IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 14, 2019

Debra Gitz, Registered Agent
Parkview Home of Freeport, Illinois, Inc.
1234 South Park Boulevard
Freeport, Illinois 61032

RE: Complaint #: IL00108683
Survey Date: January 17, 2019
Docket #: 19-C0067
Violation Type: Level B

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 Parkview Home - Freeport.

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
Parkview Home - Freeport/January 17, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PARKVIEW HOME OF FREEPORT, ILLINOIS, INC., D/B/A, PARKVIEW HOME - FREEPORT, Respondent.	)))))))))	Docket No. NH 19-C0067

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;
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 Complaint IL00108683 Investigation conducted by the Department on January 17, 2019, at Parkview Home - Freeport, 1234 South Park Boulevard, Freeport Illinois 61032. On March 13, 2019, 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 Statement of Licensure Violations 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 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). 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.

Plan of Correction and Hearing 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 14th day of March, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PARKVIEW HOME OF FREEPORT, ILLINOIS, INC., D/B/A, PARKVIEW HOME - FREEPORT, Respondent.	)	Docket No. NH 19-C0067

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Debra Gitz
Licensee Info:	Parkview Home of Freeport, Illinois, Inc.
Address:	1234 South Park Boulevard Freeport, Illinois 61032

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 14th day of March, 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
	IL6007231	A. BUILDING: _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME - FREEPORT	1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032

(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 1910306/ IL 108683 Statemen of Licensure Violation: 1 of 1 Violation	S 000		
S9999	Final Observations 300.1210a 300.1210b 300.1210d)1)2) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician.

This requirement is was not met as evidenced by:

Based on interview and record review the facility failed to ensure fall prevention interventions for R1 were implemented for the resident's safety. The facility failed to give R1 her scheduled evening dose of Alprazolam as ordered by the physician.

This applies to 1 of 3 residents (R1) reviewed for falls and medications in the sample of three.

The findings include:

1. The Nurse's Note dated 1/12/19 for R1 showed, "7:00PM - R1 was noted to have slid off her wheelchair around this time. Assisted back to her wheelchair with four person assist."

On 1/17/19 at 8:25AM, V6 (CNA - certified nursing assistant) stated, "R1 is a fall risk out of her wheelchair so she is mechanically lifted to the recliner. If R1 is not at the table with her wheels locked she is in a recliner. They said she had a fall on Friday or something. I heard R1 was by the

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S9999	Continued From page 2	S9999		

window in her wheelchair. R1 scooted forward and slid out of her wheelchair. I don't ever leave her by herself; I get the mechanical lift ready before I take her to the living room."

On 1/17/19 at 11:14AM V2 (DON - Director of Nursing) stated, "R1's fall happened on Saturday; the nurse called and said they found R1 on the floor near her wheelchair in the living room area. They hadn't got R1 to bed yet. My first question was why R1 wasn't at the table or in a recliner. They were waiting for a second person to transfer. The CNA (V13) took R1 to the living room. The other CNA (V3) I spoke to said R1 was still at the table when she went to help another resident. V3 said V13 motioned for her to come up; R1 was on the floor." At 12:50PM, V2 stated, "V13 said that evening R1 was up to the table where she should be. R1 was anxious and pushing herself away from the table. R1 can unlock the breaks of her wheelchair. To get R1 to settle down V13 put her in the living room in her wheelchair, next to the recliner. V13 went to get the mechanical lift but V9 (RN - Registered Nurse) came out of a room and told her she needed to go in and take care of a resident in the bathroom that couldn't be left alone. V13 assumed the other two CNA's would transfer R1 right away to the recliner. V13 heard the other CNA's in the room next to her transferring a resident. She assumed they had done R1 and went on to the next one. V13 was in with a resident for thirty minutes and then went to care for another resident when she heard something in the front room (living room). R1 was sitting on her foot pedals."

The Fall Risk Evaluattion dated 11/27/18 for R1 showed a score of 16 and a resident's score of 10 or greater indicates high risk for falls.

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S9999	Continued From page 3	S9999		

The Care Plan dated October 2018 for R1 showed, "Fall history: 7/8/18- R1 slid out of the chair in the television area; 7/19/18- R1's legs gave out and R1 was lowered to the floor; 1/12/19 - R1 slid out of wheelchair; R1 is only to be in the wheelchair during transfers and when at an activity or a meal and is seated at a table."

A Social Service Note dated 7/11/18 for R1 showed, "R1 did not attend her care plan but her niece did. V7 (R1's niece/power of attorney) was very upset about R1 and some things that happened over the weekend. V7 stated she was contacted this weekend about R1 falling out of the chair. Reviewed with staff and R1 did slip out of the chair, it was not observed and we are still investigating. Staff did know that R1 was taken from the dining room after breakfast in her wheelchair and set in front of the picture window. R1 was sleeping in her wheelchair and ten minutes later she was found on the floor. V7 stated she wanted R1 transferred to a recliner when she is sleeping."

The facility's Fall Protocol (4/11/18) showed, "To provide adequate assessment, treatment and interventions for a resident after a fall and to assure that appropriate documentation of information is done. Communicate the fall information and new interventions to the appropriate facility staff, including the oncoming nurse and Director of Nursing."

2. R1's Physician Order Sheet for June 2018 showed she had an order for Alprazolam 0.25mg, 1 tablet by mouth every evening in place since 4/4/18. A new prescription was received for R1 on 6/6/18 for Alprazolam 0.25mg, 1 tablet by mouth every day as needed for anxiety. R1's scheduled

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S9999	Continued From page 4	S9999		

dose of Alprazolam in the evening was never discontinued.

The Medication Administration Record (MAR) for R1 dated June 2018 showed she had Alprazolam 0.25mg, 1 tablet by mouth every evening ordered. It was given every evening in June 2018. R1's June 2018 MAR showed on 6/6/18 an order for Alprazolam 0.25mg, 1 tablet daily/as needed for anxiety was added to the MAR.

The Medication Administration Record (MAR) for R1 dated July 2018 showed no order for Alprazolam 0.25mg, 1 tablet by mouth every evening until it was written in by hand on the MAR on 7/13/18. R1's MAR showed an order for Alprazolam 0.25mg, 1 tablet daily as needed for anxiety that was in place for the entire month of July 2018. R1 received a dose of the as needed Alprazolam on 1/11/18 and 1/12/18. R1 did not receive the scheduled dose of Alprazolam in the evening from January 1 until January 13th when it was written on the MAR.

On 1/17/19 at 12:50PM, V2 (DON - Director of Nursing) stated, "R1 got an order for an as needed Alprazolam on 6/6/18 and pharmacy discontinued the scheduled dose. The nurses checked the MAR and physician order sheet (POS) at the end of June but didn't catch it as an error until six plus days. The error was caught on July 12, 2018; R1 missed 9 doses of the medication. She had been given three as needed doses."

On 1/17/19 at 1:50PM, V4 (LPN - Licensed Practical Nurse) stated, "We have two nurses that check medications. When we get orders we have an order board; when it's processed the night nurse double checks orders so they don't get

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S9999	Continued From page 5 missed. The night nurse goes to the clipboard, then reviews the physician order sheet and MAR to make sure it is on the MAR. In this case it got missed." The facility's Obtaining Medication New Order Policy (no date) showed, "The new order shall be transcribed to the medicine sheet." (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: PARKVIEW HOME-FREEPORT COMPLAINT #: 0108683
LIC. ID #: 0012526
DATE COMPLAINT RECEIVED: 01/14/19 10:50:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

X 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.