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Illinois Quarterly Nursing Home Report :: Jan. – Mar. 2017

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The Illinois Department of Public Health (IDPH) routinely conduct surveys on nursing homes to determine if any facility has violated regulations in the Nursing Home Care Act. The state agency is responsible for certifying skilled nursing homes and ensuring that they remain in compliance with federal and state rules. To keep the public informed, the Public Health Department releases quarterly nursing home reports and publishes the results of inspections and enforcement actions taken against the facility to ensure that residents of the home are receiving quality care in accordance with the 180 regulatory standards.

The nursing homes listed below received disciplinary action for one or more Type A (extremely serious) violation occurrences involving nursing home codes as defined by the Illinois Nursing Home Care Act. They include:

Alden Des Plaines Rehabilitation & Health Care Center
1221 East Golf Road
Des Plaines, IL 60016

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0028-11-22-16-Alden-Lakeland-Rehab-%26-HCC-041017.pdf

Fine:
This facility was fined $25,000 for violations.

Violations:
In a summary statement of deficiencies dated November 22, 2016, the IDPH noted that Alden Des Plaines Rehab and HCC “failed to implement fall prevention monitoring and interventions to prevent a resident at risk for falls from falling multiple times in a two day period.” The resident involved in the incident “sustained repeated falls, skin tear on the right forearm, bilateral nasal bone fracture, and subdural hematoma.”

The facility’s Admission/Transfer/discharge logs indicate that the resident “was admitted to the facility on November 3, 2016, at 12:19 PM” and had their first fall at 2:00 PM the same day, “and a second fall at 7:30 PM which resulted in the skin tear four inches long to the right forearm with a minimal amount of bleeding.” The nursing staff transferred the resident to the hospital to receive care before returning to the facility at 4:30 AM the following morning.

However, the resident “had a third fall [less than three hours later that same day on] November 4, 2016, at 6:55 AM” and was returned to the local community hospital near dinner time at 4:48 PM where test results showed that the resident suffered “subdural hematoma and bilateral nasal bone fractures.” The State surveyor noted that the facility failed to follow the home’s June 2013 Prevention of Falls policy.

Alden Town Manor Rehabilitation & Health Care Center
6120 West Ogden
Cicero, IL 60804

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0018-11-22-16-Alden-Town-Manor-Rehab-&-HCC-041017.pdf

Fine:
This facility was fined $27,000 for Type A and Type B violations.

Violations:
In a summary statement of deficiencies dated November 22, 2016, the State surveyor noted the facility’s failure to “follow its own policy governing physician notification by failing to notify one resident’s physician of a change in condition regarding worsening of arterial wounds…” The failure of the nursing staff and administration resulted in the resident being admitted to the hospital “on November 6, 2016, for bilateral gangrene to both feet and subsequent above the right knee amputation of [the resident’s] right lower limb.

The incident involved a family member notifying the nursing staff that the resident’s “right foot was black until the facility to transfer [the resident] out.” As a result of being transferred to the hospital, the resident “had the right foot amputated just above the knee due to a lack of care [the resident] received at this facility.”

Ambassador Nursing & Rehabilitation Center
4900 North Bernard
Chicago, IL 60625

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0039-12-20-16-Ambassador-Nsg-%26-Rehab-Center-041017.pdf

Fine:
This facility was fined $25,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated December 20, 2016, surveys for the State of Illinois noted this facility’s failure to “ensure policies and procedures for aspiration precautions and meal services were followed. The facility failed to adequately supervise residents on aspiration precautions that affected three” residents. “The facility also failed to identify a resident choking in the dining room which resulted in [the resident] dying due to asphyxiation and choking from a food bolus [obstruction].

The resident was found to be unresponsive in the dining room by the facility’s Administrator who was the only staff member present during the choking event. Emergency Medical Services were called to the facility where they found a cyanotic [blue skin] unresponsive resident who is transferred to the hospital and died. The patient’s December 13, 2016, Diet Type Report revealed that the resident

was to receive “soft, thin liquids, additional directions: aspiration precaution” and “1:1 supervision.”

The responding Fire Department’s report noted that the resident’s airway was opened using forceps to “remove several pieces of large sausage from [the resident’s] upper airway and lower airway beyond the vocal cords.”

Aperion Care Jacksonville
1021 North Church Street
Jacksonville, IL 62650

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0132-02-01-17-Aperion-Care-Jacksonville-041017.pdf

Fine:
The facility was fined $25,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated February 1, 2016, the Illinois State surveyors investigated three complaints filed against the facility. In one incident, the State surveyor noted the nursing home’s failure “to follow operational policies related to discharging a resident against medical advice and the emergency medical care of a mentally ill adjudicated resident, as established by the State Guardianship and Advocacy Commission.”

