

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145727	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/17/2007
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NAME OF PROVIDER OR SUPPLIER POLO REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 EAST BUFFALO POLO, IL 61064
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F9999	<p>Continued From page 6 LICENSURE VIOLATIONS</p> <p>300.1210a) 300.1210b)6)</p> <p>300.1210 General Requirements for Nursing and Personal Care</p> <p>a) 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.</p> <p>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:</p> <p>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 receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to assure the safety of a confused resident with an unsteady gait who uses a walker for ambulation. The facility did not assess R1 for his elopement risk and failed to supervise R1 who has senile dementia. R1 was identified as being an elopement risk on a previous admission of 4/14/03 to this facility. R1 left the building undetected by staff at 1:00 PM on</p>	F9999		
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F9999	<p>Continued From page 7</p> <p>7/10/07. R1 was found one block away from the facility at 1:15 PM.</p> <p>This applies to 1 of 9 residents in the facility identified as a wanderer (R1).</p> <p>Findings include:</p> <p>R1 has diagnoses of Psychosis with Bipolar Disorder, Hypertension, Severe Ulcerative Esophagitis, Insulin Dependent Diabetes Mellitus (IDDM), Hypocholesterolemia, Anemia, Parkinson's Disease and Renal Failure per Physician's Order Sheet (POS) of 7/07. The admission sheet, dated 7/5/07, shows R1 also has diagnoses of Senile Dementia, Myopia, Varicose Veins and Bells Palsy. On 7/12/07, the medical record shows that the resident had not been assessed for his cognitive abilities.</p> <p>R1 had seen a Psychiatrist prior to transfer to this facility for management of his Bipolar Disorder. R1's medications consist of Depakote ER 1000 mg (Mood Stabilization) and Seroquel 100 mg twice a day (Antipsychotic). R1 also takes Carbidopa/Levo 25/250 tab four times a day for essential tremors.</p> <p>The facility incident report of 7/10/07, at 1:15 PM shows R1 was seen walking away from the building. Statements attached to incident report from E4 (Cook) and E5 (Certified Nursing Assistant-CNA) state R1 was observed walking away from the facility while they were leaving in their cars at the end of their shift. E4 stated she drove around the block to return to the facility to let someone know where R1 was seen. At the same time, E5 stated "I took off in my car to meet him and stop him." In the Nurses Note dated</p>	F9999		
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F9999	<p>Continued From page 8</p> <p>7/11/07 at 9:30 AM, E2 (Director of Nursing) wrote, R1 was returned to the facility by staff's private vehicle.</p> <p>The Admission Assessment completed on 7/5/07 by E2 shows that R1 ambulates with a wheeled walker. In the Nurses Notes dated 7/6/07 on the 7-3 shift, E3 (Registered Nurse) states that R1 "did go out (the) door for (a) walk." E3 shows she initiated 15 minute (elopement) checks for R1. During an interview by telephone on 7/13/07 at 10:40 AM, E2 stated she was aware that R1 had attempted to leave the facility unsupervised on 7/6/07. E2 stated because of this event, the 15 minute elopement watch was initiated. Nursing Notes dated 7/7/07, 7/8/07, 7/9/07 and 7/10/07 show that R1 was outside of the facility, unsupervised, while being on 15 minute elopement checks. During an interview on 7/12/07 at 9:40 AM, E3 stated that R1 is let outside by staff dis-arming the doors to let him out unsupervised. R1 had a previous admission to this facility on 4/14/03 which identified him as an elopement risk due to dementia according to the Elopement Risk Assessment dated 4/22/03.</p> <p>The Facility Elopement Policy states, "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed on their individual care plans."</p> <p>During an interview conducted on 7/12/07 at 8:40 AM, E5 (CNA) stated that staff monitor all residents who are out of the building every 15 minutes, and confused residents are not allowed</p>	F9999		
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F9999	<p>Continued From page 9</p> <p>out of the facility unless supervised. On 7/12/07 at 8:45 AM, E2 stated the Elopement Assessment for R1 was not completed until after the elopement occurred. E2 also stated that R1 was not an elopement risk at the previous facility.</p> <p>During a phone interview on 7/12/07 at 9:10 AM, Z2 stated R1 was considered "at risk for leaving" and had made multiple attempts to leave while residing at the previous facility. Z2 also stated R1 has some dementia issues and Z2 would definitely have concerns if he was out of the facility unsupervised.</p> <p>Z1 was interviewed per phone on 7/12/07 at 9:55 AM. Z1 stated the previous facility had to keep R1 "away from the doors" because he "kept trying to get out." Z1 said R1 would remove the electronic monitoring device himself. Z1 stated R1's attempts to leave are a concern because R1 "just wanders down the road" and "doesn't know where he is."</p> <p>An interview was conducted on 7/12/07 at 11:32 PM with Z3. Z3 stated R1 would "not be safe to be out of the facility alone" and R1's "life safety skills are poor."</p> <p>On 7/12/07 at 1:00 PM, E1 (Administrator) stated R1 wandered to a house and staff saw him while they were in their cars. The only homes near the facility would require the crossing of at least one road. The Nursing Notes dated 7/10/07 at 1:15 PM show R1 wandered 1 or 2 blocks from the facility.</p> <p>Observation of R1 on 7/12/07 at 10:00 AM noted the resident ambulating to activity area with a shuffling gait, built up shoes and use of a wheeled</p>	F9999		

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F9999 Continued From page 10
walker. R1 was interviewed on 7/12/07 at 11:40 PM, and said he was on his way to "the bank" and added that he did not have his walker because "I really don't need it anyway." Review of the environment and location of the facility shows that the resident was headed in the opposite direction of the bank.

(A)

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