Z 000

COMMENTS

Original Complaint Investigation for 1323830/IL 65457

Z9999

FINDINGS

LICENSURE VIOLATIONS

340.1505b(5)

Section 340.1505 Medical, Nursing and Restorative Services
b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

This requirement is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to allow opportunity for reinstatement of motorized wheelchair privileges to maintain independence and psychosocial well-being for two of three residents (R1 and R2) reviewed for facility's removal of residents' motorized wheelchairs.

Findings include:
1. On 9/18/13 at 8:45 a.m., Z1 (R1's POA - Power of Attorney) stated, "...(R1) has been here (as a resident) for 20 years. A few years ago in 2008 they changed the rules saying that (the electric wheelchairs and scooters) were only to ride on the sidewalks. That they can't go into the parking lots... (R1) was told twice he is not allowed to go into the parking lots or in the street only on the sidewalks or on the designated crossing areas... The residents now can't go to the deer pen. They have to stay only on one side but the back end and side is where the animals are and they would have to take their chairs to the edge of the street to go there.... (R1) signed the rules (for electric wheelchairs) in 2008 but it says it was revised in 2009. How can that be?... They only started enforcing the rules this past few months. It seems like it's only (at R1's unit). E3 (RN - Registered Nurse) seems to be the only one enforcing these rules. (R1) had a stroke. (R1) is 68 years old now and has been here for 20 years. (R1) didn't get (R1's) first electric wheelchair until 2001. (R1) just got a brand new wheelchair in March (2013) and they took it away in June (2013). When (R1) had the electric wheelchair (R1) was driving all over the grounds. They did warn (R1) but (R1) blew it off. There's been a couple (electric wheelchairs) taken away but only at (R1's unit). (R1) is paralyzed on the right side and speech is off but (R1) understands very well and knows (R1) has done wrong. I asked E3 (RN) when (R1) would get it back and E3 (RN) said never. E3 (RN) said it would be considered punishment (to give the electric wheelchair back) and that (the State Agency) said that it would be punishment.... The foot pedals on the manual wheelchair don't work for (R1). (R1) propels the wheelchair with (R1's) left arm (R1's right arm is paralyzed) and uses (R1's) left leg to prop under (R1's) right leg (which is paralyzed) to help propel...
Continued From page 2

the manual wheelchair as well. It does restrict where (R1) can go. (R1) goes to the coffee shop and back but (R1) used to be able to get all over... We (Z1 and R1) did have a private meeting with (E14 Social Services and E3 RN) ... E3 (RN) concluded (R1) wasn't going to get (R1's electric wheelchair) back. I know when I go by (two other units there are residents driving towards (another unit) in the street. Tell me why they can and others can't..."

On 9/17/13 at 9:30 a.m., R1 was lying on the bed but was able to transfer from a lying to sitting position. R1 stated (R1) had a stroke 20 years ago and has resided at the facility since that time. R1 had difficulty answering questions due to aphasia (difficulty speaking due to stroke). R1 had a manual wheelchair parked at the bedside and a charger for a motorized chair sitting on the floor in front of R1's personal locker but no motorized wheelchair in R1's room. R1 indicated by gestures and short verbal responses R1 had an electric wheelchair for 10 years but it had recently been taken away permanently. R1 indicated (Z1 R1's POA) could answer questions regarding R1's electric wheelchair on (R1's) behalf.

R1's care plan dated 4/15/13 states R1 is alert and oriented and has right side hemiplegia (paralysis), Aphasia, and COPD (Chronic Obstructive Pulmonary Disease). Monthly Summary notes dated 6/17/13 and 7/26/13 state R1 is alert and oriented. MDS (Minimum Data Sets) dated 4/03/13 and 6/26/13 indicate R1 has no short term or long term memory problems. On 9/17/13 at 9:30 a.m., R1 demonstrated how R1 propels the manual wheelchair due to paralyzed right arm and right leg. R1 reports (R1) can propel to the dining hall and to the coffee shop.
Continued From page 3

but has to stop and rest at times. R1 indicated (R1) would like an opportunity to have the electric wheelchair back but R1 indicated (R1) was told (R1) could "never" have the electric wheelchair back.

A type written form titled Electric Wheelchair/Scooter Safety Rules was signed by R1 and dated 10/27/08. The form states it was formulated September 2008 and revised September 2009. The rules on the form states "... 8. You should not ride in the streets. Stay on the sidewalk... 13. Your chair may be taken away by the (facility staff) if: a. You run into another resident, staff person, visitor, or object. b. You are driving in an manner that is deemed unsafe by the staff. c. Your medical condition is or becomes such that you can not safely operate an electric chair. d. or you do not pass the driving test...".

