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

ILLINOIS VETERANS HOME AT LASALLE	0044115
Facility Name	I.D. Number
1015 O'CONNOR AVENUE, LASALLE, ILLINOIS 61301	
Address, City, State, Zip	
02630	AUGUST 1, 2007
Reviewed By	Date of Survey
INCIDENT REPORT INVESTIGATION OF 7/4/07 & 7/14/07	14647
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):

340.1505a)
340.1505a)5)

Section 340.1505 Medical, Nursing and Restorative Services

a) The facility must provide the necessary care and services to attain of maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

These requirements are not met as evidenced by:

1. Based on observation, interviews and record reviews the facility failed to monitor 1 of 1 sampled residents wearing an electronic bracelet (R2). R2 exited the facility without staff knowledge. R2 was found approximately 2 blocks from the front entrance. The facility was unaware of R2's whereabouts until he was found during a security staff's exterior patrol of the building.

2. Based on record review and interviews the facility failed to safely transfer 1 of 1 sampled residents (R1) from the toilet to the wheelchair. R1 fell to the floor during a transfer and was sent to a local hospital were he was found to have a right hip fracture.

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Findings include:

1. According to R2's most current Physician's Order Sheet, dated 7/1/07 through 7/31/07, R2 has a diagnosis of Senile Dementia and wears an electronic bracelet that will lock the exit doors if he attempts to leave. E2 (Director of Nursing) during telephone interview on 8/1/07 at 8:45 A.M., stated that when residents are cognitively impaired and are assessed as being at high risk for elopement, the facility applies the electronic bracelet to ensure the resident does not leave the facility unsupervised.

R2's most current Minimum Data Set (MDS) lists R2 as having problems with short-term memory and his cognition is moderately impaired resulting in poor decision making. The MDS also notes that R2's primary mode of transportation is a wheel chair which he propels himself.

R2 was interviewed on 7/31/07 at 10:40 A.M. When R2 was asked how long he had resided at the facility R2 stated, "I just got here." When reviewing his chart his admission date was back in February of 2005. When R2 was asked what room he resided in R2 stated, "I do not live here, I work here." R2 was sitting in his wheel chair during the entire interview.

"Incident Report", dated 7/4/07 reads, "On exterior patrol, I found (R2) in his wheel chair on Crosat Street (4:45 P.M.), East side of the road as far north as the employee parking lot. I used my cell phone to call the east wing and spoke to (E5 Registered Nurse), told her of the situation and to have someone meet me at the B hall door for us to enter the facility. (R2's electronic bracelet) was checked and is functional. Alarm testing was performed and all alarms are in working order." This report was done by E6 (Security).

E6 was interviewed per telephone on 7/31/07 at 10:00 A.M. and stated that R2 was found on the side street next to the facility. E6 said that R2 was in his wheelchair and must have crossed that street because he was caught in a rut on the other side of the road when she found him. E6 went on to say that she had done a check around the facility at 3:45 P.M. and R2 was not outside at that time so he must have left the facility sometime after that.

On 7/31/07 at 10:30 A.M. E4 (Nursing Supervisor) stated that R2 must have gotten out of the main entrance doors with another resident's family member. According to E2 the incident happened on a holiday and there would have been no staff monitoring the front door.

R2's Nurse's Notes dated 7/4/07 the last sentence reads, "Resident was diaphoretic due to the heat and his clothing was changed." According to the Illinois Department of Natural Resources the temperature in Lasalle at 4:45 P.M. was 84 degrees and sunny.

2. R1's most current Physician's Orders Sheet dated 7/1/07 thru 7/31/07 notes R1 to have diagnoses including: Cardiovascular Accident with right hemiplegia and Hypertension.

R1's Incident Report dated 7/14/07 reads, "Resident does not ambulate. (R1) stands with assist of two. Propels self about facility with 1 foot and 1 hand. Able to understand and able to express self. (E8 VNAC Veterans Nurse's Aide Certified) in orientation, providing A.M. care. Orienting

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person not present when incident occurred. Sign on bed for 2 assist to transfer. Assignment sheet indicates 2 assist. Resident leans to right when standing."

"Alleged Incident" form dated 7/16/07 faxed over to Illinois Department of Public Health notes that E8 was the only witness to the incident and reads, "Resident in bathroom holding on to rail, resident lost balance and was helped to the floor using a gait belt and wall." On the same form where it has "Status of resident" it reads, "(R1) reporting pain in right inguinal area. (R1) was crying in pain."

During telephone interview on 7/30/07 at 10:25 A.M. E8 stated that when R1's call light went off one of the other staff members told E8 to get the light. E8 said R1 was on the toilet and was wanting off. E8 stated he attempted to transfer R1 by himself because he had done this before. E8 stated that other staff persons had told him R1 could be transferred with 1 assist but he does not remember which staff. Just after E8 got R1 to a standing position R1 lost his balance and E8 had to grab the gait belt and help lower him to the floor. E8 then went to get help from E9 (VNAC).

On 7/31/07 at 1:30 P.M. E2 (Director of Nursing) stated that R1 had a similar incident back on 3/23/07 when R1 had to be lowered to the floor during a transfer to a wheel chair. E2 went on to say that from that date on R1 was to have 2 staff for every transfer. E2 said that it was even posted in R1's room that he was a 2 person transfer.

During interview with E9 on 7/31/07 at 9:45 A.M., E9 stated that E8 and E9 proceeded to get R1 up from the ground to the wheelchair before the nurse had a chance to assess R1 for injuries. E9 stated that she knew she should not have moved R1 but R1 was very insistent on getting into the wheelchair. E9 went on to say that after they transferred R1 from the ground to the wheelchair R1 started crying in pain.

On Incident Report where it list "Interventions", it reads, "Resident (R1) had surgical repair of his right hip on 7/15/07.

During interview on 7/31/07 at 1:30 P.M. E2 stated that the facility has inserviced staff on waiting for the nurse to assess a resident before moving them after a fall and that E8 was awaiting a disciplinary meeting regarding the improper transfer of R1 on 7/14/07.

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