

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2013
NAME OF PROVIDER OR SUPPLIER COLONIAL HLTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 BUREAU VALLEY PARKWAY PRINCETON, IL 61356		
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F 323	Continued From page 23 at which time the checks may be discontinued if no exit-seeking behavior is noted. b.) A list of all exit-seeking residents will be evaluated in the daily department head meeting and by the Charge Nurse on weekends. c.) In the event of an attempted elopement or elopement of a resident, that resident will be added to exit-seeking list and one on one observation of the resident will be done for 24 hours. One to one would be discontinued if no further attempts were noted. All staff, except for one Nurse who is out of the country at this time, were inserviced. Forty-eight staff were inserviced by telephone, and the remainder in person. The one Nurse will not be permitted to work, until the Director of Nursing instructs the person on the new policy and procedures. 5. On 1/14/13, the Director of Nursing audited the appropriateness of interventions in place for each wandering or fall risk resident.	F 323			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a)b)c) 300.1210d)6) 300.2900d)2) 300.3100d)2) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	F9999			

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F9999	<p>Continued From page 24</p> <p>comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.</p> <p>b) The facility shall 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 resident care plan. 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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.2900 General Building Requirements Section 300.3100 General Building Requirements</p>	F9999			

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F9999	<p>Continued From page 25</p> <p>d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods 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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Requirements are NOT MET as Evidenced by:</p> <p>Based on interview and record review, facility staff neglected to operationalize the facility's Wandering Resident policy to ensure that detailed monitoring plans were in place for four of seven residents (R1 to R4) assessed by the facility to be at risk for elopement in a sample of five. Facility nursing staff also neglected to implement any interventions when R1 was exhibiting wandering behaviors and document episodes of wandering and exit-seeking behaviors in R1's medical record, as required by the policy. The facility also failed to develop and implement effective, individualized care plan approaches to address the elopement potential for R1. This neglect resulted in R1 exiting the building without staff knowledge, falling outside the building and being diagnosed with hypothermia.</p>	F9999			

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F9999	<p>Continued From page 26</p> <p>Findings include:</p> <p>A facility Incident Summary dated 1/4/13 indicated that R1 was found outside of the building's Southeast door lying on her left side at 7:10 AM that day. The Summary stated that R1 made no complaints of pain when immediately assessed outside, but complained of pain in the right hip once R1 was back in the building. The same Summary documented that on R1's initial assessment after the incident, R1 had a body temperature of 92.4 degrees Fahrenheit (F). The Summary indicated that R1 was transported to the local hospital at 8 AM on 1/4/13.</p> <p>R1's Emergency Department report dated 1/4/13 from the local hospital indicated that R1 was disoriented, had a body temperature of 96.2 degrees F, was cold to the touch, and complained of pain in the left foot, right hip and neck upon arrival at 8:35 AM. The report indicated that R1 was placed in a heated wrap for ten minutes at a high setting to raise R1's body temperature. The report listed diagnoses of fracture of the 5th toe of R1's left foot, hypothermia, and abrasion/bruising of R1's right elbow.</p> <p>Z1 (Emergency Department Physician) stated on 1/4/13 at 2:30 PM that R1 was diagnosed with hypothermia, and that R1's body temperature was back to normal by the time R1 left the hospital early that afternoon with family to return to the nursing home. Z1 said that it was very difficult to estimate the amount of time that R1 was exposed to the cold outside, because there are so many variables. Z1 said that outside temperature was about 10 degrees F with a wind chill of plus 1 degree F at around the time R1 was reported</p>	F9999			