The surveyors also noted the facility’s failure “to operationalized the behavior management policy and [failure to] communicate, identify, and anticipate the medical needs of a mentally ill resident upon his arrest for battery on December 15, 2016.” The investigation concluded that the resident was “not receiving the emergency psychiatric care he needed” which “lead to [the resident] leaving the facility ‘Against Medical Device’ on December 16, 2016.” As a result of these failures, the resident’s whereabouts “are currently unknown.”

The Arthur Home
423 Eberhardt Drive
Arthur, IL 61911

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0106-01-10-17-Arthur-Home%2C-The-041017.pdf

Fine:
The facility was fined $25,000 for numerous Type A Violations.

Violations:
In a summary statement of deficiencies dated January 10, 2017, the State surveyor noted the facility’s failure to “both develop and implement abuse prevention policies and procedures to ensure that all abuse allegations are investigated thoroughly.” The investigator also noted the facility failed “to operationalize their current Abuse Prevention Policy” and failed to “thoroughly investigate allegations of employee abuse resulting in [a resident] being left unprotected after he witnessed and reported a verbal/mental abuse allegation.”

The surveyor also noted that the facility “allowed the alleged Perpetrator continued access to [the resident] for seven days” after the incident had occurred. During this time, the resident verbalized

that they were “afraid of the alleged perpetrator and [were] being subjected to subsequent physical abuse by the same perpetrator.”

The December 20, 2016, 12:30 PM incident involved a Certified Nursing Aide (CNA) providing care to the resident who said, “I f***ing hate” the resident while the resident was being transferred into a shower chair. Another CNA stated that the allegedly abusive CNA took the shower “sprayer and sprayed [the resident] in the face with water and it scared [the resident].”

Aviston Countryside Manor
450 West First Street
Aviston, IL 62216

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0064-01-10-17-Aviston-Countryside-Manor-041017.pdf

Fine:
This facility was fined $25,000 for Type A Violations.

Violations:
In a summary statement of deficiencies dated January 10, 2017, the state surveyor noted this facility’s failure to “provide a safe transfer to prevent a fall for [two residents at the facility, where one failure resulted in a resident] sustaining a fracture of the left femur and hospitalization.” The resident documents revealed that they experienced “unsteady sitting and standing balance” and requires “extensive assistance of two staff and has impaired range of motion in the lower extremities.”

The facility’s 10:00 PM, December 12, 2016, Fall Investigation Report states that the resident was being assisted in a transfer “to the bed from the commode that was right next to the bed” with only one assistant “when the bed began to move backward.” The Certified Nursing Assistant providing care stated that she began lowering the resident “to the floor when she heard a pop from the resident’s body.”

The resident never returned to the nursing home but instead was transferred to hospice were documentation revealed an “unspecified fracture of the left femur, subsequent encounter for closed fracture with routine healing.”

Bria of Belleville
150 North 27th Street
Belleville, IL 62226

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0037-12-06-16-Bria-of-Belleville-041017.pdf

Fine:
This facility was fined $25,000 for Type A Violations.

Violations:
In a summary statement of deficiencies dated December 6, 2016, the state investigator noted the facility’s failure to “provide antibiotic treatment for an infected pressure ulcer for [a resident].” In addition, the investigation concluded that the facility failed to “assess and provide timely treatment to address potential dehydration for one of five residents [who was] reviewed for hydration.” These

failures resulted in the resident “being admitted to the hospital was septic shock, possible source left lateral foot ulcer, and severe dehydration.”

The state investigator reviewed the resident’s November 1, 2016, Electronic Medical Record that showed the resident “has a Stage III pressure ulcer.” The resident’s November 17, 2006, Wound Report documented that the resident “has an unstable pressure ulcer on her left lateral foot measuring 0.80 cm x 1.5 cm.” On that date, her physician ordered an antibiotic (Cipro) given orally twice daily for 10 days. However, in November 20, 2016, Nurse Notes documents “a call was received from the pharmacy stating [that antibiotic] is not available in the backup pharmacy in the medication will be available tomorrow at the regular pharmacy.”

The State surveyor noted that the “Wound Physician was never notified that there was a change in antibiotics or that [the resident] was not receiving any antibiotic for the infection the pressure ulcer since November 17, 2016.” In addition, “there was no documentation that [the prescribing physician] was notified that it would not available.” Hospital records indicate that the patient was unresponsive had “minimal response to pain stimuli” and a of “temperature 99°F.” The documents also stated that the resident’s “sepsis assessment documents severe sepsis signs and symptoms plus organ dysfunction” and that the “possible source of the septic shock as the left lateral foot ulcer.”

