DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. DIXON MANOR, LLC, D/B/A, DIXON REHAB & HCC, Respondent.	)))))))))	Docket No. NH18-S0520

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on November 05, 2018, at Dixon Rehab & HCC, 800 Division Street, Dixon, Illinois 61021. On December 28, 2018, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.

3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b)5), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 03rd day of January, 2019.

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STATE OF ILLINOIS

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PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Daniel Maher
Licensee Info:	Dixon Manor, LLC
Address:	412 East Lawrence Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 03rd day of January, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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 Facility Reported Investigation to Incident of October 29, 2018/IL106968	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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

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

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations were not met as evidence by:

Based on interview and record review, the facility failed to safety transfer a resident using a mechanical lift. This failure resulted in a resident falling to the floor and sustaining a laceration requiring three staples.

This applies to 1 of 3 residents (R1) reviewed for mechanical lift transfers in the sample of 3.

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S9999	Continued From page 2	S9999		

The findings include:

R1's Electronic Medical Record shows R1 was admitted to the facility on December 18, 2007 with diagnoses including: Osteoarthritis, dysphagia, dementia, intellectual disability, and major depressive disorder. R1's Minimum Data Set (MDS) dated October 4, 2018, shows R1 has total dependence on two staff members for transferring. R1's Care Plan dated October 3, 2016, shows R1 requires a mechanical lift with two assistants for transfers.

The facility's Incident Report dated October 29, 2018, shows "Today during a (mechanical lift) transfer with two staff members present, (R1) slid out of (R1's) (mechanical lift sling). Staff attempted to intervene, but were unsuccessful in doing so in which the resident landed on the floor on (R1's) left side ...a laceration was noted to the back of (R1's) head ...resident was transferred to the emergency room where (R1) is being evaluated for further injury ...immediate education is being provided to all staff on (mechanical lift) transfers. Received a notification from the emergency room that (R1) had received treatment with three staples to the laceration of the 'upper occipital lobe'."

On November 5, 2018 at 8:50 AM, V1 Administrator stated V7 CNA (Certified Nursing Assistant) and V8 RN (Registered Nurse) were transferring (R1) from (R1's) bed to the chair. While over the bed V7 and V8 "visually checked the (mechanical lift sling) straps, but did not physically check. We would expect them to physically check the straps. V7 pulled the machine from the bed and pushed it forward. (V7) felt a tug and the top left hook became detached and (R1) fell and landed on (R1's) left side. (R1)

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S9999	Continued From page 3	S9999		

had a laceration to (R1's) head and was sent to the hospital. (R1) received three staples. The staff was reeducated on mechanical lift transfers and physically checking the straps. V7 and V8 were terminated for not following facility policy." At 9:32 AM, V2 DON (Director of Nursing) stated V2 came in to the facility to do an investigation. V2 stated V7 and V8 reenacted what happened. "They said they visually observed the hooks but unfortunately did not physically check them. The left top loop came off and (R1) fell on the ground. Both staff were terminated for not following policy that resulted in a resident injury."

R1's Progress Note dated October 29, 2018, shows, "(R1) was treated with three staples to the laceration to the upper occipital lobe."

The facility's Safe Lifting and Movement of Residents policy reviewed January 2017, shows, "Staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. The facility's undated Total Dependent Lift Competency check list shows, "To demonstrate knowledge and ability to safely transfer a resident from different surfaces using a total dependent lift ...using remote control, lift resident and apply pressure to the tilting frame to maintain an upright position ...position resident over chair or bed in upright position. Lower resident with remote while maintaining pressure to tilting frame to maintain upright position."

The manufacturer instructions on the mechanical lift revised April 16, 2013, shows, "Lift the resident above the bed by using the hand control while watching and reassuring them."

(B)

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