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F9999	<p>Continued From page 27 found out of the building.</p> <p>The National Weather Service website temperature information for the town where facility was located on 1/4/13 at 6:55 AM and also at 7:15 AM indicated that the outside temperature there was 14 degrees F with a windchill of plus 2 degrees F at those times.</p> <p>E4 [Licensed Practical Nurse (LPN)] stated on 1/5/13 at 8:25 AM that E4 reported to work on 1/4/13 at about 6:40 AM. E4 said that E4 had just started medication pass on the East wing at about 7:10 AM when Nurse Aide E6 reported that R1 was outside the Southeast exit door on the ground. E4 said that several staff responded, and that E4 saw R1 on the ground on her left side about three feet away from the door. E4 said that R1 was dressed with a long sleeved shirt, pants that were partially pulled down exposing R1's right hip and lower abdomen, socks and shoes. E4 said R1 was not wearing anything else like a coat, hat, or gloves. E4 said that R1 was alert to person, but did not respond to questions about pain or striking her head. E4 said that after R1 was brought inside, E4 took R1's vitals and gave R1 warm fluids. E4 said that E4 did not remember R1's exact body temperature at the time, but said that it was "low." E4 said that when Nurse Aides took R1 back to R1's room for toileting and dressing with warm clothing, R1 complained of pain in her right hip. E4 said that E4 reported the incident to R1's physician, who gave the order for R1 to be transferred to the hospital.</p> <p>E4 said that R1's normal daily routine was wandering throughout the facility using her</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>walker. E4 stated that R1 wore an electronic monitoring bracelet and thought it was with regard to R1's state of confusion. E4 reported that on the morning of R1's fall outside, E4 heard no door alarms sound. E4 said that E4 did remember hearing the Southeast door alarm sound though when E4 went out that door to assist R1 lying on the ground.</p> <p>E2 (Director of Nursing) stated on 1/5/13 at 9:10 AM that R1 was not at the facility at that time, but was at hospital (other than the local hospital). E2 said that late last night, the facility sent R1 back to the local hospital for continued complaints of pain in R1's right hip. E2 said that the facility learned from the local hospital in the night that R1's right hip had never been x-rayed when R1 first came to that hospital in the morning. E2 stated that when the local hospital did the right hip x-ray late in the night, a fracture was detected. E2 said that R1 was then transferred form the local hospital to the other hospital, because no local orthopedic physician was available for R1's treatment.</p> <p>An x-ray report dated 1/4/13 at 8:57 AM from the local hospital for R1's left foot indicated a displaced acute fracture of the fifth toe. An x-ray report dated 1/5/13 at 1:27 AM from the local hospital for R1's right hip indicated an impacted right hip fracture.</p> <p>While at the other hospital awaiting right hip surgery on 1/7/13 at 9:35 AM, R1 stated to the surveyor that she had pain in her right hip and that she was going to have surgery. R1 was oriented to person only, and unable to correctly identify what town she was in. R1 said that a</p>	F9999			

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F9999	<p>Continued From page 29</p> <p>couple weeks ago she fell on ice at the courthouse in yet another town and broke her hip. R1 said that it was a nice day when she fell, and that the temperature outside was probably 70 degrees F.</p> <p>E13 (LPN) stated on 1/11/13 at 2:40 PM that when she reported to work at 10 AM on 1/4/13, R1 was at the local hospital. E13 said that sometime after lunch, R1's daughters brought R1 back to the facility in a wheelchair on 1/4/13. E13 said that R1 was in the dining room sipping coffee, but was "quiet and not very active." E13 said that when CNA's took R1 to R1's room for toileting, they reported to E13 that R1's transfer was more difficult than usual. E13 said that E13 observed the next transfer of R1 to the toilet after the supper meal, and found R1 to be "shaky" and not able to ambulate independently. E13 said that the next time she checked on R1, R1 had been put to bed.</p> <p>E2 (Director of Nurses) stated on 1/17/13 at 1:50 PM no elopement precautions were put in place when R1 came back from the hospital on the afternoon of 1/4/13. E2 stated that R1's daughters said R1 could not bear weight well and E6 had told E2 that R1 did not transfer well that afternoon.</p> <p>E14 (LPN) stated on 1/15/13 at 8:50 AM that E14 came to work at 7 PM on the evening of 1/4/13 and received report from E13 concerning R1's incident earlier in the day. E14 said that R1's neurological checks were due at 7 PM, 9 PM and 11 PM that night. E14 said that when E14 checked on R1 early that evening, R1 experienced pain in the right hip on movement.</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>E14 said that she administered Tylenol to R1 at around 8:30 PM, but at 11 PM, R1 reported no relief of pain. Also at 11 PM, R1 was not able to move her right hip. E14 stated that E14 then checked R1's record for x-ray results done at the hospital early that same day, but found none for R1's right hip. E14 said that she called the local hospital and inquired about x-rays done on the right hip, learning from staff there that no x-rays were done for that hip. E14 said that after E14 called R1's physician and family members, R1 was then transferred to the local hospital.</p> <p>E6 [Certified Nurse Aide (CNA)] stated on 1/5/13 at 11:05 AM that E6 spotted R1 lying on the ground on her left side just outside the Southeast hallway door at about 7:15 AM on 1/4/13. E6 said that E6 heard no door alarms sound prior to the discovery of R1, and that R1's walker was sitting in the area between the outer and inner Southeast hall doors. E6 said that she called out for help to other staff, and that E6 and E8 (CNA) went out the door immediately to attend to R1. E6 said that E4 (Nurse) also followed them out to assess R1. E6 said R1 was wearing a sweatshirt, pants, socks and shoes at the time. E6 said that R1's pants were down partway, exposing R1's right buttock. E6 said R1 had had a shower that morning, so her hair was still damp, but stiff and frozen on the right side of R1's head. E6 said that when E6 asked R1 at the time what had happened, R1 just said she was "cold." E6 said that R1 later complained of pain in her right hip when E6 was helping R1 get into another set of clothes in the bathroom of R1's room.</p> <p>E6 stated on 1/7/13 at 12:30 PM that E6 was on her way down the Southeast hall to a room near</p>	F9999			