Brother James Court
2508 St. James Road
Springfield, IL 62707

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0123-01-23-17-Brother-James-Court-041017.pdf

Fine:
The facility was fined $10,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated January 23, 2017, the state investigator noted during a complaint investigation that the facility failed to “ensure that nursing services provided adequate nursing staff; nursing assessment; monitoring; follow-up of pulmonary status; physician notification and notification of 911 for [two residents at the facility] who developed pneumonia.”

As a result, one resident “was hospitalized and intubated due to pneumonia” and the other “was diagnosed and hospitalized with pneumonia.” The investigator also noted the facility “failed to take appropriate action to ensure that a system to monitor for abnormal vital signs and a system for 911 (emergency personnel) notification has been developed and implemented.

The surveyor’s investigation results noted that the facility’s multiple failures “have the potential to affect 92 additional residents… who reside in the facility that require nursing services.”

Citadel Estates – Hazel Crest

3701 West 183rd Street
Hazel Crest, IL 60429

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0068-01-23-17-Citadel-Estates-Hazel-Crest-041017.pdf

Fine:
The facility was fined $12,500 for Type A violations.

Violations:
In a summary statement of deficiencies dated January 23, 2017, the surveyor noted during a complaint investigation that the facility had failed to "include a guideline for assessing a risk of injury to residents when transferring and lifting while performing Activities of Daily Living (ADL). This failure resulted in the death of one resident…" The surveyor also noted that "the failure has the potential of affecting the 33 residents identified as at risk for falls."

The facility's September 30, 2016, Incident Report noted that the resident "was lowered to the floor after complaining of pain when losing her balance. An x-ray was done." The resident "had a fracture of the right and left femur." Documentation including the resident's October 28, 2016, Death Certificate noted that the resident "died from complications of bilateral femur fractures caused by a fall."

Even though the resident had been admitted to the facility on December 30, 2015 "with a history of falls," the facility never developed a Fall Care Plan until May 10, 2016, with "a goal to reduce the amount of [the resident's] falls." However, the State surveyor noted that "the care plan does not address [the resident] needing two staff members to assist in transferring."

Citadel Care Center- Kankakee
900 West River Place
Kankakee, IL 60901

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0050-12-19-16-Citadel-Care-Center-Kankakee-041017.pdf

Fine:
The State surveyor fined the facility $25,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated December 19, 2016, the state investigator noted during a complaint investigation the facility failed to "notify the physician of a resident's significant change of condition. This failure resulted in a delay in obtaining hospital treatment, delay in stabilizing the resident's abnormally high blood pressure that resulted in seizures and admission to the intensive care unit."

The Incident Report revealed that a registered nurse providing the resident care stated that the resident "has some periods of confusion, had become more confused the night prior and has been up all night." The resident's "physician had been called the prior evening and lab tests were ordered." However, in the morning, the resident "was more difficult to arouse, but she took her morning medication. Her blood pressure was very high.…"

The resident arrived at the dialysis unit and "was unresponsive. Their dialysis staff did not feel that [the resident] was stable enough treatment and felt that she required evaluation in the hospital." The record showed that when the resident arrived, her blood pressure was 182/104 and she was unable to answer questions and was noted "to be twitching." Her doctor stated on December 8, 2016, that "he was not contacted on November 26, 2016, regarding [the resident's] elevated blood pressure" and stated that "he should have been contacted" because he would not have sent her to dialysis."

Danville Care Center
1701 North Bowman
Danville, IL 61832

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0133-02-11-17-Danville-Care-Center-041017.pdf

Fine:
Due to the high-risk designation of multiple Type A violations, the facility was fined $50,000.

Violations:
In a summary statement of deficiencies dated February 17, 2017, the state surveyor while conducting a comprehensive investigation of the complaint noted the facility's failure "to honor Advance Directives regarding Cardiopulmonary Resuscitation (CPR) has documented on the Physician Order for Life Sustaining Treatment (POLST) by failing to ensure resident request for Advance Directives regarding CPR were accurately incorporated into the residents' medical record and decisions' orders for [the resident]." The surveyor noted that "this failure resulted in [the resident] not receiving CPR when found unresponsive and subsequently expiring."

A review of the resident's January 19, 2016, Social Service History and Assessment documents an option for Do Not Resuscitate (DNR) "which was not selected by the resident." The resident's January 16, 2017, 9:39 AM Progress Note indicates that a Licensed Practical Nurse "upon entering the resident's room, the resident was cold, clammy … and labored breathing." The nurse practitioner on duty "ordered that the family be notified, continue oxygen and keep the resident comfortable." Stating that the "resident is a DNR status" which was false. Because of the mistake, the resident died without receiving CPR.

