F9999 | Continued From page 17<br>Associated Psychotic or harmful behaviors. The Activity level specifies on the 6/15/06-7/15/06 POS as well as the current POS states "May Not Go Out on Grounds Unsupervised."<br><br>R1's Significant change assessment dated 07/05/06 identifies R1 as having short term and long term memory problems with cognitive skills for daily decision making at modified independence with some difficulty in new situations only. Mood and behavior patterns include repetitive health complaints, unpleasant mood in the morning, insomnia/change in usual sleep pattern and repetitive physical movements. Behaviors are identified as verbally abusive behavior, physically abusive behavior and socially inappropriate behavior, and resisting care on a daily basis. The assessment identifies falls in the past 30 days and standing balance test requires partial physical support due to not following directions.<br><br>R1 was assessed at a High Elopement Risk for assessments conducted on 6/10/06 and 7/06/06 with a score of 6 out of 7 indicators of risk. The care plan dated 6/14/06 identifies problem #4 " Resident is at risk for leaving the facility unattended (related to) confusion." The goal is Resident will not leave the facility unsupervised through 9/14/06. One of the approaches is to follow facility policy and procedure for elopement. The 7/11/06 Care plan note documents "#4 Goal not met - resident has attempted to leave facility unsupervised." R1 is also at high risk for falls per the 6/14/06 plan of care and and has been on 30 minutes interval visual checks since 6/28/06 as part of a fall prevention plan.<br><br>The Psychiatric Exam conducted by Z2 on 6/26/06 for R1 documents for cognitive status in part | F9999 | | |

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| F9999 | Continued From page 18<br>"....Patient is alert and oriented times 3. His recent memory is impaired; ....His judgement is impaired; he does not know what to do if there is a fire in a movie theater. His fund of knowledge is impaired; he does not know the name of the President, or his predecessors..... R1's mental status ..patient exhibits dysphoric affect, decreased energy and concentration. Significant irritability and resistance to care is present... Diagnosis: Depression, secondary to medical condition, Mixed personality disorder with prominent passive-aggressive features...Level 3 to 4 problems coping with living in facility and with cognitive impairment..."<br><br>R1's nurses notes dated 7/09/06 1:00 am document "at approximately 11:50 pm (resident) went out A wing exit door - staff located resident on side of road on Rt. 66 - was brought back to facility per staff without incident. Assisted resident to bed resident became angry and swung at staff, removing bed alarm by self-staff walked with resident down hallway resident wanting to leave facility. (One to one ) with resident with 10 minute checks initiated..."<br><br>The surveyor attempted to interview R1 on 7/24/06 at 9:45 am. The resident was lying in his bed, he was very agitated and was tremoring. R1 refused to talk to the surveyor. R1 was reapproached for interview on 7/24/06 at 12:30 pm. R1 denied leaving the facility after dark, or being out in the road. R1 stated, "Everyone said it was me, I never went outside after dark. That was a mistake, they had a meeting about me saying I went outside but it wasn't me."<br><br>Staff interviews conducted on 7/24 and 7/25/06, and review of the nursing schedule for 7/08/06, | F9999 | | |

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| F9999 | Continued From page 19<br>showed that the 10:45 pm - 6:45 am shift had one CNA for A wing, two CNAs for B wing and two CNA's for C wing. There was one LPN to cover both A and B wing and one LPN to cover C wing.<br><br>The following interviews demonstrate that at the time R1 exited through the A wing door, there was one CNA on A wing and one CNA on B wing . The nurse covering the A/B wings was off of the units.<br><br>On 7/24/06 at 3:50 pm CNA E4 was interviewed per telephone. E4 stated that she had been working the midnight shift on the C wing on 7/08/ 06, when the nurse from A wing called to tell them the A wing door alarm was sounding. E4 stated that she and the nurse checked R2 (high elopement risk ) first and then called over to B wing to tell them to check for R1 (high elopement risk). E4 stated that she and LPN E10 went out the front doors to look for R1. E4 stated they didn't see him in the parking lot near the building. E4 stated she didn't have her glasses on and there were a lot of bushes so she and LPN E10 got into E10's car and drove around the building and when they came around to the front they saw him (R1) walking on the side of the road. E4 stated she got R1 into the car. R1 stated that he was going home and that he would take a ride. E 4 stated R1 was at the first (north) entrance driveway to the facility. E4 stated that R1 probably walked from A wing to the second ( south) entrance driveway and then north toward town. E4 said they had R1 in the car when a lady in a car pulled up real shaken and in tears and told them she almost hit him and two other cars had swerved ahead of her. E4 stated that the lady was so shaken up that she came inside the | F9999 | | |