On 9/18/13 at 8:45 a.m., Z1 (R1's POA) reported a grievance had not been filed as neither R1 or Z1 were not aware of that process or procedure. Z1 stated Z1 didn't not know where R1's electric wheelchair is now. Z1 (R1's POA) indicated E3 (RN) told (Z1) the electric wheelchair rules have been brought up in the community meetings held on R1's unit. Z1 reports R1 does not attend community meeting on (R1's) unit. On 9/17/13 at 11:20 a.m., E5 (RN) verified R1 does not attend the units community meetings. On 9/17/13 at 4:15 p.m., Z4 (Ombudsman) stated (Z4) had inquired with E3 (RN - Nursing Supervisor) regarding R1's electric wheelchair. Z4 reported E3 stated R1 would never have the electric wheelchair back. Z4 (Ombudsman) stated, "(E3) said there was someone before (R1) and four people after (R1) and nobody's getting them back."
Typed Community Meeting Minutes from R1’s unit dated 4/11/13 state, "... Residents are encouraged to stay on the sidewalks when walking and operating power chairs as the ground is soft and uneven. The area around the Power House and railroad tracks remain off limits and residents are now encouraged to avoid going on the north side of the deer pen. Signs will soon be available indicating which areas are prohibited..."

Typed Community Meeting Minutes from R1’s unit, dated 5/09/13, repeat this same statement.

Typed Community Meeting Minutes from R1’s unit dated 6/13/13 state, "...There have been increased concerns regarding power wheelchairs/scooter usage and residents using them in a safe manner. If a chair is removed it is due to medical issue, a cognitive issue or an issue with the chair itself. The first thing that is asked when the chair is removed is 'When can it be given back?' The answer is when the condition is corrected. But if a member chooses to use their chair in an unsafe manner such as taking it into areas that are deemed unsafe, and it is given back after a certain period of time this is viewed as a discipline or punishment and this is not allowed. A member asked how we can take away something that does not belong to you. It was explained that we do not actually take the chair; we restrict the privilege of using it. A member stated that in the city if you run out of sidewalk you can use the street. Members were reminded that they signed an agreement to use in safe areas and that taking them into areas with heavy equipment and trains or high traffic is considered unsafe... It was reported that some sidewalks have areas that are uneven and unsafe..."
Z9999 Continued From page 5

An Evaluation Summary for Face to Face Exam dated 3/05/13 and signed by Z1 and Z2 (Physical Therapist) and E4 (CNP - Certified Nurse Practitioner) states R1 is "alert and orientated to name, place, staff, and time." The evaluation also states R1 is "...able to follow multiple step commands with short-term and long-term memory intact...makes all decisions independently. Communication skills are impaired due to aphasia, but client is able to make all wants and needs known...has successfully been trialed in a group 3 power wheelchair and demonstrates safe and independent mobility..." A Occupational Therapy Discharge Summary dated 4/26/13 and signed by E4 (CNP) on 4/29/13 states, "... (R1) completed training on campus...performed on curb cuts and sidewalks, ramps and doorway to coffee shop....demonstrates ability to learn new techniques quickly, adapting to the (new electric wheelchair) with demonstration of safe mobility throughout living environment..."

An incident report dated 5/17/13 at 12:45 p.m. and completed by E6 (LPN - Licensed Practical Nurse) states, "... (E8 Housekeeper) saw (R1) in far parking lot of (R1's building)... Called security... Security came... (after security spoke with R1)... (R1) came into the building and went to (R1's) room..." On 5/20/13, E3 (RN - Registered Nurse Supervisor) documented on the 5/17/13 incident report, "... (R1) has passed testing... further non-compliance will result in removal of electric chair for safety..."

An incident report dated 6/08/13 at 1:30 p.m. and completed by E6 (LPN) states, "... (E7 VNAC - Veterans Nursing Assistant Certified and E8 Housekeeper) pointed out to me that (R1) was sitting in the parking lot sunning... (E6 LPN) went..."
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** IL6015473  
**Date Survey Completed:** 09/23/2013

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>(X5) Complete Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
<td></td>
<td></td>
<td>Continued From page 6</td>
<td>Z9999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

outside and seen (R1) coming up (the road from the parking lot to R1's unit)... (R1) came up the road and got on the sidewalk.... (E6 LPN) reminded (R1) that (R1) had to stay on sidewalks. (R1) gestured to (E6) there were no sidewalks on the other side of the parking lot where (R1) liked to sit. Called security and reported (R1) from chair..." On 6/10/13, E3 (RN Supervisor) documented on the 6/08/13 incident report, "... No recent health issues or (medical) changes... Staff completed (follow up on 6/08/13 correctly - removal of chair... as noted resident warned times (two) per staff documentation... resident after incident refused to come to meals, refused manual chair that is in room... See attached - Driving Test... Will discuss at Resident Care 6/11/13..."