Frankfort Health & Rehabilitation Center
2500 East St. Louis Street
West Frankfort, IL 62896

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0124-01-26-17-Frankfort-Hlthcare-%26-Rehab-Ctr-041017.pdf

Fine:
Due to the heightened designation of serious Type A violations, the facility was fined $25,000.

Violations:
In a summary statement of deficiencies dated January 26, 2017, the state investigator after concluding an investigation into a filed formal complaint noted that the facility failed to "adequately address the potential underlying environment because of a confused resident's catastrophic reaction to a room change, by failing to identify and implement alternative non-pharmacological interventions, prior to administering an injection of anxiolytic medication."

The state investigator noted that "these failures affected [one resident] reviewed for psychotropic medication used in relation to falls. These failures resulted in [the resident] falling upon standing, sustaining a brain injury, hospitalization, and being placed in hospice care with a poor prognosis." The resident never returned to the facility.

A member of the resident's family stated during a phone call that they were informed the resident

was “going to be moved to a different room because they needed the room for another resident.” The family member “begged the facility and not to move [the resident] because of his confusion and problems with agitation and she did not feel [that the resident] would respond well to having a roommate and being in a different room.”

Gardenview Manor
14792 Catlin-Tilton Road
Danville, IL 61834

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0013-12-07-16-Gardenview-Manor-041017.pdf

Fine:
Due to the high-risk designation of multiple Type A violations, the facility was fined $50,000.

Violations:
In a summary statement of deficiencies dated December 7, 2016, the state investigator investigated an incident at the nursing home and noted the facility’s failure to “evaluate potential risk for injury and implement interventions to prevent fault for [a resident] reviewed with a history of falls.” The surveyor noted that “this resulted in the subsequent fall with serious injury and death.”

The State surveyor reviewed the resident’s September 29, 2016, 6:29 PM Emergency Apartment Discharge Summary Report that revealed that the resident “was evaluated for back contusion and fall.” Additional records including a CT scan on October 1, 2016, documents of the resident “fell two days ago.” However, there were “no nurse’s notes or other facility documentation relates will fall or emergency department visit by [the resident] on October 29, 2016.” A registered nurse signed Occurrence Investigation Report dated October 30, 2016, stated that the resident “tripped over walker.” However, there “is no further been documentation for the October 30, 2016, fall.”

An additional November 6, 2016, 11:45 PM, Nurses Notes documented by a Licensed Practical Nurse stated that the resident was “admitted to the hospital with a traumatic head injury and contusion.” The resident’s December 1, 2016, Death Certificate documents “cause of death as acute intracranial and epidural hemorrhage.”

Gibson Community Hospital Annex
430 East 19th Street
Gibson City, IL 60936

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0100-01-19-17-Gibson-Community-Hsp-Annex-041017.pdf

Fine:
The State surveyor fined the facility $25,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated January 19, 2060, a state investigator made initial comments noting the facility’s failure to “safely transfer one resident… which resulted in the resident falling, causing a humerus and femur fracture.” The incident was documented in the January 6, 2017, Incident Report stated on January 2, 2017, the resident “was being assisted by a Certified Nursing Assistant from the commode to her bed… [while] standing with her walker when she lost her balance

and fell."

The resident "complained of pain to her right arm and right leg. X-rays revealed a fractured right humerus and fractured right femur." The resident was admitted "to the hospital and underwent surgery to repair the right femur fracture."

An interview conducted with the Certified Nursing Assistant on the morning of January 18, 2016, confirmed that the CNA "was assisting [the resident and was] transferring back to bed from the commode when she fell…" The CNA "stated she did not use a gait belt during the transfer and that she was not aware that she needed to gait belt with [the resident] during transfers."

Heartland of Galesburg
280 East Losey Street
Galesburg, IL 61401

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0096-01-11-17-Heartland-of-Galesburg-041017.pdf

Fine:
Due to the high-risk designation of multiple Type AA violations, the facility was fined $50,000.

Violations:
In a summary statement of deficiencies dated January 11, 2017, the state surveyor who was conducting an investigation involving a filed complaint noted the facility's failure to "ensure all staff had knowledge of the conditions that require the initiation of CPR (Cardiopulmonary Resuscitation), neglected to follow their policy regarding CPR initiation, and failed to ensure staff provided change in status assessments for [a resident]."

