

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/02/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNITED METHODIST VILLAGE, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1616 CEDAR LAWRENCEVILLE, IL 62439</b>
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S 000	Initial Comments  Complaints 1854665/IL104248 1854878/IL104477	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.3240a) 300.3300d) 300.3300e)1)2)3)4)5) 300.3300g) 300.3300j) 300.3300k) 300.3300y)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.  Section 300.1210 General Requirements for Nursing and Personal Care	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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 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:</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>Section 300.3300 Transfer or Discharge</p> <p>d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days</p> <p>e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:</p> <p>1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)</p> <p>3) A statement in not less than 12-point type, which reads:</p> <p>"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below."; (Section 3-403(c) of the Act)</p> <p>4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)</p> <p>5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)</p> <p>g) A copy of the notice required by subsection (d)(1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act)</p> <p>j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)</p> <p>k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act)</p> <p>y) Any owner of a facility licensed under the Act shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than 10% of the residents. Such notice shall be given to the Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under subsection (u) of this Section. (Section 3-423 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview, record review the facility failed 1) to operationalize a discharge planning process 2) based on interview, record review the facility administration failed to effectively communicate it's restructuring plans to residents and family representatives being discharged to another facility to minimize the potential for unnecessary/avoidable to minimize the potential for unnecessary/avoidable anxiety or depression for 16 of 17 residents (R1, R2, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16, R17, and R18), reviewed for discharge planning.</p> <p>This failure has resulted in R1, R4, and R7 being fearful and anxious about being forced or told they need to move from their home to an unfamiliar location.</p> <p>Findings include:</p> <p>On 07/13/18 at 4pm, V4, Ombudsman, and V5, Ombudsman Trainee, stated that residents at the facility's south campus were being told the facility would immediately begin discharging residents</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>from the south campus and moving them to the facility's north campus. Both V4 and V5 stated residents stated they and their families had received no written notification of the planned discharge and that residents were not being given the choice to stay at the south campus. V4 and V5 stated residents were frightened and upset about being told they had to move. V4 and V5 stated their office had received neither written nor verbal notification from the facility about the discharges. V4 stated a friend of hers had heard about it from the news media and told her about it. V4 stated she visited the facility's south campus the first week of July 2018 and residents were confirming they had been told they would be moved to the north campus. V4 stated several families came and voluntarily moved their residents out of both campuses the week of 07/02/18 due to fears about the facility's financial solvency.</p> <p>On 7/30/18 at 10:44 am, it was verified with V1 (President/Chief Executive Officer/Administrator at North Campus) that the North Campus and the South Campus are .6 miles apart in the same town. V1 also verified that each facility operates as a separate entity having its own certification number and separate staff.</p> <p>On 07/19/18 at 08:37am, V1, President/Chief Executive Officer/Administrator at North Campus, stated that the facility is in process of restructuring its services. V1 stated neither the north nor south campus will close or cease to operate. V1 stated that the memory care unit known as the Auten Center will remain at the south campus. V1 stated that all other residents at the south campus "have been given the opportunity to move to the north campus." V1 stated those residents who choose not to move will be able to stay at the south campus. V1</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>stated the long range plan is to have adult day care services, outpatient therapy, and memory care beds in the south campus. V1 stated the south campus is not closing. V1 stated that when the facility's board met on 7/11/18 this plan was discussed and copies of the plan were distributed. V1 stated the next day she instructed staff to begin talking to residents and their families about moving. V1 stated no written notification was sent to residents, families, ombudsmen, or The Illinois Department of Public Health (IDPH) because their attorney advised them it was not necessary because the building was not closing down, and because residents were not being told they had to move, they were given a choice. V1 stated this has been the facilities plan for quite some time and denied any that any financial issues motivated these actions.