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

MULBERRY MANOR
Facility Name

0025411
I.D. Number

612 EAST DAVIE STREET, P.O. BOX 88, ANNA, ILLINOIS 62906
Address

Reviewed By

8/5/2005
Date of Survey

INCIDENT REPORT INVESTIGATION OF 7/4/05
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):

350.620a)
350.1230d)1)2)
350.3000d)2)
350.3240a)

The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reveiwed at least annually.

Direct care personnel shall be tained in, but are not limited to, the following:

Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Basis skills required to meet the health needs and problems of the residents.

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 supervison of the door, a signal is not required.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

These regulations were not met as evidenced by the following:

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350.620a)
350.1230d)1)2)
350.3000d)2)
350.3240a)
(Cont'd.)

Based on observation, interview, file review and per review of the facility's policies and procedures, the facility has neglected to develop and implement written policies and procedures that prohibit neglect for one of one client in the sample (R1) who is 78 years of age and has diagnosis of Dementia and history of elopement who eloped from the facility on 07/04/05 without staff's knowledge and the facility failed to:

a) Ensure that R1's body alarm was applied as per physician's orders to alert staff when R1 stood from a sitting position;

b) Ensure sufficient staff to monitor R1's whereabouts at all times as per the facility's policy;

c) Develop and implement written policies regarding the facility's door alarm system that would ensure that the front door alarm was on and operating to alert staff that R1 had opened the front door and had exited the facility; and

d) Thoroughly investigate the incident of R1's elopement.

The Administrator (E2), the Assistant Administrator (E1) and the Director of Nursing (E15) were notified and an Immediate Jeopardy was called on 08/02/05 at 4:30 P.M. as a result of the facility's failure to prevent neglect, due to the lack of supervision of facility staff of a cognitively impaired individual with known elopement risk.

1) Per review of the Police and Fire Department Daily Journal for July 4th, 2005, the department received a call from a female at 10:04 A.M. that someone had fallen on the railroad tracks. Further documentation identified that Z3 arrived at the railroad tracks at 10:05 A.M. At 10:08 A.M., Z3 gave the person found on the railroad tracks a ride to to the facility.

Per telephone interview with Z3 on 07/20/05 at 7:55 P.M., Z3 confirmed that R1 had been found by him on the railroad tracks at the intersection of Market Street and Davie Street. Z3 stated, "We had received a phone call that R1 had fallen on the railroad tracks and that they (a passerby) had moved her to the side of the road. " During this interview, Z3 confirmed that he had returned R1 to the facility. Z3 also confirmed that no police report had been filed.

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Per interview with Z4 on 07/26/05 at 10:00 A.M., Z4 confirmed that he was present at the Police and Fire Department when they had received the phone call on 07/04/05 regarding R1 being on the railroad tracks. During this interview, Z4 also confirmed that the train tracks at the intersection of Market Street and Davie Street are operable and are used by passenger trains and freight trains. Z4 also stated that their was, "No set schedule" as to when the freight trains come through the city.

Observation of the railroad crossing at the intersection of Market Street and Davie Street on 07/26/05 at 10:30 A.M. identified that the railroad crossing is marked and has crossing gates. To the south of the crossing gates is an intersection as to where Market Street and Davie Street intersect. The facility is located approximately .2 miles going east on Davie Street (from the railroad crossing). During this observation, the surveyor had to stop at the marked intersection of Market Street and Davie Street to wait for the cars travelling both east and west down Davie Street before turning left (east) onto Davie Street.

Per telephone interview with a representative from the Southern Illinois University Flight Dispatch and Weather Center on 07/27/05, the temperature at 10:00 A.M. on 07/04/05 was 89.6 degrees Farenheit with a Heat Index of 93-94 degrees.

Per review of the facility's Incident/Accident Report dated 07/04/05, documentation identified that the facility, "received phone call at 10:10 that resident (R1) had been found approx. (approximately) 3 houses from facility and (symbol for "and" used) were returning her..."

Per interview with E1 (Assistant Administrator) on 07/26/05 at 1:10 P.M., E1 confirmed that she had investigated R1's elopement from the facility on 07/04/05. During this interview, E1 confirmed that R1 was not found three houses down from the facility (as identified in the facility's Incident/Accident Report), but rather at the railroad crossing at Market Street and Davie Street. E1 also confirmed that daily trains come through the city via the railroad tracks where R1 was found. During this interview E1 stated, "No" when asked by the surveyor if R1 was capable of protecting herself when out of the facility unsupervised.

Per review of the facility's policy and procedures, "An owner, licensee, administrator, employee, resident or agent of a facility shall not abuse or neglect a resident..."

2) The facility failed to ensure that R1's body alarm was applied as per physician's orders to alert staff when R1 stood from a sitting position when up.

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Per review of the facility's Investigation Report for the Incident of 07/04/05, the facility concluded, "Midnight employee (E4) failed to put the body alarm on resident, R1 when she was getting her up for breakfast. The body alarm would have alerted staff that R1 was attempting to move from chair and staff would have heard and monitored her movement. This would have prevented her wandering out of facility. E4 admitted she failed to put on body alarm when called at 2:10 P.M."