The investigator noted that "these failures resulted in [the resident's] Advance Directives not being honored in that the [resident] did not receive CPR when [the resident] suffered respiratory arrest." It was also stated that "the failure had the potential to affect 29 residents reviewed for advance directives/CPR" at the facility.

The surveyor reviewed the resident's January 1, 2017, Routine Physician Order/Medication Administration Record that contained Advance Directives stating the resident was "Full Code." Additionally, the medical chart contained a "full-size, light-purple, sheet of paper that documents 'RESIDENT IS A FULL CODE'."

The resident was found unresponsive at 5:45 PM on January 3, 2017. The Register Nurse/Nurse Manager stated that because of their full code status, "CPR should have been started right away, and CPR was not done at any time." Additionally, the Registered Nurse confirmed that the resident "did not have any of the 'clinical signs' of death". The Director of Nursing stated that the staff should have "started CPR immediately upon finding [a resident] unresponsive, and [that the registered nurse] should have called for help and notified 911 services." The resident's "record of death" documents the time of death at 5:45 PM on January through 2017.

Jerseyville Nursing & Rehabilitation Center
1001 South State Street
Jerseyville, IL 62052

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0119-01-19-17-Jerseyville-Nsg-&-Rehab-Center-041017.pdf

Fine:
The State surveyor fined this facility $25,000 for multiple Type A violations that led to a resident's death.

Violations:
In a summary statement of deficiencies dated January 19, 2017, the State surveyor investigated a filed complaint and found the that the facility failed "to prevent a fall from a wheelchair while pushing a resident from a dialysis provider." The failure resulted in the resident "sustaining fractures of the cervical spine, nose and two ribs, with traumatic subdural hematoma, subarachnoid hemorrhage, and facial and right elbow lacerations."

The state investigator reviewed the resident's Electronic Clinical Record that revealed the resident "requires extensive assistance with transfers… has a limited range of motion in all four extremities and has unsteady balance, that only stabilized with staff assistance."

The January 4, 2017, Occurrence Report documents at the resident "fell over face first from the wheelchair, hitting her face on the concrete sidewalk as [a Certified Nursing Aide] was pushing her down a downward sloping sidewalk in front of a nearby general store." The Ambulance Record stated that the resident "was complaining of pain to her chin, neck, and head" and had lost blood on the ground measuring approximately 1 mL in volume. The resident's Death Certificate documented "the cause of death as 'complications of cervical and rib fractures'."

Kanthak House
724 Second Avenue
Ottawa, IL 61350

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0056-11-30-16-Kanthak-House-041017.pdf

Fine:
Due to numerous Type A violations, the facility was fined $6250 by the nursing home regulatory agency.

Violations:
In a summary statement of deficiencies dated November 30, 2016, the state investigator completed a complaint investigation and noted that the facility had failed to "prevent neglect for [two residents] who required modified diets and [one who had] a documented history of a swallowing disorder who choked on food requiring emergency services."

The facility was also noted to have failed to "ensure staff had adequate training to provide services and failed to ensure adequate staffing" for the number of residents at the facility. This is because the facility failed to "implement their own policy and procedure for neglect, supervise individuals with known special needs while eating", and "carry out physician's orders for specifically modified diets"; "implement a safe eating program," and "provide proper training on client's rights to ensure Direct Care Step does not have individuals performing services in the facility.

The state investigator noted that "there was no physical evidence in the kitchen [regarding]

individual's diet orders or instructions to modified diets according to physician's orders."

ManorCare of Palos Heights West
11860 Southwest Highway
Palos Heights, IL 60463

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0019-11-23-16-Manorcare-of-Palos-Hts-West-041017.pdf

Fine:
Due to the critical nature of the heightened risks to an injury occurring at the facility, the nursing home was fined $25,000 by state investigators.

Violations:
In a summary statement of deficiencies dated November 23, 2016, the state investigator concluded a complaint investigation and noted the nursing home's failure to "after staff members perform a two-person transfer using mechanical lift while transferring a resident to avoid a fall with injury." Investigators noted that as a result of this failure, the resident "sustained a right hip fracture and required surgery to repair it."

Meadowbrook Manor Naperville
720 Raymond Drive
Naperville, IL 60563

http://dph.illinois.gov/sites/default/files/publications/Jan-March-2017-QRPT-041017.pdf

Fine:
As a result of the seriousness of Type A violations occurring at the facility, the nursing home was fined $25,000 by state investigators.

Violations:
In a summary statement of deficiencies dated January 3, 2017, the state investigators concluded a complaint investigation involving licensure violations and noted the facility's failure to "assess and implement specific safety interventions for showering one resident with the diagnosis of dementia and high-risk for falls." The failure of the nursing staff and administration resulted in the resident "falling on wet tile and fracturing the left hip requiring surgical intervention.

