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CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

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S 000	Initial Comments Incident Report Investigation of 6/10/17/IL94801 Complaint #1763770/IL94964 R1 resides in the Subpart U: Alzheimer Unit. STATEMENT OF LICENSURE VIOLATIONS	S 000		
S9999	Final Observations 300.610a) 300.1210d)6) 300.1210b) 300.3240a) 300.7020b)6) 300.7060a) 300.7060d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	**Attachment A** **Statement of Licensure Violations**	

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each resident's comprehensive resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Section 300.7020 Assessment and Care Planning

b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident.

6) The care plan shall be implemented and

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followed by staff who care for the resident.

Section 300.7060 Environment

a) The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan.
d) Visual supervision of indoor and outdoor activity areas shall be provided, supported by architectural design. Staff shall be present in activity areas when residents are in these areas.

LICENSURE FINDINGS:

Based on observation, interview and record review the facility failed to ensure the door alarm to the courtyard on the facility's Alzheimer's Unit was engaged and the door not propped open. This failure resulted in the door alarm being disengaged, the door propped open and R1 wandering into the courtyard and remaining unsupervised for over three hours in direct sunlight with temperatures exceeding 85 degrees Fahrenheit. R1 was found unresponsive, having vomited, without vital signs and subsequently died. R1 was one of three residents reviewed for safety in the sample of five.

Findings include:

The facility's Incident Report dated 6/16/17 documents R1 was found lying on R1's back in the courtyard at approximately 5:33 PM by E7

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Certified Nursing Assistant (CNA) without a pulse or respirations. The report goes on to state vomit was noted at the sides of R1's mouth and around R1's head. The report documents the facility reviewed video surveillance and determined the nurse unlocked and propped open the courtyard door (to the outside garden). R1 is seen exiting the building (through the courtyard door) at 1:47 PM and was not seen again on the facility's interior surveillance.

R1's Physician Order Sheet dated 5/15/17-6/15/17 documents the diagnoses of Dementia with behavioral disturbance-Dementia with Psychosis, Bipolar Disorder, Anxiety Disorder and Hypothyroidism. The Minimum Data Sheet (MDS) dated 5/24/17 documents R1 has a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicates severely impaired cognition. This same MDS documents R1 requires limited physical assistance from one staff member to ambulate without any mobility devices (i.e. cane, walker).

R1's Care Plan dated 5/25/17 documents staff will know of (R1's) whereabouts and supervise (R1) when (R1) is out of (R1's) room. This Care Plan also documents to redirect (R1) from a particular female resident's room or secluded areas where there is not staff supervision. R1's Care Plan also documents R1 is at risk for falls and has an intervention dated 8/29/16 of staff to walk with (R1) when (R1) is in the garden (courtyard).

On 6/21/17 at 2:00 PM, E8 Alzheimer's Unit Manager provided a list of cognitively impaired ambulatory residents on the Alzheimer's unit. On 6/21/17 at 2:00 PM, E8 confirmed that R1 was on this list before R1 passed away.

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R1's Progress Notes dated 6/10/17 at 10:45 PM written by E5 Registered Nurse documents, "At approximately 5:30 PM (E5) was called to unit five by the nurse on duty (E6 Licensed Practical Nurse) and CNA on duty (E7). (R1) was found outside in the garden on (R1's) back supine, laying flat, torso on sidewalk with vomit on either side of head and some vomitus visible around oral cavity, and feet on soil. On initial assessment (R1) pale, nonresponsive. Initially (E5) thought (E5) felt a carotid pulse. Skin very hot to touch." E5 goes on to document, "Informed by CNA on duty (E7) and nurse on duty (E6) door had been propped open unlocked and unalarmed and that they had noticed they had not seen (R1) when they were gathering everyone for dinner."

On 6/15/17 at 10:05 AM, during initial tour of the facility, there were signs posted on all of the exit doors leading to the main courtyard. There were two signs posted on each door. The first sign stated, "Heat Advisory!!" "Be aware of the heat and don't stay out too long, drink plenty of fluids to stay hydrated." The second sign stated, "Due to extreme heat, please be cautious when outdoors. Please limit outside exposure as well and let nurse know that you will be going outside. Hydration available under Gazebo. Thanks." At this time there was a large jug of water out under the gazebo in the main courtyard area with cups next to the water cooler.

On 6/15/17 at 11:36 AM, there were three signs posted on the exit door to the courtyard on the Alzheimer's Unit. The first sign stated, "This door is to be closed and locked at all times!!" The second sign stated, "Residents are not to be in the courtyard unless accompanied by a staff member, and signed out on Resident Courtyard

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sign in/out form." The third sign stated, "Due to extreme heat, please be cautious when outdoors. Please limit outside exposure as well and let your nurse know that you will be going outside. Hydration available under gazebo. Thanks." Observation revealed there is no gazebo in the Alzheimer's Unit courtyard.

On 6/15/17 at 11:40 AM, E8 Alzheimer's Unit Manager stated the nurse is responsible for making sure the door to the garden courtyard is locked. E8 stated there is a water cooler out on the patio but they do not use it because they take out the resident's own jug of water when they take them out to the patio. E5 stated, "When it is over 85 degrees we should've never been out here (garden courtyard)." on 6/15/17 at 11:40 AM there was a water cooler on a cart in the courtyard. The water cooler is empty and facing backwards against the wall.

On 6/21/17 at 2:05 PM, E8 stated R1 was wearing sweat pants or pajama pants and a fuzzy pajama top. E8 stated this was typical for R1 as she always complained about being cold in the facility.