</p> <p>On 07/20/18 at 10:30am, V2, Administrator of the facilities south campus, stated that V1 said they did not have to give residents a thirty day discharge notice because they have the choice to stay at the south campus. V2 stated that on 07/12/18 she received a copy of the Legacy Plan from V1 and was told to start moving residents as soon as possible. V2 stated she did not contact IDPH or the Ombudsman about the moves.</p> <p>An email sent from V3 to V1 on 07/16/18 stated, "Would an official letter sent to POA (Powers of Attorney)/residents stating families/residents agree to move and having them sign (it) be a good idea?" With V1 responding, on the same date, "The documentation has to state they voluntarily (bolded) agree to transfer."</p> <p>An email sent from V16, Director of Nurses north campus, to V1 and V3 on 07/15/18 stated, "We are quickly going to run out of staff at SC (south</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>campus) so the faster we make the moves the better."</p> <p>An Admission Transfer and Discharges Policy with a revision date of 10/4/16 stated, "The (facility) shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, unless ... A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; D) The health of individuals in the facility would be endangered; E) The resident has failed ... to pay for ... a stay at the facility; or F) The facility ceases to operate. A transfer (discharge) is conducted in a dignified manner to limit transfer trauma and to ensure that resident needs are met."</p> <p>An undated Rights and Responsibilities as a Resident Policy stated, " ... You shall not be abused or neglected ... (and) The facility shall also immediately notify the resident's family, guardian, representative, conservator, and any private or public agency financially responsible for the residents care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matter arise."</p> <p>On 07/13/18 at 6:00pm, R3 stated, "Because they (the facility) are having financial problems,they're going to close this building (south campus) and move us all to the north campus. They told me about it last week, I'm not sure what day. I think it was the Social Services Director.They didn't give</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>me any kind of written notice. I don't really care one way or the other as long as I have a private room and there is enough room for all my belongings. (Resident has a lot of furniture including a recliner and a full size kitchen table and four chairs). I was not at all under the impression we had any choice in the matter. I was told you are moving. I have a lot of stuff, and I'm very attached to my things. I don't want to be in a smaller room, and I will not share a room with anybody. I'm private pay, and I'm paying a lot of money for this room." On 07/18/18 at 12:10pm, R3 stated "Now they're (staff) saying no, we never said you had to move, you can move if you want to." R3 stated she and her family are currently in the process of discussing the pros and cons of moving. R3's record had no documentation that any written notification had been sent to R3 or her Power of Attorney. R3's Minimum Data Set dated 07/03/18 documented a Brief Interview for Mental Status Score of 15, indicating R3 has no deficits in cognitive functioning. R3's Care Plan dated 07/23/18 documented a problem area of, "Takes Remeron for depression", with a corresponding intervention, "Encourage (R3) to express feelings and concerns. Listen (and) assist with a solution to concerns if there is a solution or recommendation." A Social Services Progress Note authored by V3, Social Services Director, dated 07/23/18 stated, "Met with (R3) to discuss options of her moving to north campus.....(R3) did admit to feeling depressed and lonely."</p> <p>On 07/13/18 at 6:15pm, R1 stated, "They (staff) told me we (residents) are all moving to the north building very soon, in a few days probably. They (staff) said it's because they're (facility) having financial problems. They didn't give me or my</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>son, who takes care of my business, any kind of notice. I have concerns about it. I have had good care so far, but what if I don't over there? And I don't want to have to have a roommate, I want a private room like I have now." R1's Care Plan dated 05/17/18 did not address any discharge planning or potential.</p> <p>On 07/24/13 at 2:30pm, R1 was interviewed in his new room at the facility's north campus. R1 stated, "They moved me to this building a couple days ago. They (staff) say I'm going to get a roommate. I am wondering how I will be able to wheel myself around in this room if there is another bed in here. I feel like it's upsetting to have to move. My girlfriend drives herself over to see me, but the other building was closer to her house. I felt like I didn't have any choice about moving, I just had to go along with it." R1's record had no documentation that any written notification had been sent to R1 or his Power of Attorney.</p> <p>R1's Minimum Data Set (MOS) dated, 05/09/18 documented a Brief Interview for Mental Status Score (BIMS) of 8, indicating R1 has moderate deficits in cognitive functioning. R1 's Care Plan dated 05/17/18 documented a problem area of "Cognitive loss", with a corresponding intervention of, "Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion." This same Care Plan did not address any discharge planning or potential.