Upon administer the facility in December 2016, the resident had been diagnosed with Alzheimer's disease, dementia, hypothyroidism, kyphosis (hunchback) of the back and anxiety. The resident fell on December 22, 2016, and was transferred to the hospital for hospitalization suffering from "a fracture and had risk factors for behaviors and safety." The resident's December 13, 2016, Care Plan show that the resident "was a risk for falls due to confusion, gait balance, impaired judgment, for safety awareness, wandering and psychotropic use." However, the care plan failed to assess the resident "for showering under fall prevention."

Nokomis Rehabilitation & Health Care Center
505 Stevens Street
Nokomis, IL 62075

http://dph.illinois.gov/sites/default/files/publications/NH-16-C0532-11-03-16-Nokomis-

Rehab-%26-Health-Care-Center-041017.pdf

Fine:
The state investigator fined this facility $25,000 for multiple Type A violations.

Violations:
In a summary statement of deficiencies dated November 13,016, the state investigator noted the facility's failure to "implement effective interventions to prevent pulling out a tracheostomy tube" for a resident that resulted in "asphyxiation and death [of the resident] on September 25, 2016, at the facility."

The state investigator reviewed the resident's Physician Order dated September 7, 2016, that directs the staff to "place a mitt on left-hand." At 11:30 PM on September 24, 2016, the staff entered the resident's room and noted that the tracheostomy tube was out and that the resident "was a full code so CPR (cardiopulmonary resuscitation) was initiated as per protocol." The emergency medical service team arrived five minutes later but were unsuccessful with CPR.

During the investigation "it was noted that [the resident] had a history of pulling at her tracheostomy tube, (indwelling urinary) catheter and gastronomy tube." One licensed practical nurse the facility stated that "she had seen [the resident] without her mitt on but she had never seen [the resident] take her mitt off." The resident's physician stated that "the trach being pulled out at that time could have a lot to do with her expiration."

Paxton Healthcare and Rehabilitation
1240 North Market Street
Paxton, IL 60957

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0120-01-25-17-Paxton-Healthcare-and-Rehab-041017.pdf

Fine:
The state investigator fined this facility $25,000 for multiple Type A violations.

Violations:
In a summary statement of deficiencies dated January 25, 2016, the state investigators conducted a complaint investigation involving violations and noted that the facility had failed to "recognize and thoroughly monitor changes in conditions" of a resident that "resulted in a delay in treatment for [the resident] being hospitalized for acute renal failure."

The resident's January 13, 2017, Progress Notes documents the resident "had three prior [incidents of vomiting] and two episodes of diarrhea. The resident was yelling loudly and the family was notified the [the resident was] not feeling well." The resident's physician was notified of the change in her condition and ordered Zofran at 10:41 AM. By 6:28 PM the resident was "sick and sleeping." However, by 10:04 PM, the staff was "unable to arouse [the resident] to take [her] medication."

The state investigator noted that "there was no documentation in [the resident's] medical records that [her] physician was notified of [a change of] condition from January 13, 2017, through January 16, 2017, including cognition changes, vital signs, low fluid and food intake, and nausea, vomiting, and loose stools."

Pearl Pavilion
900 South Kiwanis Drive
Freeport, IL 61032

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0099-01-31-17-Pearl-Pavilion-041017.pdf

Fine:
Due to multiple Type A (serious) violations, this facility was fined $25,000.

Violations:
In a summary statement of deficiencies dated January 31, 2016, the State surveyor noted the facility's failure to "supervise a resident at risk for falls," and a failure "to apply an alarm device correctly," and a failure to "evaluate the effectiveness of fall prevention interventions." The state investigator noted that "these failures contribute to [the resident] having repeated falls and sustaining and fracturing January 23, 2007." It was noted that the resident "expired the same day."

The resident's January 23, 2016, Fall Care Plan revealed that the resident "had a fall history of fall incidents on July 12 and 20, 2016, and on August 5, 25 and 30, 2016, again on November 17, 21, 26, and 30, 2016, on December 24, 2016, and finally on January 17 and 23, 2017.

The trauma surgeon at the hospital stated the resident's "fall of January 23, 2017, and subsequent injuries directly contributed to his death. The swelling of the spinal cord eventually impaired his ability to breathe."

Renaissance Care Center
1675 East Ash Street
Canton, IL 61520

http://dph.illinois.gov/sites/default/files/publications/Jan-March-2017-QRPT-041017.pdf

Fine:
Due to multiple serious Type A violations, this facility was fined $25,000 by state investigators in January 2017.