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F9999	<p>Continued From page 31</p> <p>the end of the hallway, when E6 first saw R1 out on the ground on 1/4/13 at about 7:15 AM. E6 stated that E6 was between the last two rooms on the left side of the hall (rooms 42 and 45) at the time. E6 said that the wood bottom panel of the inner end door blocked the view of the ground where R1 was lying, until E6 was almost at the end of the hall.</p> <p>E6 stated on 1/10/13 at 1 PM that R1 generally would wander throughout the facility, sometimes going into other residents' rooms. E6 said in the past one to three months, E6 had seen R1 open the inner door of the set of double exit doors on the Northeast and Southeast halls on occasion.</p> <p>E9 (CNA) stated on 1/5/13 at 1 PM that E9 came to work at 5:30 AM on 1/4/13 and started R1's shower right away. E9 said that when the shower was finished around 6 AM, R1 left the shower room ambulating with her walker, and went into the East dining room. E9 said this was the last time she saw R1 prior to the incident. E9 said that R1 liked to wander in the facility, and sometime in the past, R1 would try to go out doors.</p> <p>E7 (CNA) stated on 1/10/13 at 12:25 PM that E7 has seen R1 out walking on the facility patio when the weather has been nice in the past. E7 stated that this winter, R1 has still tried to go out on the patio on cold days. E7 said that E7 has had to redirect R1 from the patio door by telling R1 that the weather is too cold outside and that R1 does not have a coat on. E7 stated that E7 had observed R1 trying to go outside the patio door every day last week, probably two to three times a day. E7 stated that E7 thought this was just</p>	F9999			

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F9999	<p>Continued From page 32 typical behavior for R1, so E7 did not report these occurrences to management.</p> <p>E10 (CNA) reported on 1/7/13 at 12:55 AM that E10 was evidently the last staff person who saw R1 in the building before being found outside on 1/4/13. E10 said that E10 learned this as a result of management's investigation into the incident. E10 said that at about 6:50 to 6:55 AM on 1/4/13, E10 saw R1 walking with her walker in the center hall by room 27. E10 said that E10 redirected R1 to go back to Northeast hall, where R1's room was located. E10 said that R1 then turned around in that direction, and E10 proceeded to enter another residents's room nearby. E10 said that R1 was a "walker" in the facility.</p> <p>E10 stated on 1/10/13 at 12:40 PM that E10 had observed R1 going outside through the facility's patio door, located off the center hallway in the building, into the large fenced area on nice days. E10 said that R1 has also tried to go out the patio door when it has been too cold outside. E10 stated that within the last two weeks, E10 saw R1 go out the patio door, and E10 had to redirect R1 back into the building.</p> <p>E12 (Activity Assistant) stated on 1/10/13 at 1:25 PM that about a week ago, a nurse asked E12 to sit and do an activity with R1, because R1 was wandering around so much of the time.</p> <p>E5 (Maintenance Director) stated on 1/5/13 at 10:15 AM that E5 checks all the exit door alarms every day, and that on 1/3/13 the Southeast door alarms worked as usual. E5 said that when he checked the alarms on that door at 8:30 AM on 1/4/13 after the incident, they both worked then</p>	F9999			