</p> <p>On 07/18/18 at 10:20am, R2 stated, "A couple of days ago, the staff told me I will be moving to north campus. They asked me if I minded and I said no. I have no idea when it will happen. They didn't give me any kind of a letter." R2's</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>Minimum Data Set dated 07/19/19 documented that on that date he was discharged from the facility, with the type of discharge documented as unplanned. R2's Care Plan dated 07/19/18 documented a problem area of "Anxiety Disorder, ((R2) can be anxious about new surroundings". This same Care Plan did not address any discharge planning or potential. R2's record had no documentation that any written notification had been sent to R2 or his Power of Attorney.</p> <p>On 07/24/18 at 2:28 PM, R9 was sitting in a padded reclining chair in a sitting area by the nurse's station at the North Campus. A Progress Note dated 07/12/18 at 11:30 am notes V3 discussed with resident and HCPOA (Health Care Power of Attorney), changes and restructuring that will occur at UMV. Resident and HCPOA decided to move resident to North Campus for continued care with UMV. Paperwork will be transferred and staff notified. Move will occur today. Another note dated 07/12/18 states resident and belongings transferred. R9's current Plan of Care revised 06/13/18 documented a problem area of "COG" impaired thought process due to Neurologic Symptoms, with a corresponding intervention of "Keep the residents routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>On 07/13/18 at 5:50pm, R15 communicated via writing and indicated she is unable to speak due to having had a stroke. R15 indicated that she was told a few days ago that she will be moving to the north campus. R15 indicated she did not receive written notice. R15's Minimum Data Set dated 07/16/18 documented that on that date R15 was discharged from the facility, with the type of discharge documented as unplanned. R15's Care</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>Plan dated 06/26/18 did not address any discharge planning or potential. R15's Minimum Data Set dated 06/22/18 documented a Brief Interview for Mental status Score of 15, indicating R15 has no deficits in cognitive function. R15's record had no documentation that any written notification had been sent to R15 or her Power of Attorney.</p> <p>On 07/13/18 at 6:20pm, R4 stated, "I'm being told by the people who work here that we are all going to be moved to their north facility." On 07/18/18 at 10:33am, R4 stated, "They (staff) didn't give me a choice about moving." R4's Care Plan dated 06/19/18 did not address any discharge planning or potential. On 07/18/18 at 10:33am, R4 stated, "They (staff) didn't give me a choice about moving, but now they're changing their tune and saying they can't make us move, it's our choice. Why would I want to stay here though if there's not going to be any staff left to take care of me? The Social Services Director came in and told me about it last week. She's not sure if I can have a private room over there like I do here. I just have to go with the flow I guess, but I'd prefer to stay here. They didn't give me a discharge letter or anything like that." On 07/24/18 at 8:30am, V2, Administrator at the facility's South Campus, stated that at this point R4 and her family are leaning toward her staying at the south campus. R4's July 2018 Behavior Tracking Sheet documents that R4 is being tracked for issues with excessive/repetitive worrying about her health. R4's Care Plan dated 06/19/18 documented a problem area, "Uses Alprazolam for anxiety disorder." This Care Plan did not address any discharge planning or potential. R4's record had no documentation that any written notification had been sent to R4 or her Power of Attorney.</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>On 07/19/18 at 1:05 pm, R10 was interviewed in his new room at the north campus. R10 stated he is not sure when he moved.</p> <p>On 07/24/18 at 9:15am, V9, family member of R10, stated, "The facility called 07/14/18 at said that they were going to move (R10) to the north campus within a few days because they are restructuring and moving everybody except for residents in the dementia unit. They didn't send us anything in writing. We were concerned about it because (R10) does not deal with change very well, and at the south campus he was in a private room. Since they moved him to north, he has a roommate now. As far as I know though, it's going ok."</p> <p>R10's Nursing Progress Note dated 07/13/18 documented that at 09:35am R10 was discharged to the north campus and his belongings were taken with him. R10's Minimum Data Set dated 07/13/18 documented that on that date R10 was discharged from the facility, with the type of discharge documented as unplanned. R10's Care Plan dated 05/08/18 documented a problem area of "Cognitive loss" with a corresponding intervention of, "Keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion." This Care Plan did not address any discharge potential or planning. R10's record had no documentation that any written notification had been sent to R10 or his Power of Attorney. R10's Care Plan dated 05/08/18 did not address any discharge potential or planning.