Violations:
In a summary statement of deficiency dated January 20, 2017, state investigator noted during observations made for licensure violations at the facility had failed to keep a resident "from falling during a bed linen change." The resident "suffered a fracture to the C-1 vertebrae and two hematomas to his head."

The state investigator noted that the resident's "current face sheet notes that [the resident] has diagnoses including a left femur fracture, falls, and hypertension." The facility's January 10, 2016, Facility Report nnotes that on January 7, 2017, a certified nursing asst. was assisting the resident "with the bedpan." The resident's "linens needed to be changed, so [the CNA] assisted [the resident] with rolling back and forth in bed" but rolled the resident away from the CNA toward the resident's left side who then "rolled off the bed onto the floor."

Rosewood Care Enter Edwardsville
6277 Center Grove Road
Edwardsville, IL 62025

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0080-01-06-17-Rosewood-Care-Center-Edwardsville-041017.pdf

Fine:
Because the facility had multiple Type A (serious) violations that led to a resident's death, the nursing home received a fine of $25,000.

Violations:
In a summary statement of deficiencies dated January 6, 2017, the state investigator conducted a licensure violations survey and upon final observations determined the facility had failed to "follow facility policy/procedures for safe transfer resident's using a full mechanical lift with the assistance of two staff and failed to provide adequate supervision/safety devices during shower time for [two residents] reviewed for falls." The investigator noted that these failures resulted in the resident "falling out of the full-body mechanical lift sling during a transfer sustaining a bilateral subdural hematoma which resulted in death."

The facility's August 11, 2016, MDS (Minimum Data Set) revealed that the severely cognitive impaired was "dependent on two staff retransfers… aphasic [unable to communicate] … and at significant risk of falls." After the October 20, 2016, incident, the CNA "reported to the nurses the resident fell" and the CNA "put the resident back in bed before reporting the fall to the nurse." A hematoma was found on the resident's head, the physician was notified "and ordered to transfer [the resident] to the emergency room for evaluation."

The facility's 9:30 PM, November 1, 2016, Nurses Notes documents that the resident "had a brain bleed in multiple spots and family had admitted the resident into hospice." The resident's November 2, 2016, Death Certificate reveals the "cause of death" as "bilateral subdural hematoma due to a fall."

Sharon Health Care Elms
3611 North Rochelle
Peoria, IL 61604

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0011-11-23-16-Sharon-Health-Care-Elms-041017.pdf

Fine:
Because the nursing facility had multiple Type A violations observed during a state survey, the home was fined $25,000.

Violations:
In a summary statement of deficiencies dated November 23, 2016, the state investigator noted that the facility had failed to "properly position a resident in a mechanical lift sheet." The failure resulted in the resident "sustaining a subdural hematoma, facial laceration, and right femur fracture when [the resident] fell out of the lift sheet during the transfer."

Facility documents revealed that the resident was lying in bed with both eyes closed at 11:15 AM on November 22, 2016, and had "a laceration contusion [that] was noted near mid forehead and eight sutures in place, and bilateral lower extremities were contracted." The facility's primary physician progress Notes of November 22, 2016, documents that the resident fell off the Hoyer lift and sustained a right femur fracture laceration to the mid forehead… and was taken to the local

emergency room" for evaluation.

In an interview with the facility's Director Nursing on the morning of November 27, 2016, it was revealed that "the mechanical lift sling was positioned too far up on the resident's body; as the CNA lifted [the resident] in the mechanical lift heat up, [the resident] slipped out of the sling [… and their] feet touched the floor and then [the resident] landed on [their] face.

Sharon Health Care Pines
3614 North Rochelle
Peoria, IL 61604

http://dph.illinois.gov/sites/default/files/publications/NH-17-C0127-02-09-17-Sharon-Health-Care-Pines-041017.pdf

Fine:
Because of multiple Type A violations involving injuries of residents, the facility was fined $25,000.

Violations:
In a summary statement of deficiencies dated February 9, 2017, the state investigator noted during a complaint investigation that the facility had failed to "follow their policy by not using tray cards to ensure correct diets are followed" for a resident on a therapeutic diet. This error resulted in the resident "being served the wrong diet, choking and requiring hospitalization for aspiration pneumonia."

The facility's February 4, 2017, 6:30 PM Incident Report documented that the resident "choked on a bratwurst at dinner." A Certified Nursing Aide "performed the Heimlich maneuver and the meat was expelled." The resident was transferred to the hospital. The state investigator reviewed the resident's tray/diet card that instructs caregivers that the resident "is to receive a 'mechanical soft diet'."

