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	145950	A. BUILDING _____ B. WING _____	C 12/10/2004

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RIVER PARK HEALTHCARE CENTER	**2545 24TH STREET ROCK ISLAND, IL 61201**

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F9999	FINAL OBSERVATIONS 300.1210(a) 300.3100(d)(2) The facility must provide the necessary care and services to attain or 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 and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. These requirements are not met as evidenced by : Based on interviews, record review and	F9999		

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observations, the facility failed to monitor the whereabouts of one of two residents identified as potential wanderers (R1). The facility failed to have a system in place to monitor a exit door located five feet from R1's bedroom. The facility failed to have a system in place to monitor an unlocked and unalarmed exit door on the main floor leading to the outside. The facility failed to follow their policy for locking the front entrance door.

R1 left the facility without staff knowledge and unattended by staff. R1 was found approximately 0.5 miles from the facility.

Findings include:

Facility incident report completed on 11/29/04 at 9:00 am states,"11/28/04 at 11:20 pm, (R1) walked across the street to (local hospital) parking lot and was brought back by security (hospital) "

A copy of Z2's (security guard of local hospital) report log dated 11/28/04 was obtained. This log states,"11:15 (pm)-Called about an elderly woman wandering lot (North). (Z7) (security guard of local hospital), (Z8) (security guard of local hospital) and myself searched. (Z8) made first contact and learned she was from River Park and she was trying to go home. We had her get into the (car) and took her back to River Park. (Z 8) and myself entered through the main doors and could not find any employees. Took (R1) up to the fourth floor which is where she thought she belonged. Again found no staff for about 3 minutes. Finally a (employee) came out and while looking at the patient said 'Why (R1) where have

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you been?' I asked the patient her name and she stated (her name). I turned around and heard the elevator open and that is when I noticed that you need a key to use the elevator. We cleared at 11:37 pm."

During interview with Z2 on 12/1/04 at 6:55 am, Z 2 confirmed the log information and stated," (R1) was heading out the 17th street (parking lot) exit. She was dressed and said she was going home. After questioning her she was finally able to tell us she was staying at River Park. She was headed away from the home when she was located. When we returned the resident to the home, we were unable to find any staff. The door (north) was unlocked and no alarms rang. It was around 11:30 pm. We just went in. Somehow the guard (Z8) who made first contact found out she thought she was staying on the fourth floor. We took her to the floor and after a few minutes of yelling down the hall to the air, a Nurse or CNA (Certified Nursing Assistant) came out and took over the patient from us. It was pretty cold and snowing. She was able to tell me her name after we got back to the floor and the staff said her first name. She was wearing sweats I think."

A copy of the hospital parking lot layout was reviewed. Twentyfourth street separates the facility and hospital parking lot. There is a posted speed limit of 30 miles per hour. To get from the 24th street entrance to the 17th street exit on the opposite side of the parking lot from the facility, R 1 had to walk around a medical building or between this medical building and a psychiatric facility. At the time R1 was found by Z8, the hospital staff would have been arriving for third shift or leaving after working second shift. Z8

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found R1 on the drive exiting the parking lot and leading to 17th street at approximately 11:25 pm. This area is approximately 0.5 miles from the facility.

Z6 (National Weather Service personnel) was contacted on 11/30/04 at 2:30 pm for weather conditions for the night of the incident. Z6 stated," At 11:52 pm on 11/28/04, the temperature was 33 degrees Farenheit. Winds were Northeast at 5 miles per hour. Visibility was 3/4 mile with fog and light snow."

R1 was interviewed on 12/1/04 at 8:10 am. R1 was able to state her name, month and date of birth (unable to state the year of birth) and the current year. R1 incorrectly stated she was 81 or 82 years old. R1 stated she was worried about her house and kids and wants to go home. R1 stated she thought she left this place (incorrectly named facility) a couple of weeks ago by the stairs but staff told her,"it was a dream." R1 was unaware of who brought her back stating,"I don't know who it was. I just got in the car." R1 stated she resides in Iowa. At 12:00 noon, R1 was again interviewed. R1 did not remember meeting surveyor earlier in the day. R1 asked surveyor three times during the 8 minute conversation if I could let her go home. Surveyor explained that decision was not hers to make. R1 would reply," Oh yeah" and then ask again several minutes later. R1 stated she would hesitate before crossing a street but was unable to give further information as to why she would hesitate.

Facility admission record dated 08/18/04 shows R1 is an 86 year old resident admitted to this facility in August 2004. R1 had resided at two

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other facilities prior to this admission for brief periods. This admission sheet identifies R1 as single and never married. Z3 (niece of R1) stated on 12/02/04 at 11:50 am when interviewed that R 1 was never married and had no children during her life. In a history and physical from the local hospital dated 08/02/04 dictated by Z4 (hospital physician), R1 is identified by Z4 as: "In need of 24 hour around the clock care for her dementia, wandering and history of overdose."

