DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. GOOD SHEPHERD MANOR, INC., D/B/A, THOMAS HERBSTRITT HOUSE, Respondent.	)))))))))	Docket No. NH 19-S0029

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

Pursuant to the authority granted by the ID/DD Community Care Act (210 ILCS 47/1-101 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 21, 2018, at Thomas Herbstritt House, 4003 N RT 1 & 17, PO Box 260, Momence, Illinois 60954. On January 17, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Intermediate Care for the Developmentally Disabled Code, 77 Ill. Adm. Code 350 (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

Pursuant to Section 3-303(b) of the Act and Section 350.278 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 **$550.00**, as follows:

Type B violation for violating one or more of the following sections of the Code: 350.510e), 350.620a), 350.700a), 350.1210b), 350.1220h)j)k), 350.1230b), 350.1230e) and 350.3240a).

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
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

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 "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

Plan 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 Regulations

Dated this 18th 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:	Bruce Fitzpatrick
Licensee Info:	Good Shepherd Manor, Inc.
Address:	4129 N RTE 1 & 17, PO Box 260 Momence, Illinois 60954

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 18th 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
	IL6014260	A. BUILDING _____ B. WING _____	11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS HERBSTRITT HOUSE	4003 N RTES 1 & 17, P.O. BOX 260 MOMENCE, IL 60954

(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
Z 000	COMMENTS Annual Certification Survey - Focused Fundamental, Extended into Client Protections. Annual Licensure Survey. Inspection Of Care Survey.	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.510e) 350.620a) 350.700a) 350.1210b) 350.1220h)j)k) 350.1230b) 350.1230e) 350.3240a) Section 350.510 Administrator e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 least annually Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services h) The facility shall maintain effective arrangements through which medical and remedial services required by the resident but not regularly provided within the facility can be obtained promptly when needed. j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	Z9999		

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Z9999	Continued From page 2 k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.3240 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 ensure: 1. Policy and procedure to prevent neglect was implemented for 1 client outside of the sample (R6) with known history of elopement. R6 walked out of the facility on 12/29/17 at 3:55 AM and was picked up one mile away from the facility by police officer along a one-lane each way rural highway. 2. Policy and procedure on conducting thorough investigation was implemented for R6 who eloped from facility for approximately 25 minutes on 12/29/17 from 3:55 AM through 4:20 AM and	Z9999		

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Z9999	Continued From page 3 failed to update Policy on Elopment Procedure to include steps to take when a resident who eloped returns to the facility when there is no nursing staff on campus. 3. Staff re-training for timely notification of licensed health provider, assessment of skin status, temperature and pulse of a client returned from exposure to extreme weather was identified. Documentation of assessments of 1 client outside of sample (R6) who eloped from facility on 12/29/2018 at 03:55am Findings include: Per Facility Policy on Abuse and Neglect Section 243 (Revised 12/4/15): Definition: Neglect is a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. Imminent Danger-a preliminary determination of immediate, threatened or impending risk of illness, mental injury, or physical injury or deterioration to an individual's health that requires immediate action. Incident Management/Investigation: Response and medical attention of the victim: in the event that there is an allegation of any type of physical injury, sexual assault or any situation where a victim's health is in question, the agency shall immediately seek appropriate medical attention. Per Facility Elopement Policy Section 251 (Revised 4/23/15): Upon return of the resident to the facility, 1. The staff person who returns the resident shall bring the resident to the nurse on duty so the nurse can examine the resident for injuries. 2. The staff physician will be contacted	Z9999		

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Z9999	Continued From page 4	Z9999		

by the nurse on duty for possible further examination if appropriate."

Per R6's 8/30/18 Individual Habilitation Plan, R6 is 84 years old (83 years at time of incident) who is very active for his age, walks unassisted, communicates very well although hard of hearing. R6 has a history of elopement. R6's diagnoses include Hearing loss, Glaucoma and Anxiety. R6 requires 24-hour supervision. While in the community R6 must be accompanied by a staff member. Community Living Skills: R6 is able to find his way around familiar places. However, R6 would be very vulnerable alone in the community. R6 have difficulties crossing streets. Safety Risk Assessment: When R6 goes out in the community, R6 will remain with staff to ensure R6 does not get lost.