On 6/15/17 at 11:40 AM, E8 conducted a tour of the courtyard. There is approximately eight to ten feet of covered area right outside the building. There is a sidewalk path to the left after entering the courtyard which leads to the gate which is a designated exit from the courtyard. The gate is locked and the alarm sounding when pushed against. There is a sidewalk to the right after entering the courtyard that curves around. There are tall plants and flowers approximately two and a half feet high along the sidewalk that leads to the gate. This is the area where R1 was found lying on her back. The sidewalk is not visible from

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inside of the building due to the plants. The right side after entering the courtyard goes back about 20 feet to the fence.

On 6/19/17 at 11:35 AM, E5 confirmed she was called to the courtyard on 6/10/17 by the LPN (E6) and CNA (E7) on duty in the Alzheimer's Unit. E5 stated she verified R1's code status while checking for pulse and respirations. E5 stated the DNR (do not resuscitate) code was confirmed and E5 listened for heart tones and respirations with a stethoscope and there were none. E5 stated another nurse (E4 LPN) began making the necessary phone calls and E5 covered R1's body with a sheet as R1 was in the direct sunlight. E5 stated she tried to provide some shade for R1's body without touching R1 any further. E5 confirmed when she exited the building to assess R1 in the courtyard the door was propped open and the alarm did not alarm. E5 stated the nurse on duty on the unit has the key to disarm the door alarms.

On 6/19/17 at 11:07 AM, E4 LPN stated he made all the phone call notifications for E5. E4 stated R1 was on the ground outside. E4 confirmed the alarm did not alarm (sound) when E4 exited the building to the courtyard garden to offer assistance. E4 confirmed the nurse on duty on the unit has the key to disarm the alarms. On 6/21/17 at 2:43 PM, E8 Alzheimer's Unit Manager confirmed E6 LPN was the nurse in charge of the Alzheimer's Unit on 6/10/17 and E6's shift was from 6:30 AM to 11:00 PM on 6/10/17.

The weather history for June 10, 2017 provided by "Weather Underground" documents the temperature for June 10, 2017 from 1:00 PM to 6:00 PM was over 85 degrees and the relative humidity ranged from 29% at 1:00 PM to 30% at

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6:00 PM.

The facility's "Alzheimer's Special Care Neighborhood Garden View Court" policy documents, "Unit manager or charge nurse must determine temperature and humidity prior to any outdoor activities. Outside activities should only be conducted weather permitting outside activities discouraged if temperature is above 85 degrees/35% humidity. Resident's time outdoors must always be supervised. If residents are going outside patio door can be unlocked (otherwise locked continually) and monitored continuously for time staff have residents outside in courtyard. Fluids should be offered during any outdoor activities. Staff should ensure residents are dressed appropriately for the weather. Residents should be signed in and out and temperature/humidity noted before allowing access to courtyard. Sun screen should be offered and applied by staff if resident is unable to apply independently. Failure to comply with the locked door policy will result in disciplinary action.

On 6/15/17 at 10:35 AM, E1 Administrator stated, "Staff violated a lot of policies that day. They unlocked the door to the courtyard and propped it open. The staff no longer work here. They thought (R1) was in (R1's) room sleeping. The autopsy is not complete, waiting on toxicology." E1 then stated, "the video surveillance shows (R1) going out at 1:47 PM and was found at 5:33 PM."

On 6/15/17 at 3:43 PM, Z1 Coroner stated R1's autopsy is not complete, there are tests still pending. Z1 stated there was no evidence of trauma or injury to R1. Z1 stated R1 was extremely warm to touch. Z1 stated a liver temperature was not completed as it would be

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inaccurate because it is unknown how long R1 was laying unresponsive in the direct sunlight. Z1 stated they are waiting for other test results to determine if they can relate R1's death to heat exhaustion. Z1 also stated R1's heart looked good during the autopsy.

(A)

Section 300.1230 Direct Care Staffing
b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day.
d) Each facility shall provide minimum direct care staff by:
1) Determining the amount of direct care staffing needed to meet the needs of its residents; and
2) Meeting the minimum direct care staffing ratios set forth in this Section.
j) Skilled Nursing and Intermediate Care
For the purpose of this subsection, "nursing care" and "personal care" mean direct care provided by staff listed in subsection (f).
5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act)
k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by

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registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act)
l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used:
1) The facility shall determine the number of residents needing skilled or intermediate care.
2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category.
3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility.
4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.
5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required
The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act.
6) The amount of time determined in subsections (l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include

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S9999	Continued From page 10 time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census. These requirements are not met as evidence by: Based on record review and interview the facility failed to have 10% of nursing and personal care provided by an RN (Registered Nurse) for 1 of 14 days reviewed. This failure has the potential to affect all 143 residents residing in the facility. Findings Include: The undated spread sheet provided by E1 Administrator on 6/22/17 documents staffing hours for the time period of 6/8/17 through 6/21/17. This spread sheet documents an average skilled census of 12.2 residents and an average intermediate care census of 126.9 residents, which requires a minimum of 36.36 RN (Registered Nurse) hours a day. The spread sheet documents the following date and hours that do not meet the minimum requirements: Sunday, 6/18/17 - 24.5 RN hours, short 11.86 hours On 6/22/17 at 3:00 PM, E1 confirmed these hours are accurate. The Facility Data Sheet dated 6/15/17 documents 143 residents reside in the facility. (AW)	S9999		