On 9/19/13 at 4:35 p.m., E24 (Administrative Assistant) reported E2 (DON - Director of Nursing provided a copy of the Resident Care Meeting minutes of 6/11/13 but indicated R1 did not have a driving test. E24 stated E3 (RN Nursing Supervisor's) documentation was a referral to the electric wheelchair safety rules R1 signed on 10/27/08 and not a driving test.

Resident Care Meeting minutes dated 6/11/13 state, "... (R1) was out in the parking let again with (R1's) electric wheelchair. On (5/15/13) nursing staff met with (R1) and on (5/17/13) Security met with (R1), so we have those conversations documented, and (R1) was caught in the parking lot again. They removed (R1's) chair. Now (R1's) back up on the unit, taking (R1's medications), and is in a manual chair.... (E14 Social Services) sent out an e-mail with (Z1's - R1's Power of Attorney) questions and (Z1) wants to have a meeting. (E3 RN Nursing..."
Continued From page 7

Supervisor) and (E14 Social Services) will meet with (Z1). (E1 Administrator) said either they're safe or they're not. E3 (RN Nursing Supervisor) said they are going to do a repeat SLUMS (mental status exam) on (R1). (E23 Social Service Director) said they've not been successful getting a SLUMS with (R1) in the past (due to) aphasia (disorder of language due to stroke) - (R1) gets really frustrated trying to answer the questions. (E17 Medical Director) said (R1's) SLUMS is irrelevant to the issue...

A policy titled Wheelchairs, Electric/Scooter Removal From Resident dated August 2012 states, "... Any resident driving their electric wheelchair or scooter in an unsafe manner will be immediately removed for the chair and placed in a manual wheelchair... A determination of the cause of the unsafe driving will be made by the Physician/CNP (Certified Nurse Practitioner) and other staff as deemed necessary... The electric wheelchair or scooter will not be reinstated until a decision has been made that the resident: a) No longer has the medical condition that caused the resident to be unsafe in driving the wheelchair/scooter; or b) has improved cognition such that he/she is safe to drive the electric wheelchair... When the Physician/CNP has evaluated the medical/cognitive problem and a determination has been made whether or not the resident will be allowed the use of electric wheelchair or scooter, a care plan meeting will be scheduled with the resident and/or family.... The resident may or may not be required to take a retest for driving skills... The resident will be required to again agree to and sign the Electric Wheelchair/Scooter Safety Rules form if the chair is reinstated... Driving in an unsafe manner including but not limited to: driving while intoxicated, driving too fast, driving in the middle..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____________________________</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL6015473</td>
<td></td>
<td>09/23/2013</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

ILLINOIS VETERANS HOME AT QUINCY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1707 NORTH 12TH STREET
QUINCY, IL 62301

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
</tr>
</tbody>
</table>

**PROVIDER'S PLAN OF CORRECTION**

(Each corrective action should be cross-referenced to the appropriate deficiency)

**COMPLETE DATE**

---

**Continued From page 8**

of the road instead of the sidewalk, not signing out before leaving the building, running into objects, another resident, staff person or visitor may lead to permanent removal of the electric wheelchair or scooter...

On 9/18/13 at 10:25 a.m., R5 was sitting in an electric wheelchair on the patio outside his unit. R5 stated (R5) didn't know of any electric wheelchair rules. R5 indicated (R5) used to go all around (in R5's electric wheelchair) but now (R5) "just stays put".

On 9/18/13 at 11:00 a.m., R6 was sitting in an electric wheelchair on the patio outside (R6's) unit. R6 stated, "... No restrictions that I know of. I can go anywhere I want..." On 9/18/13 at 11:10 a.m., R7 crossed the street in a cross walk area in an electric wheelchair. R7 stated, "I went to the bank and got lost. My (spouse) is in (a nursing care unit)... (spouse) just came yesterday...not sure how I can get there (in the electric wheelchair)." Regarding electric wheelchair rules R6 stated, "... Supposed to stay on the sidewalks, I guess..." On 9/18/13 at 11:20 a.m., R8 was sitting in an electric wheelchair in front of (R8's) unit. R8 indicated (R8) was not aware of any rules, and stated, "They (residents in electric wheelchairs) go all over anywhere they want. Some go to (local grocery store), some go to (a local fast food restaurant), and some even go to (a local bar)..."