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| F9999 | Continued From page 20 | F9999 | | |

building for about a half hour to calm down. E4 stated she told R1 that he had almost gotten hit by a car and the resident denied it and was very confused. E4 stated that R1 was wearing sweat pants a shirt and white socks (no shoes). E4 stated R1 also did not have his walker with him. E4 stated that no one had asked her to write a statement after the incident.

LPN E6 was interviewed by telephone on 7/24/06 at 9:40 am. E6 stated that she had been on B wing (where R1 resides) for the 3:00 pm - 11:00 pm shift . E6 stated that R1 was having a good afternoon with no behaviors on that shift. E6 stated she was covering the A wing from 11 pm until 1:00 am. on 7/08/06. E6 stated she had left the A wing for approximately 7-8 minutes to talk to a nurse on C wing about a resident. E6 stated she doesn't remember which way she walked when she went to C wing but on the way back she came through the dining room area and front office. E6 stated it was when she got to the vending machines that she heard that the door alarm was sounding. (Per E6's written statement taken on 7/09/06 this was approximately 11:50 pm.) E6 didn't know how long it had been sounding. E6 stated when she got to the A nurse's desk, CNA E7 was coming out of a room. E6 stated she looked out both doors (two exit doors at end of T corridor on A wing) and couldn't see anything so she stayed in the building, notified C wing and started a quick head count with priority being the new lady (R4). E6 stated that when she had looked toward the road she could see the parking lot, beyond that it was dark and she didn't see anything moving. E6 stated at that time she didn't know it was R1 until she called C-wing. E6 stated we thought maybe the new lady had gone to the door and set it off. E6

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| F9999 | Continued From page 21<br>stated that she did not go outside, she saw R1 when they brought him back in the car. E6 stated that his clothes were not messed up, he was dressed except he was wearing socks (no shoes) , and there was no active bleeding or evidence of injury. E6 stated R1 would not let her do any other assessment and was raring to go back out again. E6 stated "He made it out there without shoes and a walker. He's pretty quick when he gets upset." E6 stated she had heard that "(R1) had been out in the middle of the road."<br><br>CNA E7 was interviewed per telephone on 7/25/ 06 at 9:50 am. CNA E7 was working on A-wing on 7/8/06 on the 10:45 pm-6:45 am shift. E7 stated that she had started work at 10:45 pm and was on the wing the whole time. E7 stated that she did not see R1 on her wing prior to the door alarms sounding. E7 stated that she was in a resident's room with the door shut, (close to the nurse's desk) assisting a resident to the commode and was starting to help (R3) back to bed when she heard the door alarm go off. E7 stated she finished with the resident, estimating that it took her 3-4 minutes to respond to the alarm. E7 stated she ran around checking her residents and then the B wing nurse came running down and told her that R1 was out. E7 stated she ran out the side door at the back to see if anyone was out there. E7 stated it was dark and she couldn't see far. E7 stated "I had run out back to look and as I came around the front they already had (R1)."<br><br>LPN E10 was interviewed on 7/25/06 at 6:10 am per telephone. E10 had been working on the C wing on the night of 7/08/06. E10 stated "The A wing nurse had called the wing to report the outdoor alarms on A wing were sounding. (CNA | F9999 | | |

