

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/13/2018
NAME OF PROVIDER OR SUPPLIER HAVANA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HARPHAM STREET HAVANA, IL 62644		
(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
S 000	Initial Comments Investigation of Complaint #1824094/IL103643	S 000			
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210a) 300.3210o) 300.3240a) 300.3300d) 300.3300f) 300.3300j) 300.3300k) 300.3300l) 300.3300m) 300.3300n) 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 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 on their status as a resident of a facility. (Section 2-101 of the Act) o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise 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 300.3300 Transfer or Discharge 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 f) A request for a hearing made under subsection (e) of this Section and Section 3-403 of the Act shall stay a transfer pending a hearing or appeal of the decision, unless a condition which would have allowed transfer or discharge in less than 21 days as described under subsections (d)(1) and (2) of this Section develops in the interim. (Section 3-404 of the Act) 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	S9999			

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S9999	Continued From page 2 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) k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act) l) A resident subject to involuntary transfer or discharge from a facility, the resident's guardian or if the resident is a minor, his or her parent shall have the opportunity to file a request for a hearing with the Department within 10 days following receipt of the written notice of the involuntary transfer or discharge by the facility. (Section 3-410 of the Act) m) The Department of Public Health, when the basis for involuntary transfer or discharge is other than action by the Department of Healthcare and Family Services with respect to the Title XIX Medicaid recipient, shall hold a hearing at the resident's facility not later than 10 days after a hearing request is filed, and render a decision within 14 days after the filing of the hearing request. (Section 3-411 of the Act) n) The hearing before the Department provided under subsection (m) of this Section shall be conducted as prescribed under Section 3-703 of the Act. In determining whether a transfer or discharge is authorized, the burden of proof in this hearing rests on the person requesting the transfer or discharge. (Section 3-412 of the Act)	S9999			

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S9999	Continued From page 3 These Regulations were not met as evidence by: Based on interview and record review, the facility failed to give the resident the opportunity to make the choice to remain in the facility for one of five residents (R1) reviewed for Involuntary Discharge in the sample of 11. This failure resulted in R1, after residing at the facility for 13 years, to be transferred to another facility in Chicago away from family and against R1 's wishes. This transfer caused R1 emotional upset to the point where R1 refused medication and would not leave R1's room, only to be transferred yet again to another facility in Chicago. Findings include: Based on interview and record review, the facility failed to give the resident the opportunity to make the choice to remain in the facility, failed to attempt behavioral interventions prior to issuing an Involuntary Discharge Notice and allow a resident to remain in the facility pending appeal of Involuntary Discharge Notice and failed to provide timely written notification of an Involuntary Discharge and Opportunity of Hearing to a resident representative for one of five residents (R1) reviewed for Involuntary Discharge in the sample of 11. This failure resulted in R1, after residing at the facility for 13 years, to be transferred to another facility in Chicago away from family and against R1 's wishes. This transfer caused R1 emotional upset to the point where R1 refused medication and would not leave R1's room, only to be transferred yet again to another facility in Chicago. Findings include: The Facility's Involuntary Transfers and	S9999			

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S9999	Continued From page 4 Discharge policy (date unknown), states "Prior to transfer or discharge the Social Service Director shall counsel the resident and summarize the counseling session in the resident's record. R1's Physician Order Sheet dated 6/2018, documents R1 had diagnoses which include Cerebral Vascular Accident with right sided hemiplegia, and Aphasia. R1's Plan of Care last updated on 6/22/18, states "(R1) is able to point and make gestures to make needs known; staff and residents understand (R1's) communication techniques." (R1) communicates by saying bulls**t, damn, and hand gestures. "R1's Minimum Data Set (MDS) assessment dated 6/15/18, documents R1 is unable to ambulate and requires a wheelchair for locomotion. R1's Medical Record and behavior monitoring sheets dated 1/1/18 through 6/22/18 (date R1 discharged) does not document any physical behaviors towards others until 6/13/18. A Notice of Involuntary Transfer and Discharge and Opportunity for Hearing dated 6/14/18, documents R1 was given a 30 day notice of Involuntary Discharge, citing the facility was seeking to discharge R1 to another facility due to "the safety of individuals in this facility is endangered." The Notice of Involuntary Discharge cites R1's proposed transfer/discharge date as 7/14/18. A United States Postal Services receipt/tracking form documents V7's (R1's Power of Attorney) copy of the Notice of Involuntary Discharge and Opportunity for hearing was not mailed until 6/21/18 and V7 did not receive the Notice until 6/27/18 (5 days after R1 was discharged to another facility).	S9999			

