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

ILLINOIS VETERANS HOME – ANNA	0046599
Facility Name	I.D. Number
792 NORTH MAIN STREET, ANNA, IL 62301	
Address, City, State, Zip	
	AUGUST 4, 2006
Reviewed By	Date of Survey
INCIDENT REPORT INVESTIGATION OF 7/28/06	
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):

340.1505e) Section 340.1505 Medical, Nursing and restorative Services

e) All necessary precautions shall be taken to assure that the resident's 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.

This requirement is not met:

Based on record review and interviews the facility failed to implement adequate procedures to prevent one resident from the sample of three residents from exiting the facility unassisted by staff.

Findings include:

1. A review of the incident report dated 7-28-06 at 3:30pm, shows that a housekeeping staff person (E2) was leaving the facility and saw R1 across the street up to the fourth drive. Observation of this location on 8-3-06 shows that the area is approximately 20 feet from the facility property, and 500 feet from the closest facility exit door. The report states that E2 was able to bring R1 back to the facility. The incident report identifies that R1 has a diagnosis of Alzheimer. The incident report fails to identify when R1 was last seen prior to being found outside, and thus the length of time unsupervised is not identified. The report also identified that R1 was without injury.

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Observation of the surrounding area on 8-3-06, shows that there is a large pond that is approximately 700 feet from the back door of the facility, and a rock quarry approximately 1200 feet from the facility. Observation of R1 on 8-3-06 at 2:00pm, shows R1 to be ambulatory but very confused. Interview with R1 shows that R1 is unable to identify what a red sign with the letters "S T O P" mean. Interview with Z2 (R1's physician) on 8-3-06, confirms that R1 can not recognize dangers, and is not suppose to be out of the facility unsupervised.

Interview with administrator (E3) on 8-3-06 at 1:15pm, shows that the facility investigation concluded that the backup door alarm to door #16 was turned off for a delivery. The electronic monitoring alarm for door #16 has a 54 second delay. E3 feels that a staff member keyed in the code number to exit door #16 which allows a 54 second time frame of disablement, and then keyed in again upon exiting which again allows a 54 second timeframe for disablement. E3 states that R1 probably followed a staff member out during change of shift. E3 believes that R1 was last seen at shift change or approximately 10 minutes prior to being found at 3:30pm. E3 confirms that the alarm did not sound to alert the staff that R1 had exited the building, and that R1's personal door alarm device was functioning at the time of the elopement.

Interview with Z1 staff from the Southern Illinois University airport reports the weather on 7-28-06, as temperature of 86 degrees Fahrenheit, relative humidity of 70%, with a heat index of 95.1 degrees Fahrenheit, and partly cloudy.

E3 stated on 8-4-06 that the facility decreased the time of disablement to 15 seconds (minimum setting). E3 stated that staff have been in serviced on 8-3-06, in making sure they stay with vendors during deliveries, backup alarm to stay on at all times, and also to watch the door during exiting the building to monitor for any resident following their exit.

(A)