ANCHORAGE OF BEECHER
Facility Name

0033803
I.D. Number

1201 DIXIE HIGHWAY; BEECHER, IL 60401
Address

Reviewed By

06/08/2005
Date of Survey

ANNUAL LICENSURE AND CERTIFICATION SURVEY; INCIDENT REPORT INVESTIGATION OF MAY 5, 2005, IL 16837 - SEE F698; INCIDENT REPORT OF MAY 7, 2005, IL 16838 - SEE F698
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. 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):

300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and pschosocial 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.

300.1210 b)3) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day-a-week basis:

Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

300.1210b)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 recieves adequate supervision and assistance to prevent accidents.

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300.1210b)6) (Cont.)

Based on observation, record review and interview, the facility failed to have a consistently functional electronic monitoring system and failed to monitor two of six residents (R2 and R9) at risk for elopement. R2 and R9 left the facility unattended and without staff knowledge. These failures resulted in R2 leaving the building on May 5, 2005, undetected by staff and when R9 left the facility on May 7, 2005, undetected by staff. Both residents were recovered within 200 feet of the facility and brought back to the facility uninjured.

The findings include:

The administrator told the surveyor none of the staff heard the door alarms sound when R2 and R9 left the facility. On May 26, 2005, surveyor and E15 (maintenance) tested the electronic device for the doors. This system has magnetic wrist band worn by the residents. When the resident reaches for the door handle, the magnets set off an alarm.

The alarm was working during the test. This system has certain limitations that can make it fail. If you put your hand over the magnets, it will disrupt the magnetic field and no alarm will sound. If you open the door with your left hand or hip and the magnet on your right wrist is away from the door, the alarm will not sound. If the door is already open, the alarm will not sound. The resident could slip out with someone else that had opened the door.

R2 is a 90-year-old resident who was admitted on January 2, 2004. Among R2's diagnosis on the physician order sheet date of May 31, 2005 are spinal stenosis, hypertension, dementia, depression and osteoarthritis.

Review of the Minimum Data Set indicates R2 wheels himself all over the facility. Because of this, R2 was placed on Code protocol February 9, 2004. Code protocol is a facility procedure where all staff are responsible to respond to the receptionist call on the half hour for the where-abouts of those residents with code names.

During the survey code protocol was used and residents on the code list were checked every half hour. R2 has also been wearing a magnetic alarm band as of December 23, 2003 because of elopement risk.

Record review of accident and incident reports indicated that R2 and R9's elopements are the only ones in the last year.

Record review of R2's nurses notes indicate that around 9:10 p.m., R2 refused to go to bed. The facility's investigation has signed interviews with CNA indicating they asked R2 if he wanted to go to bed about 9:10 p.m.

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300.1210b3)
300.1210b)6)
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E11 (Registered Nurse) was interviewed on May 27, 2005, at 12:30 p.m. E11 indicated that the south nurses station got a call at 9:30 p.m. from a lady passing by the facility saying there was an old man in a wheelchair in the pharmacy parking lot. The pharmacy is next door to the facility. I went out the front door. E12 was bringing R2 back to the facility. R2 said he was going to the tavern. I took R2 to his room and checked for injury. No injuries were apparent. R2 was out of the facility at most 20 minutes. R2 was last seen by CNA at 9:10 p.m. and was back in the facility a little after 9:30 p.m. R2 didn't have his wrist alarm band on. We think he cut it off with his scissors. He has a metal bracelet now. He still tries to take it off.

E12 (Registered Nurse) was interviewed on May 27, 2005, at 12:40 p.m. E12 provided the following information. "When the 9:30 p.m. call on May 5, 2005 came in, I went out immediately. We found R2 in the Northwest corner of the parking lot. R2 was easily redirected back to the facility. There were no injuries. He could not have been out long because they had asked him if he wanted to go to bed at 9:10 p.m. and we found him right after the 9:30 p.m. call."

The parking lot is by a busy state highway.

Z1 was interviewed on May 25, 2005, at 1:00 p.m. Z1 provided the following information. I was told about R2 getting out. No harm was done. R2 probably wanted a breath of fresh air. R2 probably cut the alarm band off with his scissors. I tried putting an alarm magnet on the wheelchair but if you open the door, the alarm doesn't go off. You can't wear the alarm on an ankle. It has to come close to the opener. If you hide it under long sleeves, it will weaken the signal. He wears a metal band now. I don't think it will come off.

The facility's investigation of R2's elopement includes 10 signed statements by staff members confirming staff did not hear any alarm sound. None of the staff witnessed R2 leave the facility.

R9 is an 88-year-old resident who was admitted May 23, 2005. Among R9's diagnosis on the Physician order sheet dated May 31, 2005 are cataracts, hypertension, urosepsis, dysphagia, dementia and hemiplegia.

Record review of R9's nurses notes indicate that on May 6, 2005, at 2:00 p.m. R9 was trying to open the lobby doors. A call was placed to family and doctor for a wrist alarm for R9. Order was approved and wrist alarm was placed on resident shortly after 2:00 p.m.

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300.1210b)3)
300.1210b)6)
(Cont.)

Nurses note of May 7, 2005 at 1:30 p.m. say that R9 was seen outside the front entrance by a volunteer. Volunteer called for help. R9 was returned to the facility without injury.

E13 (LPN) was interviewed on May 27, 2005 at 12:45 p.m., E13 indicated that E14 (CNA) told E13 that R9 had gotten out and was about 10 feet from the front door. When E14 brought resident back in, E13 checked R9's vital signs. R9 had no injuries. R9 had just gone past the front door when R9 was spotted and brought back. Probably out for a minute. Resident was wearing an electronic alert system but no alarm was heard. R13 does not think R9 can open the door by himself. A visitor probably held the door open for him.

E14 was interviewed on May 27, at 12:55 p.m. E14 provided the following information. The volunteer yelled man in wheelchair outside. I rushed outside and grabbed the wheelchair. R9 was leaving the sidewalk. It's about 10 feet from the front door. I asked him if he wanted some fresh air? R9 said yeah. He didn't resist going back in. He wasn't hurt. I took him to the nurse (E13). I didn't hear any alarms. I don't know how R9 got the door open. R9 was out less than a minute. This was about 1:35 p.m. on May 7, 2005.

The facility's investigation of R9's elopement includes 13 signed statements by staff members that confirm staff did not hear any alarm sounds.

E1 (administrator) was interviewed. E1 believes R2 cut off his arm band alarm and slipped out with some Mother's Day visitors. E1 believes R9 was let out by visitors that were trying to be nice and held the door open for R9.

E16 (maintenance) was interviewed on May 26, 2005. E16 provided the following information. The front entrance has a magnetic door system. The other exit doors have alarms that activate when the door is pushed on. After a 15-second delay, the door will open. The alarm will not turn off until a staff person comes and resets the alarm. The surveyor observed the door alarms were working.

E15 (maintenance) was interviewed on May 26, 2005. E15 indicated the door alarms are tested about every other day. Review of test logs shows door alarms were tested and working On May 5, 2005, May 6, 2005, and May 9, 2005.

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DEPARTMENT OF PUBLIC HEALTH
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