IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 06, 2019

Marikay Snyder, Registered Agent
Midwest Health Operations, LLC
830 West Trailcreek Drive
Peoria, Illinois 61614

RE:	Complaint #:	IL00107756, IL00107823
	Survey Date:	December 10, 2018
	Docket #:	19-C0037
	Violation Type:	Level A, Level C

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Sauk Valley Senior Living.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

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

Enclosure
cc: Administrator
File
Sauk Valley Senior Living/December 10, 2018//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. MIDWEST HEALTH OPERATIONS, LLC, D/B/A, SAUK VALLEY SENIOR LIVING Respondent.	)))))))))	Docket No. NH 19-C0037

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; 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 "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

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 Complaint IL00107756 and IL00107823 Investigation conducted by the Department on December 10, 2018, at Sauk Valley Senior Living, 1000 Dixon Avenue, Rock Falls, Illinois 61071. On February 05, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care 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 Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" 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 CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Sauk Valley Senior Living, 1000 Dixon Avenue, Rock Falls, Illinois 61071 on February 24, 2019. The Facility's current license number is 0053330. The term of the conditional license shall be from March 05, 2019 to September 04, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 05, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.1210b), 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 Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; 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.

Plans of Correction, Hearing and Waiver Requests 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 6th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. MIDWEST HEALTH OPERATIONS, LLC D/B/A, SAUK VALLEY SENIOR LIVING Respondent.	))))))))))	Docket No. NH 19-C0037

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; 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:	Marikay Snyder
Licensee Info:	Midwest Health Operations, LLC
Address:	830 West Trailcreek Drive Peoria, Illinois 61614

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 6th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
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
	IL6001929	A. BUILDING _____ B. WING _____	C 12/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUK VALLEY SENIOR LIVING	1000 DIXON AVENUE ROCK FALLS, IL 61071

(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 Complaint Investigation 1817838/IL107756 1817903/IL107823	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.1210b) 300.1210d)6) 300.3240a) 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by:300.510a) Based on observation, interview and record review the facility failed to ensure a resident's safety and prevent a resident from being burned by his heater. This failure resulted in R1 sustaining second and third degree burns to his left upper back and posterior left arm when he fell back against a heater mounted to the wall in his room on 12/4/18. This applies to 12 of 16 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R14) reviewed for safety in a sample of 16. The findings include: The facility document entitled SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 12/4/18 states, "Resident laying across bed with head on wall, shoulder on heater. Resident stated he went to get up to go to the bathroom by himself and fell backwards on the bed. Resident did not use call light. Large red area noted on left upper shoulder blade and on left arm. Large blisters noted, and two dark areas on upper area of wound." On 12/4/18 at 11:35AM, V5 (Certified Nursing Assistant-CNA) was making R1's bed. V5 stated, "His bed was closer to the heater; we moved it	S9999		

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S9999	Continued From page 2	S9999		

out this morning." V5 explained that she used to be able to walk between the bed and the wall but it was a tight fit (maybe a foot between the bed and the wall.) V5 was asked what happened to R1. V5 stated, "R1 didn't have his call light on but V3(CNA) found him. He laid on the heater and the top of his shoulders were burned. He was sent out to the hospital about 1:30AM. I guess the heater gets super hot when it is set on high. The CNAs last night went to touch it and couldn't even touch it, it was that hot. We keep them set at 'comfort zone.'. He is (Physically) able to adjust it if he wants to but I'm not sure if he ever did."

On 12/4/18 at 11:55AM, V2 (Maintenance Director) stated, "We added those heaters to the cold rooms last year when the boiler couldn't keep up. They are in 10 rooms (8 currently occupied rooms), one on the sun porch and one by the front door. They should be set at 'comfort zone' if they are even on. The residents have the ability to adjust them (knob in place) if they want to but I don't know that anyone ever has." At 2:50PM V2 confirmed that he had never measured the surface temperature of the heaters before and he does not have a policy related to who should regulate the heaters or what they should be set at. V2 stated he was not aware of any staff or residents ever messing with the heaters in the past.

On 12/4/18 at 1:30PM, V3 (CNA) stated, "I did rounds about 10:00PM and checked on him then I saw him again around 11:00PM. Around 1:00AM when I got down to his room again I found him sitting on his bed, leaning against the wall. His face was red and he was clammy. He was shaky. I went and got the nurse and asked her to come look at him. We sat him up in the wheelchair and asked him if he had any pain. He said, 'A little' but

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S9999	Continued From page 3	S9999		

said he was okay. He usually uses his call light but I'm not sure why he didn't this time. The skin on his back was red and blistered, from about the middle of his shoulder blade to his elbow. Then the ambulance came. After we moved the bed we noticed the heater was on high; I turned it off. He might have turned it up himself. He likes his room warm and likes a lot of blankets."