</p> <p>On 07/19/18 at 1:30pm, V7, family member of R12, stated, "We were aware the facility was having financial problems, some of the staff had</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>told us, and people in the community are talking about it. On the 13th or 14th the facility notified us that (R12) would be moving to the north campus. There was no written notification sent about it." R12's Minimum Data Set dated 04/18/18 documented a Brief Inventory for Mental Status Score of 3, indicating R12 has severe cognitive deficits. R12's Care Plan dated 05/10/18 documented a problem area of, "Impaired cognition" with a corresponding intervention," Keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion." The same Care Plan did not address any discharge potential or planning. A Minimum Data Set dated 07/13/18 documented that on that date R12 was discharged from the facility with the type of discharge documented as unplanned. R12's record had no documentation that any written notification had been sent to R12 or her Power of Attorney.</p> <p>On 07/19/18 at 1:50pm, V8, family member of R14, stated, "(V3) called last week and said beginning immediately, all residents except dementia care unit residents are going to be moved to the north campus. They said the facility is restructuring its services and consolidating residents at the north campus. They didn't send me any kind of written notice. I agreed with the move, the other building is nicer and newer, and I had originally wanted (R14) admitted to the north campus anyway. They moved her on 07/13/18 and as far as I know, it's going ok."</p> <p>R14's Care Plan dated 05/10/18 did not address any discharge potential or planning. A Minimum Data Set dated 07/16/18 documented that on that date R14 was discharged from the facility with the type of discharge documented as unplanned.</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>R14's Care Plan dated 05/10/18 documented a problem area of, " Impaired cognitive function" with a corresponding intervention, " Keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion." This same Care Plan did not address any discharge potential or planning. A Minimum Data set dated 07/10/18 documented a Brief Interview for Mental Status Score of 3, indicating R14 has severe deficits in cognitive functioning. R14's Cumulative Diagnosis List on the electronic health record listed a diagnosis of Anxiety Disorder and Major Depressive Disorder Single Episode. R14's record had no documentation that any written notification had been sent to R14 or her Power of Attorney</p> <p>On 07/19/18 at 3pm, V6, family member of R7, stated, "(V3) contacted me on 07/12/18 and said that all the residents except for dementia care are going to be moved to the north campus building. They said (R7) could be moved last to give her a little more time, but they would be moving her within two weeks. No other options were given to us. The south campus is only two blocks from my house. The ombudsman told me though that she has the right to stay in the facility if she wants to, which she does. I told them (staff) she wants to stay, and I want her to stay, but now some of the nurse's aides are saying that if she stays, she'll be the only resident left, and that's got me concerned." On 07/20/18 at 1 :20pm, R7 stated, "I want to stay here." V6 stated she, R7, and the rest of the family have decided she will not move to the north campus.</p> <p>R7's Care Plan dated 04/23/18 documented a problem area of, "Cognitive loss" with a corresponding intervention, "Keep the residents routine consistent and try to provide consistent</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>caregivers as much as possible in order to decrease confusion." This same Care Plan did not address any discharge potential or planning. R7's record had no documentation that any written notification had been sent to R7 or her Power of Attorney.</p> <p>R7's Care Plan dated 04/23/18 Care Plan did not address any discharge potential or planning.</p> <p>On 7/18/18 at 10:05 AM, V13 (Family/Power of Attorney for R5) stated R5 has Dementia and could not live unsupervised. R5 moved into a room on the South Campus in February 2018. V13 said a few weeks ago staff told her they were closing one of the hallways at the South Campus, so they moved R5 to a different room on another hallway at the South Campus. V13 said, V3 (Social Service Designee), called her last week and said they were closing the South Campus and would be moving R5 from the South Campus across town to the North Campus. V3 said the move would take place in a couple of weeks. V13 said R5 was moving today. V13 said she did not receive any written notice prior to R5's move from one facility to the other. V13 said she attended a Care Meeting at the South Campus the end of May 2018 to discuss R5's care and no one mentioned anything about R5 moving. R5 most recent Plan of Care revised on 05/11/18 did not address any discharge potential or planning. R5's Minimum Data Set (MDS) dated 07/18/18, notes RS's cognitive skills are moderately impaired. R5 most recent Plan of Care revised on 05/11/18 documents a problem area of "Cognition," with a corresponding intervention of, "Keep the resident's routine consistent and try and try to provide consistent cares givers as much as possible in order to decrease confusion." This same Plan of Care did not address any discharge potential or planning.