Review of the written statement submitted by E9 (direct care staff) on 07/04/05 identified, "Between 9:30 and 9:40 A.M. I noticed R1 did not have her body alarm on. I went down on A wing to get the body alarm. I was unable to find so I continued to look for it. I finally found it in between her mattress and bed board. I walked up to table 6 where R1 was sitting and R1 was not there. I began looking for her. Could not find her. Notified QMRP and Nurse that R1 was not in the building. That is when we received a call that R1 was approximately 4 houses down and was being returned. R1 was then assessed by the nurse and was put 1:1 with staff."

Per interview with E1 (Assistant Administrator) on 07/14/05 at 1:55 A.M., E1 confirmed that E4 was the staff member that had forgotten to place R1's body alarm on her on 07/04/05 when getting her up in the morning. Subsequent interview with E1 on 07/20/05 at 8:00 A.M., E1 stated that R1 generally gets up about 6:00- 6:30 A.M. and has breakfast in the dining room about 7:00 A.M.. Review of the morning assignment sheet for 07/04/05 identified that seven staff were on duty at this time. No documentation was noted that would identify who was responsible for monitoring R1 during the breakfast meal. On 07/26/05 at 1:10 P.M., E1 confirmed that she still did not know who had monitored R1's table during breakfast on 07/04/05.

Per interview with E2 (Administrator) on 07/20/05 at 8:05 A.M., E2 confirmed that the staff who monitored R1's tables during the breakfast meal at 6:30 A.M. should have noticed that R1's body alarm was not on. Subsequent telephone interview with E2 on 07/27/05 at 4:45 P.M., E2 stated that E10 had been the staff member that was assigned to R1's table during the breakfast meal on 07/04/05.

Per file review, no record was maintained by the facility that would identify when R1's body alarm was applied and or removed prior to her elopement on 07/04/05.

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Review of R1's behavior program dated 07/01/04 identified, "R1 has a primary diagnosis of moderate MR (mental retardation) and is basically non verbal. She has a Hx (history) of dementia and may become confused or start to wander. R1 would not be able to avoid danger or even yell for help. When she leaves an unsupervised area it is not with the intent to leave. She is merely wandering around due to her confused state of mind..." Under the section of the behavior program marked as, "PREVENTION MEASURES IN PLACE" documentation identified that R1 is to be "monitored closely by staff."

3) The facility has neglected to ensure sufficient staff to monitor and supervise R1's whereabouts at all times as per the facility's policy.

Per review of the facility's policy on Missing Residents, the policy identifies, "It is the policy of this facility to provide supervision of its residents." Per review of th facility's policy on Staffing, the policy identifies, "It is the policy of this facility to maintain sufficient numbers of staff to meet and/or exceed the minimum staff/client ratios as delineated by the federal Medicaid standards."

Per review of the facility's census for 07/04/05, the facility's census was 76. During the Entrance Communication with E1 (Assistant Administrator) on 07/14/05, E1 confirmed that all seventy six of the clients had been home at the facility on 07/04/05. Review of the staffing schedule for 07/04/05 and as confirmed per employee time cards and staff interviews, seven staff members, one nurse and two QMRPs were scheduled during the timeframe (between 9:00 A.M. - 10:00 A.M.) when R1 eloped from the facility on 07/04/05.

However, further review of the facility assignment sheet for the morning of 07/04/05 and as confirmed per E1 (Assistant Administrator) on 07/14/05, the facility did not maintain an adequate staffing pattern to prevent R1 from eloping from the facility without staff's knowledge.

Review of the assignment sheet for 07/04/05 identified that between the hour of 9:00 A.M. - 10:00 A.M., the following staff were assigned to the following areas of the facility :

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E5 (direct care staff) was assigned 1:1 with R4 on A wing;

E3 (direct care staff) was assigned to activities for the dining room area;

E9 (direct care staff) was assigned to A wing;

E6, E10 and E11 (direct care staff) and E8 (QMRP) were assigned to the Blue House which is in a separate building from the facility. (Interview with E8 on 07/14/05 confirmed that she work in the Blue House and was in the Blue House during the hours of 9:00 A.M. to 11:30 A.M. on 07/04/05 with the three other staff members.

E8 also stated that generally 23 to 24 individuals attend the Blue House. Review of the B wing roster for the Blue House roster identified that twenty four individuals receive active treatment services in the Blue House); and

E7 (QMRP) was monitoring C wing hall for E12 (direct care staff) who had left the facility (per request of the administrator) to go to a local store to get fireworks. After E12 returned to the facility, E12 went to laundry to get a laundry cart for C wing showers.

(The assignment sheet does not identify the nurse nor her assigned activities during this time frame.)

Per review of the facility's assignment sheet, documentation identified that E9 was the staff who was responsible for R1 and the other twenty five females of the A wing of the facility during the morning shift on 07/04/05 (after E4 left at 9:00 A.M.). (R4 is not included within the above count since she was with E5 on 1:1.)

Review of the A wing level of functioning list that was provided to the surveyor on 07/14/05 identified that twenty seven females live on the A wing of the facility. Further documentation identified that four of the individuals function at a mild level of mental retardation, eight individuals function at a moderate level of mental retardation, seven individuals function at a severe level of mental retardation and eight individuals function at a profound level of mental retardation.

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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

Facility Name

I.D. Number

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

Facility Name

I.D. Number

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DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)