On 9/18/13 at 11:30 a.m., E9 (RN - Nursing Supervisor) reported the residents who reside in (the building E9 supervises) are allowed to run their electric wheelchairs and scooters in the street along the sidewalk that leads to the building. E9 stated it is the only sidewalk on the grounds that has a curb. E9 verified residents (in electric wheelchairs and scooters from E9's
Continued From page 9

building) that go the physical therapy do ride in the street to access the Physical Therapy building. An electric wheelchair/scooter list dated 9/17/13 indicate there are 17 residents using electric wheelchairs/scooters in E9's building.

R1's Physician Orders include a late entry stating, "... Take member out of (electric wheelchair due to) safety issues...". R1's Interdisciplinary Progress Notes dated 5/15/13 at 10:00 a.m. state E6 (LPN) read R1 the electric wheelchair rules telling R1 "someone" had see R1 riding R1's electric wheelchair in parking lots. The 5/15/13 notes indicate Z1 (R1's POA) was notified. Interdisciplinary Progress Notes dated 5/17/13 at 12:45 p.m. verify E6 (LPN's) observations of R1 documented on an incident report of the same date. Neither the Incident Report or the Interdisciplinary Progress Notes for R1 on 5/17/13 indicated Z1 (R1's POA) was notified. R1's Interdisciplinary Progress Notes on 6/08/13 at 1:30 p.m. written by E6 (LPN) verify E6's observations of R1 on 6/08/13 documented on an incident report of the same date and indicates Z1 (R1's POA) was notified.

Late entry Interdisciplinary Progress Notes for R1 dated 6/11/13 at 1:30 p.m. written by E3 (RN Nursing Supervisor) indicate a meeting was held regarding the removal of R1's electric wheelchair. The notes indicate R1, Z1 (R1's POA), E3 (RN Nursing Supervisor) and E14 (Social Service) present. E3's 6/11/13 notes state, "... Feels (an appeal) is needed and will seek appeal... (Z1) felt a one month removal would be enough of a time frame without chair..." On 9/17/13 at 11:00 a.m., E3 (RN - Nursing Supervisor) stated the decision to permanently remove R1's electric wheelchair "was above me." On 9/18/13 at 11:40 a.m., E14 (Social Services) indicated (E14) was not part of
### Illinois Department of Public Health

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING:**

**DATE SURVEY COMPLETED:**

**PRINTED:** 01/09/2018

**FORM APPROVED:**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
<td>Continued From page 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

```plaintext
the decision making process for permanent removal of (R1's) electric wheelchair. E14 reported (E14) participated in the meeting with R1 and Z1 (R1's POA) at the request of E3 (RN - Nursing Supervisor).

A Social Service Assessment dated 6/11/13 and completed E22 (Social Services) states, "...Diagnosis of Depression was changed to history of Depression on 11/10/10... (R1) used an electric wheelchair until 6/08/13 at which time it was removed... Since 6/08/13 (R1) has declined some meals and medications... Feels discouraged and depressed in the last two days since the removal of (R1's) electric wheelchair, but denied suicidal thoughts... did not feel depressed prior to the removal of (R1's) electric wheelchair... (R1's) aphasia is felt to have affected the overall test results and the score of 4/30 is not believed to be an accurate reflection of (R1's) cognitive abilities..."

On 9/17/13 at 3:40 p.m., E7 (VNAC) stated R1 "drives really good. Never has had problems." E7 (VNAC) reported R1's electric wheelchair was taken away because R1 was driving out sunning in the far parking lot (adjacent to R1's unit). E7 (VNAC) denied R1 has behavior problems or is resistive with care. E7 (VNAC) stated, "...When I make beds upstairs I look out the window and I see others by the deer park (in electric wheelchairs) on the road...". E7 (VNAC) indicated the facility had started enforcing electric wheelchair/scooter rules more strictly this past summer but R1 has been sunning in (R1's) electric wheelchair in this parking lot "for years."

On 9/17/13 at 2:45 p.m., E8 (Housekeeper) stated R1 goes in the parking lot to sun and has been "doing it for years." E8 reports staff were
```

---

**STATE FORM**

**STATE Form 496L11**

---

Illinois Department of Public Health
Continued From page 11

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>Z9999</td>
<td>Z9999</td>
<td></td>
</tr>
</tbody>
</table>

told residents are not to be in the street, parking lots, or down by the Power House in their electric wheelchairs. E8 (Housekeeper) reported "...They've got to cross the street here to get to the sidewalk and the parking lot to get to the next sidewalk... (R1) sits in the sun on the side of the patio now but has to have help to get there...". E8 indicated R1 always sat in the parking lot "way back away" from everything.