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S9999	Continued From page 5 R1's Nurses Notes dated 6/22/18, document R1 was discharged to another facility. On 7/9/18 at 4:30 p.m., V7 (POA) stated "I did not receive my (Involuntary Discharge Notice) until 6/27/18 after (R1) had been discharged from the facility for 5 days." On 7/10/18 at 1:25 p.m., V1 (Administrator) stated "I don't know why we didn't mail (V7's) ID Notice until 6/21/18. It should have been mailed the same day we issued it (6/14/18)." An Incident Report dated 6/13/18 at 5:45 a.m., documents R1 placed R6 in a "choke hold" around the neck and threw R6 to the floor from a dining room chair. R6 was not injured. The Incident Report documents a nurse immediately responded and separated the residents and R1 had 1:1 supervision until Emergency personal and Police arrived. R1 was sent to the local Emergency Department for evaluation and treatment for inappropriate behaviors. R1's plan of care was revised on 6/13/18 with the following: Send to Emergency Department for evaluation and treatment due to behavior; R1 did not qualify for psychiatric placement. Local Emergency Department indicates "no risk."; Discharge plan 6/13/18, POA aware of Involuntary Discharge with 30 day notice due to aggressive behavior displayed towards other resident; R1 to be 1:1 supervision until other placement located; R1 will not have a roommate until discharge; R1 had charges signed against him on 6/13/18; Facility to notify local Police Department when R1 is placed at another facility; POA is also currently seeking other placement." R1's plan of care was revised on 6/22/18 with the following: "Transfer to Chicago. R1's Plan of Care does not document	S9999			

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S9999	Continued From page 6 any further interventions were implemented regarding R1's one time physically aggressive behavior." A Social Service progress note completed by V2 (Administrator in Training) dated 6/14/18, states "(R1) was given notice of 30 day Involuntary Discharge due to physically assaulting another resident (on 6/13/18). (R1) said 'Bulls***t' and threw papers at me. Explained to (R1) that POA (Power of Attorney) is also aware of seeking appropriate placement and 30 day notice. (R1) became louder stating 'Bulls***t' and pushed papers out of my hands. Papers left on (R1's) bed." On 7/9/18 at 8:17 a.m., V1 stated R1 had never been physically aggressive towards another resident until 6/13/18. V1 (Administrator) stated the Involuntary Discharge was issued on 6/14/18 and the effective dated of the proposed discharge was 7/14/18. V1 verified that the discharge notice documents an appeal can be filed up to 10 days after receiving the Involuntary Discharge Notice. V1 stated R1 was placed on 1:1 supervision until (R1) was discharged to another facility on 6/22/18. V1 stated no other interventions were attempted prior to issuing R1 an Involuntary Discharge Notice. V1 stated "(V7/R1's Power of attorney) did not want to appeal the discharge. He was fine with it so we found (R1) a new facility and transferred (R1) with the approval of (V7). V1 was not aware if R1's medical record documenting any staff attempts to explain to R1 that (R1) had the right to appeal the discharge that was initiated by the facility. V1 stated the facility was not aware of V6 filing an appeal on behalf of R1 until after R1 was discharged.	S9999			