Physician's orders for the month of 11/16/04 through 12/15/04 include diagnoses: Depression with history of overdose, Arthritis, Senile Dementia and Dementia. The latest physician progress note by E10 (attending physician) is dated 11/2/04. This note states: "Dementia, Unable to remember date/time but knew 2004." Z 5 (Psychiatrist) progress note dated 9/23/04 states,"(R1) memory is severely impaired."

The current Minimum Data Set (MDS) for R1 dated 11/15/04 includes the following information: "(R1) moves independently indoors, is moderately impaired in decision making (decisions poor, cues/supervision required), experiences varying mental function over the course of the day, experiences strong identification with past life and roles, expresses sadness/anger/empty feelings over these lost roles and her conditions/diseases make her cognitive, activity of daily living, mood and/or behavior patterns unstable (fluctuating, precarious or deteriorating)."

The facility has four levels. The second, third and fourth levels are living areas for residents. The main level houses offices and ancillary

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departments. R1 resides on the fourth floor of the facility utilized for dementia and behavior residents. R1 resided in the unsecured part of the unit outside the secured dementia unit/annex. Approximately 5 feet from R1's bedroom is the west stairwell door.

Observation and testing of this stairwell door was done on 12/1/04 at 8:20 am. This door alarmed when opened and automatically turned off when the door closed. E1 (Administrator) was interviewed on 12/1/04 at 8:30 am and informed of this finding. E1 stated,"The door alarms and it keeps alarming until it is shut off by pushing the button." E1 went with this surveyor to check the west stair doors on 2nd, 3rd and 4th floors. E1 then confirmed the finding that these doors alarmed when opened and shut off immediately when the door closed without staff intervention.

On 12/2/04 at 11:30, the west stair doors were again tested and again noted to shut off automatically when closed. E1 was interviewed immediately after this observation regarding this. E1 stated,"I was wrong about how I thought they (doors) worked. The magnetic strip causes the alarm to sound when the seal is broken. Once the magnets reconnect the alarm stops. It was designed for a person who is in a wheelchair. It would take them awhile to maneuver inside (stairwell doorway) and staff could intercede. We are going to have a code pad alarm installed which will have to be reset by staff."

The North front door is the main entrance to the facility for visitors and staff. On 12/2/04 at 1:30 pm, E1 was interviewed regarding the North (front) door alarm system. E1 stated,"The front

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door alarm turns on a light on the second floor (nursing station). When it turns on the staff is to call for an exterior door check. A receptionist is in the office until around 6:30 pm. The door is locked around 11:30 pm after 11 pm - 7 am staff is here." The policy "Exit Doors Security" was reviewed on 12/2/04. This policy does not address monitoring who enters/exits from the north door nor is there a policy in place regarding any alarm system to be utilized after administrative staff leave at 5:00 pm. This policy states, "The north entrance door, Front, will be locked at 11:30 pm everyday and reopened at 6: 00 am the next morning." E1 was interviewed regarding the policy on 12/3/04 at 9:03 am E1 stated,"The door alarm (front door) has not been in use and the new policy will ensure it is used again.

E3 (Director of Nurses/DON) was interviewed on 12/1/04 at 11:00 am. E3 stated,"On Sunday (11/ 28/04) at 1:30 pm, they (facility staff) called me because (R1) was very agitated. They caught (R 1) going down the steps a couple of times, the stairs across from her room and redirected her. I said to put (R1) in the annex (secured part of the dementia/behavior unit on fourth floor) and closer observation, every 30 minutes. They called me around 2:00 pm and said (R1) got out of the annex. I told them to put her outside the annex and continue 30 minute checks. I was called around 11:15 to 11:30 pm and told she had been brought back from (hospital) parking lot. (R1) cognitive level varies. I don't know if she would find her way back - would depend on her level at the time. The front door is usually locked around 11:00 pm by third shift."

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E4 (Licensed Practical Nurse/LPN) was interviewed on 12/1/04 at 7:30 and 10:45 am. E4 stated,"I did work Monday (11/29/04) day shift. I was not told anyone left. We give report to each shift verbally." E4 described R1 as,"Short term memory poor. I don't know for a fact whether or not (R1) would be able to get back. We are visually checking her every 30 minutes, for a couple of days now."

E11 (Activity staff) stated in interview on 12/1/04 at 7:40 am,"(R1) talks about leaving a lot. She hasn't left that I know of."

