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

REGENCY NURSING CARE RESIDENCE — Facility Name
0036178 — I.D. Number

2120 WEST WASHINGTON SPRINGFIELD, IL 62702 — Address

20068 — Reviewed By
04-22-2005 — Date of Survey

COMPLAINT #0541664/IL16417 — Type of Survey
02566 — 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):

300.1210b)6)
300.1220b)3)
300.3100d)2)

General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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.

The DON shall supervise and oversee the nursing services of the facility, including: Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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.

This Requirement was NOT MET as evidenced by:

REGENCY NURSING CARE RESIDENCE | 0036178
Facility Name | I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

Based on observation, record review, and interview it was determined the facility does not always assure each resident receives all necessary precautions and/or supervision to ensure their safety as all door alarms are not kept turned on when they are not under visual control, door alarms are not able to be heard throughout the facility, and not all resident safety alarms are functional (R1) and/or kept on residents who have been assessed as elopement risk (R1,R6). The facility does not always keep care plans up to date, revise them as necessary, and/or have interventions for staff to take for nine of nine residents care plans reviewed that are identified as elopement risk. This includes R1,R2,R3,R4,R5,R6,R7,R8,R9.

Findings include:

Observation of R1 on 04/21/05 at 9:00a.m. showed her to be in the dining room eating breakfast; needed verbal cues to eat. Observation showed her to have an alarm signaling device on each shoe attached by the shoe laces. Observation of R1 at 9:40a.m., accompanied by E1 (Administrator), showed her to be ambulating and when she went through the double doors from the West hall to the East hall her alarms on the shoes did not set the wall alarm off. Observation of R1 showed she walks about with a steady gait and at times in a fast walk.

Observation of R4,R5,R6,R7,R8, and R9 on 04/21/05, accompanied by E3 (Assistant Director of Nurses) from 10:40 through 10:45a.m. showed them all to have an alarm signaling device on one wrist except for R6. Observation of R4, on 04/21/05 at 9:45a.m., ambulating through the alarmed door which connects the lobby of the facility to the West hall showed her wrist alarm signaling device to set off the wall alarm.

Observation on 04/20/05 of the list the facility had prepared as potential elopers showed R1 and R2's name with their picture on the list at the two nurses stations and at the reception desk.

Nurses note on 04/15/05 at 2005 documents R1 left the facility and walked to Chatham Road, was found and brought back by Z1; no injury. R1 did not have safety alarm on because she always takes it off, "hence no one hear or no when she left the facility." "She has attempted to go out several times but stopped by staff members today."

During interview of R1 on 04/21/05 at 9:40a.m. she did not remember leaving the facility and asked if she had someone with her and was told no by E1 and she made no other comment; communicate through writing to R1 as she is very very hard of hearing.

During interview of E11 LPN (Licensed Practical Nurse) at 1:35p.m., E4 RN at 2:30p.m., and E13 (Receptionist) at 12:35p.m. on 04/20/05 they all stated the list of residents who are a risk for elopement was just placed in their area 04/20/05; each list identified only R1 and R2.

REGENCY NURSING CARE RESIDENCE
Facility Name

0036178
I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

During interview of E1 on 04/20/05 at 8:30a.m. she stated she had placed the facility's new door alarm policy at each nurses station and the employees time clock but she could not be sure that everyone read it. She stated "today is payday" so will have each employee read the policy and sign they have read. E1 provided a copy of the signed inservice on the door alarms to surveyor on 04/21/05.

Review of the facility's policy/procedure for a resident who successfully leaves the facility grounds unattended and resident is located showed documentation, in-part, the facility is to conduct an emergency meeting of the elopement committee, is to discuss interventions on care plan-what worked? What failed? Modify care plan; Complete new Elopement Risk assessment, and Inservice staff. The policy/procedure was not followed in that a new Elopement Risk assessment was not done and an inservice was not given.

During interview of E1 on 04/20/05 at 9:27a.m. she stated R1 lives on the West hall and went out the West exit door. She stated the front door is locked and alarmed from 7:00p.m. to 7:00a.m after the receptionist leaves. She stated the West exit door was locked and the alarm turned on at 8:00p.m. after visiting hours. E1 stated R1 cuts the alarm signaling devices off when they are placed on her so at this time the alarms are through her shoe laces the past two days and it has worked well for the two days. E1 stated R1 and R2 are the two residents who are the facility's elopement risk and stated both of the residents have their name on a paper as an elopement risk at the nurses station and the reception desk as well as the East wing nurses station as E1 has wandered over onto the East side. E1 stated now the staff have to document every 30 minutes where is R1 is seen. E1 stated there was no constant supervision of the West exit door when the alarm was turned off; usually nurse was near.