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S9999	Continued From page 7 Facility Incident Reports dated 3/7/18 (R11), 3/27/18 (R9, R10), and 5/17/18 (R8, R5), document resident to resident physical altercations. On 7/9/18 at 8:45 a.m., V1 (Administrator) stated there have been no Involuntary Discharges issued in the past year due to resident to resident altercations except for R1. R1's plan of care states "(R1) communicates by saying bulls**t, damn, and hand gestures. (R1) is able to make gestures to make needs known; staff and residents understand (R1's) communication technique." On 7/9/17 at 1:16 p.m., V5 (R1's primary physician) stated "The facility staff told me (R1) had been physically aggressive prior to (R1's) altercation with another resident on 6/13/18. I asked them for the incident reports but they never did provide them to me. I have no knowledge of (R1) ever being physically aggressive and I've known (R1) for years." On 7/9/18 at 2:10 p.m., V4 (Social Service Director) stated R1's record did not document attempts of counseling R1 regarding the Involuntary Discharge Notice or allowing (R1) the opportunity to communicate (R1's) desire to remain in the facility. On 7/9/18 at 2:30 p.m., V3 (Administrator in Training) stated "I didn't discuss the Involuntary Discharge Notice (ID) with (R1) anymore (after issuing the ID on 6/14/18). (R1) was able to make (R1's) needs known. I didn't specifically ask (R1) if (R1) wanted to remain in the facility. I only gave (R1) the discharge papers."	S9999			

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S9999	Continued From page 8 On 7/9/18 and 7/10/18, V4 (Social Service Director), V11 (R1 Family Member), V13, V14, V15 (Certified Nurse Aides), V16 and V17 (Licensed Practical Nurses) all stated they had no knowledge of R1 ever being physically aggressive towards others. R1's Medical Record dated 6/14/18 through 6/22/18 (date of discharge) does not contain documentation that R1 was counseled regarding the involuntary discharge or allowed the opportunity to express his desire to remain in the facility. On 7/10/18 at 10:31 a.m., V6 (Ombudsman) stated: "I received notification of (R1's) Involuntary Discharge via fax on 6/14/18. I went to the facility to meet with (R1) on 6/18/18 to discuss (the Involuntary Discharge) with (R1). (R1) was very upset over the discharge and did not want to leave (R1's) home of 13 years. I have known (R1) for years and (R1) was definitely cognitively intact. (R1) did not want to move to another facility so I asked (R1) permission to file an appeal to the Involuntary Discharge. (R1) agreed to the appeal. I file the appeal with (the State Agency) on 6/19/18. (The State Agency) then sent all parties involved a Notice of Prehearing Conference which was scheduled for 6/27/18 at 10:00 a.m. When I arrived at the facility on 6/27/18 at approximately 9:00 a.m., I was told my staff that (R1) had been discharged on 6/22/18 to a facility in Chicago. The facility is not allowed to discharge a resident during the appeal process. (R1) was not given the opportunity to speak for (R1's) self and express (R1's) wishes." (R1) was able to communicate with gestures and make (R1's) needs known. I have since gone to Chicago to see how (R1) was doing and (R1) was very unhappy at the new facility.	S9999			

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S9999	Continued From page 9 (R1) cried and clearly let me know (R1) did not want to be there. I called there about a week later and the new facility told me that (R1) was not there but would not give me any details." The State Agency "Notice of Prehearing Conference" dated 6/20/18, documents a prehearing phone conference was scheduled for 6/27/18 at 10:00 a.m. On 7/9/18 at 11:04 a.m., V4 (Social Service Director) stated V4 had not discussed the opportunity to appeal the Involuntary Discharge with R1. V4 stated "I only talked to (V7) about it. (V7) was fine with us sending (R1) to Chicago." On 7/10/18 at 11:05 a.m., V12 (Chicago Facility/Director of Nursing) stated "(R1) was discharged from here on 6/29/18. (R1) was not happy here. (R1) was refusing most cares and would not take (R1's) medications. (R1) wouldn't talk to the staff. Other than being upset with the new environment (R1) had no other behaviors. Never did (R1) get physically aggressive. We were able to find (R1) another facility in Chicago." On 7/9/18 and 7/10/18, V4 (Social Service Director), V9 (Regional Ombudsman), V10 (New Facility/Social Service Director), V11 (R1 Family Member), V13, V14, V15 (Certified Nurse Aides), V16 and V17 (Licensed Practical Nurses) all stated that R1 was able to make R1's self understood with non-verbal communication and R1 was able to understand others. (B)	S9999			