E5 (Certified Nursing Assistant/CNA) was interviewed on 12/1/04 at 10:30 am. E5 stated,"I did not know (R1) left the building until today. (R 1) is on 30 minute checks. (R1) always has her bags packed and is ready to go. (R1) even unplugs her television. I don't think she knows where she is or how to get back if she did leave. The front door is unlocked when I get here at 6: 00 am. I don't know who locks or unlocks it."

E6 (LPN) was interviewed on 12/1/04 at 6:00 pm. E6 stated,"(R1) was very agitated and threatening to leave (11/28/04) - more than normal. Day shift (11/28/04) put her in the annex but she kept coming out. We thought it was making her more agitated so she stayed on the outside of the annex."

Z3 (niece of R1) was interviewed on 12/2/04 at 11:50 am. Z3 stated she is Power of Attorney for R1. Z3 states she visits as much as she can and has contact with R1 by phone several times a week. Z3 stated,"I was told my aunt left the unit and security from the local hospital brought her

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back. I am not surprised she tried to leave. She gets really confused at times. She didn't know who I was when I visited her before. No way do I think she would find her way back alone. She knows her name but rarely knows where she lives or the time."

E12 (CNA) was interviewed on 12/2/04 at 11:00 am. E12 stated,"I made rounds with the nurse (11/28/04, third shift) and don't remember seeing (R1). 4th floor is not my regular unit. I don't get report and did not know she was on 30 minute checks, had a bad day or that she was trying to leave that day. I didn't know she had been in the annex (on 11/28/04). Security from (hospital) brought her back somewhere around 11:30 - 11: 35 pm (11/28/04). That was when I found out she was having problems that day. I didn't know she left until she was brought back."

E9 (LPN) was interviewed on 12/3/04 at 10:00 am. E9 stated,"I come on at 10:00 pm (11/28/04). I make rounds after report. (R1) was in her room at 11:00 pm. I gave some medicine to a person near her room and then changed some oxygen tubing. I did not hear any alarms. The fire alarm door across from her room shuts off automatically. When she came back she was fully clothed with her coat and shoes. They told me in report she had tried to escape (11/28/04). The security (from local hospital) brought her back around 11:25 pm. I didn't know she left. I don't have access to the keys to lock the door on the main floor. I think second floor does on the weekends and the supervisor during the week."

Staffing schedule was reviewed for 11/28/04, third shift. One CNA (E12) and one LPN (E9)

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were assigned to the 4th floor. Thirtyeight residents were living on this unit divided between the secure and unsecure portions. This staffing was confirmed thru interviews with E3 on 12/1/04 , E9 on 12/3/04 and E12 on 12/2/04.

Nursing notes were reviewed from admission to 12/1/04. These notes contain at least 38 entries describing R1 as alert to name with confusion to date and time. They also describe R1 as sometimes difficult to redirect with poor short term memory impairment. These same nursing notes also have approximately 60 documented episodes of R1 stating,"I want to go home. I am leaving. Bags packed. Asking staff to call a cab ."

On 9/20/04 at 8:36 pm, nursing notes state," Resident keeps trying to call her house and look for way out of facility."
On 10/2/04 at 12:55 pm nursing notes state," Resident insist that she is leaving today. Bags are packed and ready."
On 10/12/04 at 11:35 am nursing notes state," Resident will go to activities and then will get up and attempts to go out front door."

Nursing notes on 11/28/04 at 3:31 pm state," Resident is uncooperative. Resident is disruptive . Resident wanders with staff, movement oblivious to safety, yells shouts. Resident at nurses station stating she wants to leave and go home. Explained to resident that this is her home now. Started yelling screaming "I am going home . Unable to calm down. At 1:30 pm resident yelling I will kill myself if I have to stay here."

Nursing notes on 11/28/04 at 10:05 pm state,"

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F9999	Continued From page 22 Resident was very agitated about being confined ... with 'crazy' people. Was constantly seeking exit from the Annex. Does not recall any of what happened that resulted in her being placed in Annex." E3 (DON) stated during interview on 12/1/04 at 11:00 am,"They caught (R1) going down the steps a couple of times (on 11/28/04), the stairs across from her room and redirected her." The Social Service Notes and Activity Notes were reviewed from admission to 11/29/04. These notes confirm the MDS findings of confusion at times with mental functioning varying over the course of the day. The Interdisciplinary Care Plan dated 11/15/04 and Certified Nursing Assistant Assignment Cards dated 11/15/04 were reviewed for R1. The Care Plan does not address this behavior of wanting to go home nor are approaches listed to assist staff in methods of redirection appropriate for R1. The CNA Assignment Card does not include information regarding exit seeking behaviors or approaches to use to calm and redirect R1 when R1 states she wants or needs to return home.	F9999		