On 9/17/13 at 11:55 a.m., E6 (LPN) stated, "... (R1) likes to go and park in the very last parking area and sun bathe. (R1) goes all over the grounds with the electric wheelchair..." E6 reported on 5/15/13 E6 showed R1 a copy of the rules and read them to R1. E6 indicated (E6) did this at the request of E3 (RN Nursing Supervisor) but it was not verified that it was R1 noted on the facility street/parking lot in an electric wheelchair on 5/15/13. E6 (LPN) stated, "(R1)'s been doing this for years (sitting in the parking lot sunning). It's not a new policy just new to push the rules..."

On 9/18/13 at 10:15 a.m., R4 was preparing to drive an electric wheelchair on a sidewalk with E10 (Restorative Aide) standing next R4's electric wheelchair supervising R4. R4 reported R4 was being tested in order to get (R4's) wheelchair privileges back. R4 stated, "This is the third time." R4 indicated (R4's) lost privileges to operate the electric wheelchair in the past because "I run into things and people." E10 (Restorative Aide) verified R4 is being tested for electric wheelchair reinstatement for the third time.

On 9/18/13 at 10:30 a.m., E4 (CNP) stated E4 did not participate in care plan meetings with R1. E4 indicated (E4) did not participate in the decision to remove R1 electric wheelchair permanently and
Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015473

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C. 09/23/2013

NAME OF PROVIDER OR SUPPLIER

ILLINOIS VETERANS HOME AT QUINCY

STREET ADDRESS, CITY, STATE, ZIP CODE

1707 NORTH 12TH STREET
QUINCY, IL  62301

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued From page 12

can not explain the thought process or reason for the permanent removal.  E4 (CNP) indicated E3 (RN - Nursing Supervisor) requested a written order.  A Physician Progress Note dated 8/07/13 written by E4 (CNP) states, "... Out of (wheelchair power) permanently due to not staying out of the street..."

On 9/19/13 at 3:00 p.m., regarding electric wheelchair reinstatement, E1 (Administrator) stated, "...It's all or nothing.  I hate them (electric wheelchair/scooters).  I wish they'd never allowed them here in the first place..."

2.  R2 stated on 9/17/13 at 9:25 am, "Get that letter out of that shelf there that I wrote and read it. It's about my wheelchair they took away from me." The letter is a typed complaint which is dated 7/19/13. The complaint includes the following:  "You of course are aware that I had an electric wheel chair for a while.  But all of a sudden it has been taken away from me by those who really had no business doing it. (Two) girls approached me about my right hand with a worried feeling about my hand being crushed and wanted me to stop using the chair because of it. I showed them my hand was not injured in any way. They threatened to turn the power off where I wouldn't be able to move at all. We talked and argued and they did turn the power off the chair. Then they said I could go on, of course I could not move then and didn't try until they told me they were turning it back on. At which time I decided I had better move to another location and avoid the interference. However, when I turned the power back on to move I found that the power was many times stronger than it had been on and my chair plunged ahead jumping in the air and almost hitting (R9) and landing me into another person's eating table."  R2 said, "The girls had
disengaged my power chair and when it was turned back on it went faster that it was supposed to so it plunged forward. It wasn't my fault. I've always worked with machinery. I know how to use machinery, power saws and all. I'm 95 years old and all I want to do before I die is to walk. That is my one goal. I was able to go over to therapy when I had the electric wheel chair. Now I can't get there so I can't walk the parallel bars in the open gym."

Restorative Nursing Orders dated 7/23/13 under Section 2 include the following Restorative order: "D/C (Discontinue) open gym - (R2) no longer able to come to therapy building independently."

