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

Illinois Veterans Home at Quincy
Facility Name

0044107
I.D. Number

1707 North 12th Street, Quincy IL 62301
Address

Reviewed By

November 10, 2005
Date of Survey

Annual Licensure, Incident Report Investigation of 10/27/05
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):

340.1505 a)
340.1505 b)3)

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 shall be provided to each resident to meet the total nursing care needs of the resident.

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.

These requirements are not met as evidenced by:

Based on observations, record reviews and interviews, the facility failed to monitor and observe 1 of 4 confused residents sampled, (R7), in order to prevent harm. R7, a confused resident, walked away from the facility and was found dead.

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340.1505 b)3)
(Cont'd.)

Findings include:

Review of the admission face sheet for R7, dated 10/26/05, indicates that R7, admitted on 10/20/05, was 84 years of age with diagnoses including: Dementia, Peripheral Vascular Disease, Hypertension and Depression.

The facility incident report dated 10/27/05 for R7 was reviewed. It reports that R7 was last seen at 5:30 P. M. while eating supper. After supper he was observed in his room watching television. It documents that R7 was noted at 5:45 P.M. to not be on the unit. He was found dead on the following day, 10/28/05 at 1:43 P.M.

Nursing note dated 10/23/05 at 5:30 P.M. reports: Member anxious, looking for family to come and get him, thinks he is in (another city) and his brothers are coming to get him and take him home. States, "They are sadly mistaken if they think I am going to stay here." Member went out East door to see if friends had come. Returned to unit one on one with member. One to one that member's mother and father were coming to get him. Staff orientated that father would be over a hundred. 9:00 P.M., Says he was looking for his dog, continue to orientate to his surroundings. 10/24/05 at 12:00 A.M., nursing documented: Wandering in hall, asking where his wife is. One to One.

Social Service note dated 10/24/05 (no time given): Met with member at Nursing request. They are reporting confusion/disorientation. He is confused in regards to time and place. He does report confusion and memory difficulties. I asked (R7) to stay on or close to the unit. Did review about Depression diagnosis and also Dementia diagnosis that he is not being treated for. Nursing note at 9:15 A.M., Requesting to go home and feed his dog.

MAR (Medication Administration Record) for R7 dated on admission, records a nursing order to Monitor For Elopement Q (every) one hour. The order is dated 10/24/05 and initialed each shift from the 24th through the 27th.

10/25/05 Social Service note at 11:30 A.M. He continues to not be oriented to situation, cannot state where or why he is here.

Nursing note 10/26/05 at 5:00 A.M. No attempts to elope this shift, thus far.

Social Services on 10/27/05 at 9:10 A.M. reports: Resident reports being depressed today. Thinking about his home and his dog, "This isn't how I wanted to end my life. I wish somebody would help me."

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At 12:30 P.M. on 10/27/05, the nurses documents: Resident was found at deer pen looking for a Catholic Church - was returned by female personnel. Resident wants to go home. At 3:00 P.M. on the same day, 10/27/05 the nurse documented, Resident was returned to unit by housekeeping personnel. Was found walking down the hill out front trying to go home. Next shift notified.

Nursing note on 10/27/05 at 5:30 P.M. reports that Member had eaten meal in dayroom, he had eaten another member's tray, then stopped by nurses station with money to pay for his meal. When told already paid for, he then started to walk out of the unit towards the (dining building). When asked where he was going he said, "H---, I don't know." Then turned around and went down to his room. At 5:45 P.M. nursing noted: Member noted to not be on unit at this time.

During interview with Z1, (Clinical Director of Outpatient Clinic an outside agency located on grounds) on 11/3/05 at 3:05 P.M., Z1 stated, "I was the one who took (R7) to the nursing unit from the deer pen that day. I was out for my noon walk when I saw thisgentlemen in a short sleeved shirt. It was really chilly that day, so I approached him and tried to ask him a couple of questions. He said he was looking for a church so I pointed at the chapel behind him and he just looked confused. He could not tell me why he was here or even if he lived here. I knew right away that he was very confused. His arms were very cold. I don't know the people there so I just took him into the first housing I came to. I took him up to the nurses station and told the lady at the desk, This man is lost, cold, and very confused. She just looked at me, nodded and sat back down. I thought he would be taken care of, so I just left him there."