</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>On 07/23/18 at 3:48 PM, V15 (Family/Power of Attorney for R18) said approximately two weeks ago V3 telephoned to discuss moving R18. V15 said she spoke with V3 last week. V3 said R18 could move from the South Campus cross town to the North Campus. V15 said V3 told her R18 could stay at South Campus but he would be moving from room to room because of construction. V15 said R18 has a diagnosis of Alzheimer Disease and she is not comfortable moving him from room to room. V15 said R18 has changed rooms three times in two months at the South Campus. V15 said she is concerned R18 will be upset because his surroundings are unfamiliar and he does not understand what is happening. V15 said she is unsure how this has affected R18 since she lives three hours away and has not been able to visit R18 this summer. V15 said she did not move R18 closer to her in the past because she was afraid moving him would have had a negative effect. V15 said she did not want R18 to be upset, scared or more confused because he is not in the environment he is used to being in.</p> <p>R18's MOS dated 07/05/18, notes a SIMS score 03/15, indicating R18 has severe cognitive deficits. R 18's Plan of Care revised 05/21 /18, notes a problem area of, "Cognitive Loss/Dementia", with a corresponding intervention "Keep the residents routine consistent and try or provide consistent care givers as much as possible in order to decrease confusion. The Plan of Care did not address discharge potential or planning.</p> <p>At 2:27 PM on 07/24/18, R11 said they just showed up one day and moved me over here.</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>R11 said I can amok here. A Progress Note dated 07/12/18 at 6:54 PM, notes V3 talked with R11's family regarding restructuring and changes at the South Campus Building. V3 notes R11 will be moving next week. A Nursing Progress Note dated, 07/13/18 at 14:20 (2:20 pm) notes R11's was discharged to the North Campus. R11's MOS dated 07/10/18 notes a BIMS score of 11/15 indicating R11 has moderate cognitive impairment. R11's most recent Plan of Care revised on 05/23/18 documents a problem area of Cognitive Loss), with a corresponding intervention "Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The same Plan of Care does not address discharge potential or planning</p> <p>An Electronic Mail Message dated 07/13/18 at 9:33 AM, from V3 (Social Service) to V15 (family member/POA) documents, "It was decided South Campus will be phasing out providing care to nursing residents. Yes this includes your grandfather (R18). You have options! If you choose you can transfer to another facility or ride it out here at South. We have availability at our UMV (United Methodist Village) North Campus. Several Residents and Staff are transferring to North Campus because of the smoother transition and staying with the UMV organization."</p> <p>An Electronic Mail Message dated 07/13/18 at 9:33 AM, from V3 to V15 documents, "It was decided South Campus will be phasing out providing care to nursing residents. Yes this includes your grandfather. You have options! If you choose you can transfer to another facility or ride it out here at South. We have availability at our UMV (United Methodist Village) North Campus." Several Residents and Staff are</p>	S9999		
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S9999	<p>Continued From page 18</p> <p>transferring to North Campus because of the smoother transition and staying with the UMV organization. R18's most recent care plan dated 05/21/18 does not include discharge planning.</p> <p>11. On 07/23/18 at 9:48 AM, V14 (Power of Attorney for R6) stated V3 telephoned her and told her the South Campus was closing. V14 said V3 asked her if she was ok moving R6 to the North Campus. V14 said she is not sure when R6 will be moving. V14 said she is not aware of receiving any written information regarding moving R6 from one facility to another. V14 said R6 does not understand what people tell him. V14 said R6 no longer recognizes his family. R6's current Plan of Care revised 05/06/18, documents a problem areas of "Cognitive Loss/Dementia" and "Anxiety "with a corresponding interventions "Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor the resident for safety. The resident is taking anti-anxiety meds which are associated with an increased risk of confusion, anemia, loss of balance, and cognitive impairment that looks like dementia and increase risk of falls, broken hips and legs." The same Plan of Care does not address discharge potential or a plan.</p> <p>On 07/22/18 at 2:25 PM, R17 said they told her she could move to the other building. R17 said she saw the new room and was glad to move. R17 said she is unaware of receiving any paper work prior to moving. A progress note dated 07/17/18 at 14:03 (2:03 PM) notes R17 was discharged to the North Campus. R17's current Plan of Care revised 07/17/18 does not include discharge planning.</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>A Progress Note dated 07/12/18 at 6:54 PM, notes V3 talked with R11's family regarding restructuring and changes at the South Campus Building. V3 notes R11 will be moving next week. A Nursing Progress Note dated, 07/13/18 at 14:20 (2:20 pm) notes R11's was discharged to the North Campus. R11's current Plan of Care dated 07/09/18, does not include a discharge plan. R11's MDS dated 07/10/11, notes R11's discharge is unplanned and return is not anticipated.</p> <p>R16's electronic health record notes she has a diagnosis of Mental Retardation and Cerebral Palsy. A Progress Note dated 07/17/18 notes R16 was discharged to North Campus. R16's current Plan of Care reviewed on 07/10/18 does not include a plan for discharge. The MDS, dated 07/17/18 notes R16's discharge is unplanned and return is not anticipated.