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| F9999 | Continued From page 22<br>E4) had mentioned R1 was up so we ran out the front door and jumped into my car, felt it would be faster." E10 said she was driving and (E4) was in the passenger side. E10 stated we saw someone by A wing so drove that way and saw it was (CNA E7) so we went around the back of the wing by the buildings and the cornfields looking for a break in the corn and calling his name... As we came along the north side of the building we caught a glimpse of someone by the road and I also saw three cars coming towards us. All I could think of was I needed to get those cars to slow down so I drove toward the stop sign, like I was going to run the stop sign and pull onto the road." E10 stated when they got to (R1) and got him in the car, and (CNA E4) said she saw someone pull into the entrance. E10 said a girl pulled in and said she had almost hit him. LPN E 10 stated she didn't know if (R1) had tried to go out the doors prior to this incident, but he had gone out the doors by the Physical Therapy doors on the 3-11 shift last evening (7/24/06). E 10 stated that the alarm had sounded and he was out there, they brought him in reluctantly, and he was not hurt. (Per review of R1's nurse's notes this occurred on 7/24/06 at 9:30 pm.)<br><br>CNA E8 and CNA E9 were assigned to B wing where R1 resides on 7/08/06. Neither CNA were aware that R1 had left the wing until notified by telephone. E8 was interviewed on 7/24/06 at 4: 40 pm per telephone. E8 stated that she only works every other weekend and was working on B wing the night of 7/08/06. E8 stated that she started the shift at 10:45 pm and she saw R1 was lying in his bed at that time. E8 stated that she hadn't gotten report yet, (which is usually around 11:45 pm) when she heard the phone ringing and it was the A wing Nurse (E6) calling to say the | F9999 | | |

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| F9999 | Continued From page 23<br>alarm was ringing. E8 said she also received a phone call from C wing. E8 said she checked R1 's room and he was gone so she told the other CNA, (E9), that she was going outside to look for him. E8 said it was dark and she was trying to look for him in the trees. E8 did not take a flashlight. E8 said she went out the back door took a right and went all the way around the building (approximately 10-15 minutes) and then saw E4 bring R1 in. E8 stated that she wrote out a statement and gave it to the nurse. E8 confirmed seeing R1 in bed at 10:45 pm. E8 stated that she was responsible to to do the half hour checks which she would have done at midnight with the first bed checks.<br><br>CNA E9 was interviewed on 7/24/06 at 3:20 pm and on 7/25/06 at 1:35 pm by telephone. E9 stated that she had left B wing around 11:45 pm to walk over to C wing and then to use the restroom and go to the break room for coffee. E9 stated she heard the alarm ringing when she came out of the break room. E9 stated that she hadn't seen (R1) up in the hallway that night. E9 stated as soon as we heard about the alarm, (E4 and E10) got into a vehicle and drove around. E 9 said "We know who the elopement risk people are. R1 says he wants to go home a lot." E9 stated a lady said she had just about hit (R1) with her car. She stayed in the building and left her name and phone number. E9 stated that the Director of Nurses (E3) had told them all to write a statement. E9 said there were no inservices held to discuss the incident after that. When asked on 7/25/06 at 1:35 pm about the 1/2 hour checks for R1, E8 responded that one of the CNA's usually walks down to check on the residents but sometimes they forget to write it down. | F9999 | | |

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| F9999 | Continued From page 24<br><br>The documentation of the 30 minutes checks for R1 for 7/08/06 was reviewed. The form was blank from 6:30 am until 2:30 pm. From 3:00 pm until 10:30 pm R1's whereabouts were noted. R1 was documented as in bed at 10:30 pm . There was nothing written for 11:00 pm or the 11:30 pm half hour checks. R1 was documented to be out of the building at 12:00 am on 7/08/06 and in bed at 12:30 am on 7/09/06.<br><br>There was no documentation in the nurse's notes nor the facility incident report about the resident being almost hit by a car and no mention of a witness in a car. On 7/24/06, at 3:30 pm Acting Director of Nurse's E2 was asked for the motorist and staff written statements and any investigation report they had for R1. On 7/24/06 at 4:20 pm E 2 stated that she had left a voice mail for the Director of Nurse's to try to locate the statements or additional investigation report. E2 brought the written statements to surveyor to review on 7/24/ 06 approximately 4:45 pm.<br><br>Motorist, Z1's signed written statement said "Was driving south on old (Route) 66. Noted a person walking in the middle of the road. Had just turned bright head lights back on. Noted also 2 other cars going North on 66 that were going much faster. Felt I'd either hit the resident or go into the ditch. Neither happened."<br><br>Z1 was interviewed per telephone on 7/16/06 at 9 :50 am. Z1 confirmed that she was driving south on the highway at at least 60 miles per hour sometime between midnight and one am. Z1 stated she didn't see (R1) until he was almost right in front of her. Z1 stated she swerved off the road toward the building and up onto the | F9999 | | |