E17, (Housekeeper) was interviewed on 11/4/05 at 10:10 A.M. E17 stated, "The only reason I watched him go down the hill was because I had watched them bring him back in earlier that day. Also, I had noticed him early that morning coming up past the power house in a short sleeve shirt. It was a cool day. Later on I heard some say he was lost. I was there by the nurses station when the lady brought him in from the deer pen. I heard her tell them he was lost."

On 11/9/05 at 8:15 A.M., E25, (Licensed Practical Nurse) was interviewed regarding the nursing order to monitor R7 for elopement. E25 stated, "I put that in the MAR because he was obviously confused and we wanted to make sure everyone watched him."

R7's application review, dated 9/15/05, prior to admission, indicates under the Physician notes that R1 is mentally incompetent and under Physician concerns, E13, Medical Doctor, had written; wandering??. E13 was interviewed on 11/2/05 at 2:00 P.M. E13 stated, "I wrote question wandering because it said he was mentally incompetent." Application review indicates R7's wife and all other family are deceased and that he has a friend who is his Power of Attorney for healthcare and finances. In the preadmission information was also noted a Home Health Certification dated 8/24/05 which lists diagnoses including: Senile Dementia and Abnormality of Gait. The facility Elopement Assessment dated 10/20/05 has three areas to be used to evaluate the resident. Only box 1 (yes) and box 2 (no) are completed. Box 3 is blank. The instructions indicate 2 to 3 yes responses is High Risk. The assessment is not complete as to whether or not the resident is High Risk Elopement - which then instructs, Place in a secured unit.

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Z5, City Police Detective, was interviewed on 11/2/05 at 1:15 P.M. Z5 stated, "He was found in a creek bed side lying on his back in a somewhat seated position. The creek was at the bottom of a 30 to 40 foot hill and had 3 to 4 inches of water in it. It was 30 to 40 feet wide. From one third to one half of his body was in the water. The train track was at the top of the hill. There was a smoothed dirt area at a 90 degree angle that appeared he had tried to get up it or possibly slid down. It was straight up 4 to 5 feet. He had no obvious injuries that would suggest he fell from the 40 foot hill. He did have a bruise to his right cheek, superficial scratches on both forearms. There was blood on a sticker bush and leaves gone, like he had tried to pull himself up by it. It appeared that he just gave up and sat down. He was wearing a short sleeved, like a golf shirt, pants, shoes and a ball cap, but no coat. The city crew found him about 1:45 P.M. (10/28/05). It was about 20 hours after he was last seen. The creek was about 1.8 miles from the facility, if, he took the city street. The creek was about 3 blocks from the river."

The Midwest Climate Control was contacted on 11/2/05 at 9:00 A.M. They reported the official overnight low was 35 degrees with winds at about 5 miles per hour.

The facility is located on approximately 200 acres in the city limits. There is a railroad track and a creek running along the back of the buildings, which continues West beyond the area where R7 was found.

Interview with E19, Security Chief, on 11/3/05 at 1:00 PM during tour of the area, indicates that it is suspected that R7 left the South West smoking door exit from the unit he resided on. He reported that the search dog picked up R7 's scent there and proceeded down the hill towards the train track. The dog touched on several doors on the buildings along the way, would go back and forth from the tracks to the woods and continued East across the city street hitting on doors until he lost the scent about 4 blocks east. R7 was found West about 1 and a half miles. The creek is very rough with several waterfalls and large rocks. It would have been very difficult for him to make his way there and the railroad tracks are about 40 feet up the hill from where he was found."

During the observation of the suspected route, it was noted R7 would have walked about one half mile to the 35 MPH city street, turned right, gone over the creek bridge, crossed the railroad track, which had lighted signal and crossing guards. Then he had to go left into a park with a 15 mph speed limit on a very winding road. It was approximately one half mile to reach the final park on the left where he was found. There was a grassy area leading to a wooded area with a path into the creek where he was found.

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