During interview of E2 (Director of Nurses) on 04/20/05 at 10:25a.m. she stated the door alarm on the West exit door is now on at all times and staff must respond even with visitors. E2 stated visitors are unable to disconnect the alarm. She stated the West exit door was the only door that was unlocked and the alarm turned off. E2 stated R1 is confused most of the time and is only oriented to herself and has poor judgment/safety awareness. R1 is deaf. E2 stated E4 RN (Registered Nurse) and E5 RN were on duty the night R1 (04/15/05) left the facility. E2 stated E5 reported the incident to her and the resident had no injuries. E2 stated she informed E1 the following Monday (04/18/05) of R1 eloping. E2 stated R2 eloped a year ago and the elopement had been investigated; had not eloped since. E2 stated the elopement risk list is at the nurses station on the West wing and at the reception desk. E2 stated R1 has a Power of Attorney for Healthcare and a bank oversees her finances. She stated R1 does have a very steady gait and used to run track.

REGECNY NURSING CARE RESIDENCE
Facility Name

0036178
I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

During interview of E4 RN on 04/20/05 at 2:30p.m. she stated R1,R2,and R3 all try to leave the facility and have gotten out. E4 stated R4 goes out into the parking lot to look for her car; maybe once or twice weekly. E4 stated R4 wears a wrist alarm signaling device. She stated the residents who wear heavy sweaters over there safety alarm signaling device causes the alarms, at times, not to go off. She stated she has found R4 in the parking lot when she comes to work (works evenings) and the wrist alarm did not go off due to resident having long sleeves on. She also stated at times it depends on the side the resident is wearing the alarm signaling device whether it goes off or not ; ie: alarm signaling device on the right wrist and the wall alarm (door module which receives the signal from the signaling device) on the residents left. She stated on 04/15/05 she saw R1 by the nurses station around 8:00p.m. and about 8:05p.m. Z1 (visitor) called to say she had R1; stated E5 and E6 CNA (Certified Nurse Aide) saw R1 about 8:00p.m. also. E4 stated R1 is very very hard of hearing and confused. She stated the evening of 04/15/05 was a warm evening and the resident was wearing a long sleeve knit top and slacks. She stated she got R1 off the elevator once and expressed concern to E2 and E2 turned the elevator off for the day. E4 stated the West exit door was unlocked and the alarm turned off until 7:00p.m. and then the door would be locked; she understood the 11:00p.m.-7:00a.m. shift turned the alarm on. She stated you cannot hear the door alarms or the wall safety alarms (module that gets signal from the residents safety alarm) when you are in a resident's room and the door to the room is closed. She stated all staff were away from the nurses desk and in rooms so the West exit door was not under visual control, the door was unlocked and the alarm off when R1 left the facility. She stated R1 and R2's being an elopement risk list was placed at the nurses station today (04/20/05). She stated she had expressed her concern to management of the wall alarms not always functioning properly; also of R1 needing more supervision. She stated on the night R1 left the building she was in a resident's room with the door closed. Surveyor requested E4 highlight the names on a resident roster who are at a risk for elopement and she identified R1 through R9.

During interview of E7 CNA on 04/21/05 at 3:25p.m. she stated she was working on 04/15/05 but was in giving a resident a shower. When she came out of the resident's room E6 CNA informed her R1 had left the facility. She stated the last time she saw the resident was when she got her linen to give the resident's shower.

During interview of E9 CNA at 3:24p.m. she stated she was on the schedule for 04/15/05 but she did not work.

REGENCY NURSING CARE RESIDENCE
Facility Name

0036178
I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

During review of R1's clinical record showed her to have a diagnoses, in-part, of Dementia with Psychotic Behavior, Depressive Mood, and Hearing Loss. Record review showed she has a Power of Attorney for Healthcare and Finances. Review of the 03/14/05 Psychiatric Follow-Up documentation showed, in-part, R1 is Paranoid, takes off safety bands, is hard of hearing, and has Dementia; received increase of Zyprexa to 7.5mg. at bedtime. Review of the nurses notes show documentation the resident is oriented to self only, wanders through halls and in other resident rooms on a daily basis, interferes with care being given to other residents at times. Nurses note on 04/15/05 at 2005 documents R1 left the facility and walked to Chatham Road, was found and brought back by Z1; no injury. R1 did not have safety alarm on because she always takes it off, "hence no one hear or no when she left the facility." :She has attempted to go out several times but stopped by staff members today."; 04/18/05 1100 "Due to elopement on 4/15/05, Resident put on Q 30 min surveillance", alarms placed on shoes--all other shoes removed from room, care plan updated. Review of the nurses notes back to admission on 11/26/04 showed the resident not to leave the safety alarm on her wrist or ankles and attempts to leave facility; on 01/09/05 at 1530 R1 was noted to be on the driveway in front of the building--CNA states resident was walking down driveway away from the building--returned with the CNA and receptionist was asked to inform staff when stepping away from her desk so that front door alarm can be turned on. Review of the "Elopement Risk Assessment" showed the resident is at a risk for elopement; no date on the assessment but documented in part "Informed alarm to be on @ 1900", wrist safety alarm "not effective." Review of the "Elopement risk, check every 30 minutes" form showed the form was begun at 7:00a.m. 04/18/05.

Review of R1's care plan showed on 03/31/05 there is documentation she removes her safety alarm signaling device and had thrown over ten away since admission so they are not effective and therefore staff "should respond to all door alarms quickly"; on 04/18/05 documentation she eloped on 04/15/05 and is to have safety alarm signaling device on both shoes and is to have 30 minute location checks; door alarms on West main entrance will be on at all times. Care plan was not revised and interventions put into place when the facility knew the resident would not keep the safety alarms on which was as far back as her admission and there were no new interventions put into effect from the time she eloped on 04/15/05 until 04/18/05 to ensure her safety.