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| F9999 | Continued From page 25<br>section of old highway between the two entrances to the nursing home parking lot. Z1 then was able to get back on the road and pulled into the south facility driveway. Z1 stated the resident had been in the middle of the two lanes and then had started to go back toward the building across her lane. Z1 stated she didn't know how he made it past those other two cars as fast as they were going. Z1 stated as she pulled into the driveway she saw a vehicle and facility staff with the resident. Z1 stated "The staff did not know anything about what had just happened or what I did." Z1 stated she was freaking out by then. Z1 stated "I've had animals walk out in front of me before but never a person !"<br><br>The facility is in a rural location along a two lane highway with a 55 mph speed limit. Beyond the highway are railroad tracks that run parallel to the highway. The facility is set back from the road with a large parking lot and a lawn with trees between the facility and the highway. Sections of the old highway are located between the facility lawn and the highway between the two entrance driveways. The facility has three resident wings. The A wing is on the front left of the building and the B wing is on the front right. The C wing is located on the back (west) side of the building. The highway is approximately seventy five yards east of the facility from the A wing exit door. The facility is surrounded on the south, west and north sides of the facility by a lawn and cornfields . There is also a hedge row of trees to the west and north side. Per interviews with staff and observations made on 7/25/06, each wing has a separate door alarm system. The signal for each wing is only audible to the staff on that wing and in the vicinity of the wing. | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145930 | A. BUILDING _____ B. WING _____ | C 07/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LIVINGSTON MANOR** | **RURAL ROUTE 1 PONTIAC, IL 61764** |

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|---|---|---|---|---|
| F9999 | Continued From page 26<br><br>The facility policy and procedure entitled " Resident Wandering/ Elopement" revised December 6, 2002 was reviewed. The policy stated under #6, "When a Door Alarm Sounds, Staff Shall Immediately Respond to and Determine the Cause of the Alarm. The staff person responding to the alarm will check the outside of the building to determine if a resident had exited the building. If upon investigation no reason can be found for the sounding of that alarm, the C wing charge nurse should be notified. The C wing or medicare charge nurse shall initiate an accounting of all residents."<br><br>The policy also states "During the initial 15-30 minutes, cover a radius of one mile from the facility. This should include both searches by car and by foot." Per above interviews, the facility staff from each wing searched the grounds, however a thorough search of the front parking lot grounds to the highway was not completed first. The majority of the staff started searching the back of the facility as the A wing exits to the back parking lot and fields as well as the front parking lot and highway.<br><br>Facility policy states "Contact the Illinois Department of Public Health State Survey Agency, Call or fax report within 24 hours of the incident and prepare a complete report at the completion of the incident This shall be reviewed with the Administrator and Director of Nursing Services before submission."<br><br>Per interview with Acting Director of Nursing E2 and Administrator E1 on 7/25/06, at 4:30 pm, there was no incident investigation report completed that they were aware of. Director of | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F9999 | Continued From page 27<br>Nursing E3 had received the written statements from staff and the witness. There had been no inservices or revisions in policy as a result of the incident. The Administrator, E1 stated on 7/25/06 at 4:30 pm that he had no answer for why R1's incident had not been reported to the Department . E1 stated that he had not seen the written statements until today when they were provided to the surveyor. E1 stated that he was aware of R1's incident as it had happened a few days after he had started as interim administrator.<br><br>(A) | F9999 | | |