On 12/5/18 at 9:10AM, V5 (Licensed Practical Nurse-LPN) stated, "I was in another resident's room a few doors down from {R1}. {V3} came to get me and told me I have to come look at {R1}. When I went in there {R1} was just laying across the bed. He said, 'I was trying to go to the bathroom.' He said he forgot to use his call light. We got him up to the wheelchair. He was sweating profusely and then I noticed the redness on his back and the blisters. I got a cool towel and just kind of dabbed the areas. I called {V1}(Administrator) and then I called 911 and sent him out. He never appeared to be in any pain. He was able to answer every question I had appropriately. Even when I dabbed the area on his back, he never winced. Never said a word about pain. The blisters were huge and he had 1/4-1/2 inch darkened areas in two spots. When we pulled the bed away from the wall, V3 noticed the heater was set to high - it was very, very hot. We usually have them set to 'comfort zone.' It is possible he messed with it. He was not calling out for help at all."

On 12/6/18 at 8:30AM, R1 stated, "I got up to take a pee. My foot slipped and I fell back on the bed. I landed against the heater. I felt it but I couldn't move. Then they found me there. I was only there for about 2-3 seconds. There was no time to yell. They found me. I never mess with the heater and I never asked anyone to turn it up. I'm

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S9999	Continued From page 4	S9999		

not sure how it got set to high."

On 12/4/18 at 12:05 PM, Surveyor and V2 measured the surface temperature of the heater in R1's room after being set to high for approximately 30 minutes. Using the facilities infrared thermometer the top of the heater (where R1 laid) measured 145 degrees Fahrenheit. Surveyor touched unit with hand and found it too hot to allow hand to remain in place for more than a few seconds.

A tour of the facility on 12/4/18 showed there are electric baseboard heating units in rooms: 3, 5, 6, 8, 9, 11, 12, 14, 20 and 22. These heaters have the potential to cause injury to the following residents as they reside in the rooms with the wall heaters: R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R14. Review of these resident's most current Minimum Data Sets shows that the residents have the ability to ambulate with or without assistance or have the ability to propel their wheelchairs within their rooms and therefore have access to the wall heaters.

On 12/10/18 at 1:15PM, V1 confirmed that the facility did not have a policy related to the use or the regulation of the wall heaters used in resident rooms.

R1's Minimum Data Set of 8/14/18 shows that R1 has diagnoses including Schizophrenia, Depression and Alcohol Dependence with Alcohol Induced Persistent Dementia. This same document shows that R1 scored a 14 on his BIMS (Basic Interview for Mental Status) = No cognitive impairment and shows that R1 is able to walk independently in his room.

The Hospital Emergency Documentation dated

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12/4/18 states, "Patient has a history of Schizophrenia, Psychosis, Depression and Dementia. Is here for burn to left upper extremity and left upper back. Patient verbalizes he got up to go to the bathroom and fell and that his feet was caught against the heater and he could not get up when he tried. He states did not call out for help... Per nursing home patient got up to go to the bathroom and fell against a heating element at the facility. Patient sustained burn to posterior left arm and left upper back..." This same form states, "Skin warm, dry, no pallor, partial thickness burn to lateral/posterior side of left arm from forearm to left shoulder with several blisters noted on left shoulder, left posterior arm. There is extension of burn to the left upper back to midline over approximately 3 dermatomes {an area of skin that is mainly supplied by a single spinal nerve} width with area of 3rd degree burns, approximately 1% (BSA- Body Surface Area) with total burned area approximately 6% (Left arm and left upper back)."

The Electric Baseboard Heater Owner's Guide states, "This heater is hot when in use. To avoid burns, do not let bare skin touch hot surfaces. Keep combustible materials such as furniture, pillows, bedding, papers, clothes and curtains away from heaters."

(A)

(Violation 2 of 2)

300.510

Section 300.510 Administrator

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S9999	Continued From page 6 a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. This requirement was not met as evidenced by: Based on interview and record review the facility failed to employ a Licensed Administrator to manage the facility. This applies to all 26 residents residing in the facility. The findings include: On 12/10/18 at 11:15AM, V1 (Acting Administrator) stated, "We do not have a licensed Administrator at this time. It has been about a month or so. She left as Administrator on October 17, 2018. My paperwork for my temporary administrator's license is in the works in the corporate office." The undated facility document entitled Job Description Administrator states, "The Administrator is responsible for managing, planning, organizing, staffing, directing, coordinating, reporting, budgeting and the physical management of the facility, residents and equipment in a way that the purpose of the facility shall be maintained in accordance with all established practices, policies, law and applicable State Regulations. The Administrator will manage and conduct the business of the facility in a manner that protects the facility license and certification at all times. The major goal of the Administrator is to provide an atmosphere in	S9999		

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S9999	Continued From page 7 which residents may achieve their highest physical, mental and social well-being." Responsibilities include: Maintain written policies and procedures that govern the operation of the facility." (C)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: SAUK VALLEY SENIOR LIVING COMPLAINT #: 0107823
LIC. ID #: 0053330
DATE COMPLAINT RECEIVED: 12/05/18 14:42:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: SAUK VALLEY SENIOR LIVING COMPLAINT #: 0107756
LIC. ID #: 0053330
DATE COMPLAINT RECEIVED: 12/04/18 09:48:00

IDPH Code	Allegation Summary	Determination
131	RESIDENT INJURY	\

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

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