However, during an interview, the Assistant Director of Nursing stated that on February 4, 2017, Sunday night the staff did not use tray cards on the trays." The following morning, the facility's Dietary Manager stated that "all residents have a tray (diet) card. The tray cards are in the kitchen and the dietary staff is to use the cards to set up each tray for each resident then send the tray out to be delivered. There is no way for the cook to serve according to the tray cards for likes, dislikes, allergies, special needs if they do not see the tray card."

Timbercreek Rehabilitation & Health Care Center
2220 State Street
Pekin, IL 61554

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0031-12-02-16-Timbercreek-Rehab-%26-Hlth-C-Ctr-041017.pdf

Fine:
Due to multiple Type A violations that led to the injury of a resident, the facility received a fine of $25,000 issued by state surveyors.

Violations:
In a summary statement of deficiencies dated December 2, 2016, the state investigator made final

observations during a certification survey the facility had failed to “ensure one resident was safely transferred from their bed to the wheelchair. This failure resulted in the resident “falling sustaining fractures of the second, third, and fourth fingers on the left-hand.” Investigator also noted that the facility failed “to conduct a thorough investigation of [the resident’s] fall and failed to accurately report investigation results to the State Agency” in violation of State laws.

The facility September 22, 2016, Nurses Notes stated that a licensed practical nurse document that a resident “was being transferred … by a CNA (certified nursing assistant) when the CNA lost grip of [the resident who then] fell to the floor on the left side of the body to the bedroom floor, resulting in the skin chair on the left-hand and bruising. The resident was sent to the hospital emergency room for further evaluation.

Hospital records dated that on November 22, 2016, the resident reportedly suffered acute mild displaced fractures of the second and third distal flanges and acute nondisplaced fracture the fourth distal phalanx (finger bone).

West Suburban Nursing & Rehabilitation Center
311 Edgewater Drive
Bloomingdale, IL 60108

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0126-01-03-17-West-Suburban-Nsg-&-Rehab-Ctr-041017.pdf

Fine:
This facility was fined $25,000 for Type A violations.

Violations:
In a summary statement of deficiencies dated January 3, 2017, the state investigators conducting an incident report investigation occurring on December 15, 2016, noted the facility’s failure to “prevent verbal and physical abuse from occurring to [a resident at the facility].” An investigator noted that this failure resulted in a resident “experiencing sleeplessness and fearfulness after being punched in the face for calling out for staff assistance.”

It was noted that the resident’s “medical diagnosis makes assessing the effects of physical abuse difficult. A reasonable person would not want to be verbally chastised or physically abused when requesting help.”

During an interview with the resident on December 20, 2016, it was revealed that “on December 14, 2016, [the resident] was yelling for help and a Certified Nursing Assistant came in my room and said ‘what do you want? Shut up!” Then all of a sudden BAM, BAM, BAM, he punched me and the mouth three times. …. I did not call for help [any time the CNA] was working. I told [the floor nurse] in the morning what happened because I did not think it was right for [the CNA] to yell at me and punch me when I asked for help.”

Winning Wheels
701 East 3rd Street
Prophetstown, IL 61277

http://dph.illinois.gov/sites/default/files/publications/NH-17-S0008-11-15-16-Winning-Wheels-041017.pdf

This facility received a $25,000 fine for serious multiple Type A violations.

Violations:
In a summary statement of deficiencies dated January 15, 2016, the state surveyors conducting an investigation involving licensure violations cited the nursing home for their failure to “keep a resident free from physical abuse on November 13, 2016. The failure resulted in [a staff member] hitting the resident in the face with a closed fist three times which resulted in physical injuries to the right side of the face and a change in [a resident’s] behavior as manifested by societal and paranoid behaviors, and documentation of symptoms of posttraumatic stress disorder [PTSD].”

The surveyors noted that the resident’s October 31, 2016, Psychotropic Medications Assessment shows that the resident “has behaviors which alter his ability to function including: resist care, verbally abusive, physically abusive, yelling out, anxious complaints, and combative behavior.”

However, the resident stated in an interview that “on the night of November 13, 2016” two Certified Nursing Assistants ““pushed him into his room for a shower” and one of the CNAs “was in the room and turned the shower on and [the other CNA] attacked him [while] standing over him and hit him in the face.” The resident said, “that he had not provoked her or had any issues with [that CNA] and this assault came out of nowhere.”

Rating System

Every nursing facility receives a rating between one and five stars issued by CMS (Centers for Medicare & Medicaid Services). The star rating can assist the resident, their family members and caregivers in determining the level of care the home provides. This performance rating is based on the numbers or lack of deficiencies found during inspections and surveys. The Public Health Department will usually act quickly when “immediate jeopardy to a resident’s health or safety” is at issue.

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