STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)



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|---|---|
| GOWIN PARC OF MATTOON | 0048769 |
| Facility Name | I.D. Number |
| 300 LERNA ROAD SOUTH, MATTOON, ILLINOIS 61938 | |
| Address, City, State, Zip | |
| | JULY 6, 2007 |
| Reviewed By | Date of Survey |
| COMPLAINT 0762651 | |
| 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.

**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):

**330.330**
**330.710a)c)2)**
**330.1120a)**
**330.3060g)**

**330.330 Definitions**

Personal Care - assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual.

**330.710 Resident Care Policies**

a) The facility shall have written policies and procedures which shall be formulated with the involvement of the Administrator. These written policies shall be followed in operating the facility.

c) These written policies shall include, but are not limited to, the following provisions:

2) Resident care services including physician services, emergency services, personal care services.

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**330.1120 Personal Care**

a) Each resident shall have proper daily personal attention and care.

**330.3060 General Building Requirements**

Every building shall:

g) Have each exterior door equipped with a signal that will alert personnel in the area if a resident leaves the building. An exterior door that is supervised during certain periods during the day or night 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.

This requirement is not met as evidenced by:

Based on observation, interview, and record review the facility failed to supervise R2, one of four residents sampled. Further, the facility failed to have policies that addressed supervision of residents who are allowed out of doors.

Findings include:

Review of R2's most recent Physician's orders dated July of 2007 showed R2 has diagnoses of Senile Dementia, Vascular versus Alzheimers; Psychosis and Aggression due to Senile Dementia.

A document identified and signed by the Administrator is an incident report describing the circumstances of 6/16/07 involving R2. The report read in part, "... Conclusion: based on talking to staff present, resident was given hydration, checked on during appropriate intervals and it's family's wishes that he be outside."

Nurses notes dated 6/16/07 at 4:05 PM and signed by E6, Licensed Practical Nurse (LPN), indicated R2 had gone missing from the facility's supervision. The notes stated, "...Went to look for res (R2) to give 4:00 P (PM) medicine, found res outside in backyard of house B...res was observed sitting in backyard A around 1:15 p (PM). Res (R2) was standing next to rod [sic] iron fence in house B (backyard) face bright red, sweating and drooling. Res (R2) unable to ambulate on his own took two to assist back inside. Res (R2's) wife (Z2) came to visit and observed condition. Sat res (R2) down cool towels applied to forehead (and) back of neck, pushed fluids...then gave res (R2) a tepid

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shower...Res reported feeling better. Cont (continued) to push fluids, Tylenol 1000 mg. given, gatorade provided...notified Executive Director...2+ pitting edema noted to bil (bilateral) ext (extremities). Res (R2) sitting on sofa (with) bil ext (elevated).....7:30p (PM)...cont (continued) to push fluids (water) (and) gatorade...Res (R2) reports feeling a little wobbly. Con't (continued) to need assist with ambulation (and) toileting. Has been incontinent of urine x 2..."

Interview with E6 on 7/2/07 at approximately 1:30 PM on the telephone confirmed the nurses notes. E6 stated, "On 6/16/07 at 1:05 (PM) I had observed (R2) outside in the swing. E7 and E8, Certified Nurses Assistants (CNAs), said yes they knew he was out there. At 3:30 (PM) I missed (R2). I was doing med pass. I ran outside, he had climbed over the fence (a fence that separates one half of the back yard from the other half)... he (R2) was tearing at the (patio) umbrella...his (R2) face was beet red and he was drooling...I was trying to get him inside...he was very confused...wife (Z2) said this is how he was when he had his stroke...His wife helped me get him inside...gave him fluids and a tepid shower...I took his temp...I don't recall what it was...it was elevated..."

When asked if staff had been supervising (R2), E6 stated, "I know the CNAs did not know (how long R2 had been out) because (E7), one of the CNA's asked me how long he (R2) was out (outside). Also, (E8) did not know how long he (R2) had been out there because I asked him. I found him (R2) at 3:30 PM and (R2) was still sitting and weak at 8:00 PM...and he is usually up and pacing...he also still had 3+ pitting edema to mid-calf both legs. The doctor was notified and had me watch him..."

Interview with Z1, Physician, on 7/2/07 at approximately 1145 AM, confirmed E6 had notified him on 6/16/07 of the problems with R2. Z1 stated, "(E6) stated to me they (the CNA's) had taken him (R2) outside and forgot him. She (E6) said his (R2's) face was red and he was having difficulty walking. She said his legs were swollen. She told me she was rehydrating him and he was getting better. I told her to continue monitoring him... R2 is severely cognitively impaired and would not have any idea how long he was out or how hot he was getting..."

Interview with Z2, R2's spouse, on 7/2/07 at approximately 2:30 PM per telephone indicated she arrived on-site on 6/16/07 just when staff located R2. Z2 stated, "...he was still outside when I came up...he was having trouble walking. I did say he was walking somewhat like he did when he had his stroke...He was red in the face...I don't remember if he was drooling or slobbering...I inquired as to why he was on the wrong side (of the fence). Someone had said that he (R2) set a game device on edge and climbed over the fence...he would not have awareness enough to come in out of the heat..."

Interview with the local airport monitoring station on 7/2/07 at approximately 1:30 PM indicated the ambient air temperature at the airport at 1:00 PM on 6/16/07 was 93 degrees

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Farenheit (F). At 2 PM the temperature was 94 degrees F. and at 3PM the temperature was still 94 degrees F.

Interview with E10, Chief Executive Officer, on 7/2/07 at approximately 1:00 PM indicated the facility did not have a policy that addressed supervision of residents when outside. In addition, an interview with E11, President, on 7/6/07 at approximately 10:00 AM showed the facility lacked a policy addressing the supervision and oversight concepts that are required under the Personal Care section of the regulations.

Interview with E9, CNA on 6/28/07 at approximately 3:00 PM showed the back yard door alarms were turned off the afternoon of 6/16/07. E9 stated, "I was working that day...they had the alarms turned off that day - they are supposed to check on them (the residents). I believe it was a hot day that day..."

Interview with E10 on 7/27/07 at approximately 1:00 PM indicated the back yard door alarms are sometimes turned off so residents can come and go at will. E10 stated, "yes, sometimes we will turn off those alarms... they supervise the residents when they do..."

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