A Restorative order dated 7/31/13 for Ambulation with assist of one to and from toilet, meals and activities and at every opportunity was to start on 8/1/13, 29 days after the power chair was taken. The facility incident report dated 7/3/13 at 8:00 am includes the following, "(E20/VNAC/Veterans Nurse Aide Certified) had taken (R2) to the restroom. As (R2) was coming out of the restroom (E20) was giving (R2) his glasses, (R2) started talking and ran over (E20's) foot with electric wheelchair. (E20) said stop, your running over my foot. (R2) said, "Oh, I am sorry." R2's nursing note dated 7/3/13 at 8:00 am, reports, "(E20/VNAC/Veterans Nurse Aide Certified) reported that (R2) ran over (E20's) foot with electric w/c (wheelchair). W/C removed at this time and supervisor notified." Nursing note at 2:30 pm on 7/3/13 states, "PT (Physical Therapy Supervisor) here and reviewed w/c safety rules. W/C reinstated as earlier incident was accident and not poor driving skills." At 6:00 pm on 7/3/13, the nurse documented, "Witnessed (R2) in dining room sideswipe another member's wheel chair and then got electric wheel chair caught on the corner of a table and was moving the table. I told (R2) I was
Continued From page 14

go to have to disengage (R2's) wheelchair because of safety issues. " On 7/3/13 at 6:10 pm, the nurse charts, "Order obtained by (E19/Medical Doctor) on call to keep (R2) out of electric wheelchair and have (R2's) medical doctor order a safety test on 7/5/13."

Physician orders for R2 include the following, "7/3/13 at 10:25 am, Retest in electric w/c. Signed (E16/Medical Doctor): 7/3/13 at 6:10 pm, "Keep (R2) out of electric wheelchair. Have safety test on 7/5/13." On 7/9/13 at 2:36 pm, "(discontinue) retest on w/c of 7/8/13."

A form with R2's name titled EVALUATION FOR USE OF AN ELECTRIC WHEELCHAIR, dated 7/8/13, and located in R2's medical record. It is signed and dated by E16 (Medical Doctor). The evaluation includes the following: "Alert and oriented." E16 answers (Would there be any specific restrictions with this resident operating an electric wheelchair?) with, "Use only in open areas like common/dayroom and outside."

Comments, "Usually not allowed to drive into dining area due to close quarter at his table." E3 (RN/Registered Nurse/Supervisor) was asked on 9/18/13 at 9:00 am to clarify the evaluation as it appears to allows R2 to use the electric wheelchair not deny the use of it. E3 stated, "I can't speak for (E16/Medical Doctor). In the chronological order of things (R2) can't use it because the retest was discontinued the day after the evaluation. I can't explain how that happened the day after the eval."

The facility policy titled, WHEELCHAIRS, ELECTRIC/SCOOTERS, REMOVAL FROM RESIDENT, revised 8/12, includes the following:

Policy: The (facility) has the right to remove a resident from an electric wheelchair if the resident is deemed as an unsafe driver.

PROCEDURE:
4. Physician to obtain an order to "Remove
Z9999 Continued From page 15
resident from the electric wheelchair and place in a manual chair for resident safety."
5. The electric wheelchair will not be reinstated until a decision has been made that the resident:
a) no longer has the medical condition that caused the resident to be unsafe
b) has improved cognition such that the is safe to drive the electric wheelchair
6. When the physician has evaluated the medical/cognitive problem and a determination has been made whether or not the resident will be allowed the use of electric wheelchair, a care plan meeting will be scheduled.
7. The resident may or may not be required to take a retest for driving skills."
A complaint form dated 7/22/13 was provided as follow up to R2's letter of complaint dated 7/19/13. It states, "I feel my power chair privileges have been withdrawn without adequate review or due process. My speed controller had been moved by staff. I was unaware of this and an accident resulted."
Nursing note dated 7/23/13 at 1:00 pm by E3 (RN/Supervisor) states, "(R2) did request to talk with me about (R2)'s electric wheel chair and the possible issue of getting his chair back. I again informed him I got his letter - after review of issues (R2) would not get chair back. That if (R2) wished (R2) could talk to social services about an appeal process. (R2) informed me he already had."
On 9/19/13 at 8:30 am, E15 (RN) was asked why R2's electric wheelchair was taken away when the evaluation dated 7/8/13 states (R2) can use the chair in open areas such as common/dayroom areas. E15 stated E15 was not involved after the initial incident and did not know what happened afterward.
The MDS (Minimum Data Set) for R2 dated 7/26/13 notes R2 to have the diagnosis of
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z9999</td>
<td></td>
<td></td>
<td>Continued From page 16 Chronic Airway Obstruction and scored a 15 in cognitive decision making noting his cognitive abilities to be totally intact.</td>
<td></td>
<td></td>
<td>Z9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>