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F9999	<p>Continued From page 33</p> <p>as well. E5 said that E5 maintains a log book in which he checks off alarms for each exterior door in the building when the alarms work properly when tested.</p> <p>E5's door alarm test sheet for December 2012, inspected on 1/5/13, contained check marks for every exterior door alarm location, indicating that the alarms were functional. The January 2013 test sheet also indicated by check marks that all door alarms were functional when tested for the first four days of the month.</p> <p>The Southeast hall double exit doors were located at the far end of the hallway. The inner door was wood frame with a glass panel in the center, and the outer door was mostly glass with an aluminum frame. The outer door was equipped with both a built-in central alarm contact on the door jamb and a portable battery powered alarm unit attached to the face of the door. Both alarms were operating when the door was opened on 1/5/13 and again on 1/7/13. The outer door was locked from the outside when closed, so R1 could not have re-opened the door once outside. A sidewalk led from the door onto a larger asphalt walkway which extended around the South side of the building. The area outside the door was enclosed by a fence which also enclosed the facility's South patio area.</p> <p>Neither of the Southeast doors were equipped with hardware to detect a resident electronic monitor bracelet. This type of hardware was noted only on the facility's front door and two doors leading to the facility's main parking lot. The facility's patio door was located off the middle of the Center hallway which joined the East and</p>	F9999			

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F9999	<p>Continued From page 34 West wings of the building.</p> <p>R1's Diagnosis Codes sheet dated 6/22/12 indicated diagnoses of Schizoaffective Disorder, Senile Dementia with Depressive Features, Depressive Disorder, among others. R1's Elopement Risk Assessment sheet, which included assessments done on 12/5/12 and 1/4/13, indicated that R1 scored a "3" and a "4" on those dates, respectively. The sheet stated that a score of "4 or more indicates risk and requires interventions/care plan."</p> <p>R1's Care Plan last updated on 11/28/12 listed a problem of "Elopement Potential for injury R/T exit seeking, looking for something." for R1. The total approaches listed for this problem were: "1:1 time; Attempt to identify the antecedent to the behaviors (cause); Family/significant other visit; Implement a toileting schedule; Offer food/drink; Place resident picture in the Elopement binder at each desk; Redirect with activity; and Electronic Monitor Bracelet, check daily."</p> <p>E11 (Care Plan Coordinator) stated on 1/7/13 at 1:20 PM that a Dementia resident who is ambulatory and wanders meets the criteria for elopement precautions. E11 said that the facility would rather error on the side of safety for residents exhibiting this behavior. E11 said that elopement precautions are to place an electronic monitor bracelet on the resident, put the residents's picture in the "wander book" at the front and back nurses' stations, and have staff "watch these residents more." E11 stated that having staff "watch" the residents did not mean that these residents would be placed on a specific monitoring schedule though.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2013
NAME OF PROVIDER OR SUPPLIER COLONIAL HLTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 BUREAU VALLEY PARKWAY PRINCETON, IL 61356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	Continued From page 35 E2 (Director of Nursing) stated the following on 1/8/13 at 11:20 AM with regards to the approach of "1:1 time" listed in R1's Care Plan: "We don't do one to one time, that is, staff sitting with a resident at all times. One to one is meant at the time, for example, a Nurse would redirect a resident." E2 also stated with regards to facility procedure for elopement risk residents that an electronic monitor bracelet is to be placed on the resident as a precaution, but that the care for these residents "really isn't any different." E2 said that residents who become "exit seekers" need to be placed in another facility with a locked Dementia Unit. E2 said that the facility also does not admit residents with this behavior. When the fact that the Southeast door had no electronic monitoring equipment present to detect R1's monitor bracelet at the time of R1's elopement, E2 stated on 1/8/13 at 11:20 AM that the area in which R1 was found outside was fenced. E2 said that R1 could not have left the area. (A)	F9999			