</p> <p>On 07/24/18 at 2:20 PM, R16 was sitting in a padded rocking chair in a sitting area at the North Campus. R16's Minimum Data Set dated, 07/09/18, documents R16's BIMS score is 08 of 15, indicating severe cognitive impairment. R16's Plan of Care dated 07/10/18 documented a problem area of "Cognitive Loss", with a corresponding intervention of "Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The same Plan of Care did not address any discharge potential or planning. A Progress Note dated 07/12/18 notes V3 contacted R16's family and they decided to move R16 to the North Campus. The same note indicates the family was told R16's new room would not accommodate all of R16's furniture and possessions. A progress note dated 07/16/18 notes, V18 (Family/ R16), assisted R16 with the</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>transfer. Some of R16's possessions were placed in storage.</p> <p>On 07/19/18 at 1:50 PM, R13 was in a wheel chair at the North Campus. R13's most recent MOS dated 07/16/18 notes R13 has severe cognitive impairment. R13's current Plan of Care, revised 05/02/18 documented a problem area of "Cognitive Loss", with a corresponding intervention of "Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The same Plan of Care did not address discharge potential or a plan. A Progress Note dated 07/12/18 at 6:59 PM, documents V3 talked with R13 and her Health Care Power of Attorney. They discussed restructuring and changes. V3 notes R13 was discharged to the North Campus on 07/16/18. R13's current plan of care revised on 05/02/18 does not include a discharge plan. The MDS dated 07/16/18, Section A notes R13's discharge is unplanned and return is not anticipated.</p> <p>A Progress Note dated 07/12/18 at 11:30 am notes V3 discussed with R9 and HCPOA (Health Care Power of Attorney), regarding changes and restructuring that will occur at UMV. Resident and HCPOA decided to move resident to North Campus for continued care with UMV. Paperwork will be transferred and staff notified. Move will occur today. Another note dated 07/12/18 states resident and belongings transferred. R9's current Plan of Care revised 06/13/18 does not include a discharge plan. The MDS, dated 07/12/18 notes R9's discharge is unplanned and return is not anticipated.</p> <p>On 07/19/18 at 9:40am, V3, Social Services Designee, stated that there was an administrative</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>meeting on 07/12/18 between V1 and the board of directors. Immediately after that meeting, V1 passed out copies of the facility's Strategic Plan dated July 2018. V3 stated V1 told her the plan included immediately moving all residents on the south campus, with the exception of those residing on the dementia care unit, to the north campus. V3 stated V1 instructed her to immediately begin contacting the residents and their families about moving. V3 stated V1 did not specifically say why these moves were to take place, except to say that restructuring of the facility is occurring, and V3 stated she is aware "Staff have been leaving in droves." V3 stated she talked to all involved residents and their Powers of Attorney prior to their moving. V3 acknowledged that no written notification was sent to residents or their families. V3 stated that her consultant had recommended written notification be sent, but there was not time, and some residents were moved so quickly she did not realize they had been moved. V3 stated she had asked V1 if she could prepare a letter, and V1 told her she (V1) would talk to the facility's attorney about it. V3 acknowledged that no formal discharge planning was done, and stated there had not been enough time to do this. V3 stated she had not contacted the ombudsman nor the Illinois Department of Public Health about the transfers. V3 acknowledged she felt the process was rushed.</p> <p>On 07/24/18 at 2:00pm V3, Social Services Designee, stated that the normal procedure for discharge planning is that when a firm discharge date is set, she begins the discharge planning process. V3 stated this process varies according to resident needs and to where the resident will be discharged. V3 stated for example if the resident will be discharged home, she might</p>	S9999		
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(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
S9999	<p>Continued From page 22</p> <p>make a referral to a home health agency. V3 stated she has worked at the facility two years and the situation with multiple residents being transferred from the south to north campus was not something she had previously dealt with, but that ideally discharge planning should have been done. V3 again stated that in this situation there had not been time for discharge planning and she felt the move was done too quickly.</p> <p>On 08/01/18 at 2:10pm, V26, Minimum Data Set/Care Plan Coordinator/Interim Director of Nurses at the south campus, stated,"(V3, Social Services) normally does the discharge portion of the care plan. With the (recent) transfers (from south campus to north campus) however, there wouldn't have been time for anybody to do any discharge planning. We (staff) would come in in the morning to be told that specific residents would be moved that morning, and then an hour later, they were moving totally different residents. It was extremely chaotic." V26 stated they do not address discharge planning with residents upon admission to the facility.</p> <p>The South Campus Bed List dated 07/23/18 notes R3, R4, R6, R7 and R18, still reside at the facility. An undated North Campus Hallway Room List, presented to the surveyors on 07/25/18 notes R1, R2, R5, R9, R10, R11, R12, R13, R14, R15, R16 and R17 reside at the North Campus.</p> <p>(C)</p>	S9999		