REGENCY NURSING CARE RESIDENCE
Facility Name

0036178
I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

Review of R2 through R9's clinical record showed them to have a diagnosis of Dementia. Review of the physicians orders showed them to have a safety alarm signaling device order and all but R3 were assessed by E2 as being a risk for elopement (none of the elopement risk assessments have a date on them); R3 had no elopement risk assessment. Review of R9's clinical record showed documentation she got out onto the facility's property on 04/09/05 at 1845 and E1 and E2 were unaware of this when brought to their attention by the surveyor on 04/21/05. The Director of Nurses stated on 04/20/05 she believed she did all elopement risk assessments in January 2005 but on 04/21/05 she stated she may have started some of them the end of December 2004.

Review of R2 through R9's care plans showed them not to be current and R5,R8, and R9 did not address residents being at a risk for elopement. The other care plans, except R3, document the resident is to have a safety alarm on at all times but that is the only approach to being at a risk for elopement even when that approach does not always work. Review of R6's care plan showed R6 is to have a safety alarm on but does not identify she removes it thereby no interventions documented to ensure the safety of the resident. Review of R3's care plan showed documentation he is at a high risk for elopement but does not document any type of monitoring; documents if he elopes will meet with his family.

Review of the facility policy/procedure for the door alarms which was in effect on 04/15/05 showed documentation, in-part, "The door alarm system is to remain on-line (NOT SILENCED) at all times, except for extenuating circumstances." "The lobby doors should be taken off line at approximately 8:00a.m.(10:00a.m.)-weekends & holiday and put back on line at approximately 7:00p.m.The West-Side Entrance/Exit should be taken off line at approximately 7:00a.m. and put back on line at approximately 8:00p.m.." Review of the new door alarm policy documents the West-side entrance/exit will be alarmed at all times; not put into effect until 04/18/05.

During interview of E1 and E2 throughout the days of the survey they agreed with the surveyor that when the door alarm was off it could not be constantly under visual control as the staff had to care for residents although they stated usually a nurse was nearby.

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

REGENCY NURSING CARE RESIDENCE — Facility Name
036178 — I.D. Number

2120 WEST WASHINGTON SPRINGFIELD, IL 62702 — Address

20068 — Reviewed By
04/11/05 — Date of Survey

COMPLAINT #0541664/IL1647 — Type of Survey
02566 — 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):

REGENCY NURSING CARE RESIDENCE — Facility Name
0036178 — I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

Observation of the exit doors on the West and East wings on 04/20/05 showed them all to sound when the door was opened and staff to respond to the alarm. Surveyor noted when she was at the end of the West wing you could only slightly hear the alarm for the doors going off and then to hear them you had to be specifically listening for them; when in a residents room could not hear the door alarm at the end of the hall and could not hear it if in a resident's room with the door closed. Alarms could not be heard at the end of the West wing if you were talking to someone. On the East wing you could not hear the door alarms as the door alarm panel is on the West wing; staff on the West wing have to call the East wing if a door alarm goes off or they do not know a door has been opened.

During interview of E12 (Maintenance) on 04/21/05 at 8:38a.m. he stated he does not check/monitor the door alarms unless someone puts in a work order that an alarm is not working. He stated he would start checking/monitoring all the door alarms monthly and documenting the checks.

During interview of E1 and E2 they stated the safety alarm signaling devices are checked monthly for their expiration date and whether they are working. E2 stated safety alarms are placed on wheelchairs and walkers but when they are placed on equipment of the resident the resident also has one on their body.

Review of the safety alarm manufacturers directions showed the safety alarms should be checked daily and not placed next to metal such as on wheelchairs as that might interfere with the signal sent to the door modules.

Review of the facility's safety alarm signaling device policy/procedure showed even though the manufacturer documented not to use the safety alarm on metal it is all right to use them on the wheelchairs

During interview of E1 she stated the safety alarm door modules are only on the doors on the West wing. Surveyor asked on 04/20/05 about R3 who is a elopement risk; on 04/21/05 R3 was placed on 30 minute location checks by E1 and E2. E2 stated the resident would not wear a safety alarm signaling device.

Observation of the front door on 04/21/05 in the morning it was noted the receptionist would be away from her desk at three to four minute intervals and no staff was around; the front doors were unlocked and not alarmed at these times.

REGENCY NURSING CARE RESIDENCE
Facility Name

0036178
I.D. Number

300.1210b)6)
300.1220b)3)
300.3100d)2)
(Cont'd.)

During interview of E1 on 04/21/05 at approximately 11:00a.m. she stated usually when the receptionist leaves her desk she lets her know and she watches the monitor in her office until the receptionist returns but was not informed of any absences this morning.

Observation showed the street in front of the facility to be a five lane highway as it has a center turn lane and it is a main thoroughfare; Chatham Road is the same. R1 walked to the intersection of the street in front of the building (Washington) and Chatham Road.

(A)