Per Facility's 1/2/18 Summary of Investigation of Incident Of Elopement "on 12/29/17 at approximately 3:55 AM, R6 walked out of and away from facility. An area Police Officer saw R6 walking along Route 1(and) 17, north of (campus facility is located) approximately 15-20 minutes later. R6 was dressed in jeans, a sweater, his coat and his hat. The air temperature at the time was approximately nine degrees. R6 was returned to the facility about 4:25 AM by police. Upon his return, R6 was assessed with no apparent injuries noted. As a precaution, R6 was sent to the Emergency Room for evaluation at about 6:10 AM. R6 returned from ER at 10:15 AM and was diagnosed with cystitis (infection of the bladder wall)."

Per the Local Police Field Report, "on 12/29/17 at 4:01 AM, Responding Officer Z3 and Detective Z4 were dispatched to the area of 5000 N Highway 17 for a subject walking northbound,

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staggering. Advised (by) a passerby (who) wanted a well being check on the subject. R6 had no identification on his person. Realizing that he was only about a half mile from (campus of facility), Z3 attempted to make contact with the staff. R6 was released to campus Supervisor E17 after speaking with staff E18 who determined they are missing a resident."

Per Facility's Investigation Report on 1/2/18: North door alarm at facility sounded on 12/29/17 approximately at 3:55 AM. DSP's (Direct Support Person) E19 and E20 who were working at the facility did not recognize if this was door or fire alarm. Supervisor E17 was notified of the alarm. E17 notified Security staff Z1 to check the alarm. Z1 and E17 were at the facility at 3:56 AM and 3:57 AM respectively. E19 and E20 reported to E17 that all clients are in the facility. Z1 disengaged the alarm on the north door and saw no footprints on the snow as Z1 looked through the door's window. At approximately 4:20 AM, E17 received a call from local police asking if the campus is missing a client. E17 asked E19 and E20 to again check if all residents are in the facility. E17 was informed that R6 is not in bed at his facility. About the same time, a police officer arrived at another residential facility on campus (about half mile away from R6's facility) and spoke with staff E18. Police officer asked E18 if they were missing a client. Shortly, a second police officer arrived and informed the first officer that R6 was missing from his facility. E18 escorted police officers and R6 to facility of R6. R6 was dressed in jeans and sweater and had his coat and hat on. R6 was given blankets and went back to sleep. Licensed nursing staff notified at 6:00 AM and gave directions to morning supervisor to have R6 evaluated in the local emergency room. R6 returned to facility with

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Z9999	Continued From page 6 diagnosis of cystitis (infection of the bladder wall). Nursing staff was informed of R6's elopement at 6:00 AM and Nursing staff directed supervisor to send R6 to ER for evaluation. The direction to have R6 evaluated in the ER was given 1.5 hours after R6 was returned to the facility. Review of the Campus Map where facility is located validates that R6 lives in the southwest building on campus. The residential facility that police first arrived was approximately 500 feet away northeast from the facility of R6. The report of where R6 was picked up by police on the highway is exactly one mile from the building of R6's facility. 5000 N and Highway Routes 1 and 17 is at a t-intersection in a rural farm area. (An online search for the address and map of facility shows that Routes 1 and 17 is also called Dixie Highway that goes north and south. And 5000 N is also called St. George Road, goes east and west.) Route 1 and 17 is a one lane each-way highway with posted speed limit of 55 miles per hour. There are no sidewalks along Route 1 and 17. Outside the lines for each lane is approximately 1.5 feet of paved road followed by gravel and then it dips down to a grassy area. There is one street light located west and south from the facility of R6. Except for the street light across from facility of R6, there is no other street light on Route 1 and 17 from R6's facility through the t-intersection of 5000 N. The area around Routes 1 and 17 and 5000 N is surrounded primarily by rural farmland. Interview with QIDP E2 on 11/02/18 at 1:30 PM validate that nursing staff are on campus from 6:00 AM through 9:00 PM. When a client is in	Z9999		

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Z9999	Continued From page 7 need of medical intervention outside of those hours, it is usual practice to send clients out to the emergency room for evaluation. Review of facility documentation regarding the incident do not include any temperature, pulse or skin assessment of R6 upon return to the facility by police officers on 12/29/18 at 4:25 AM. Administrator E3 conducted the investigation. E3 was asked on 11/2/18 at 12:53 PM questions about the 12/29/18 incident of elopement and provided the following answers: Did R6 have socks and shoes on? They said R6 was fully dressed, he had black tennis shoes on. Were R6's clothes damp or wet? Nobody said anything about him being wet. Was R6's skin status assessed? R6 was given blankets. Did R6 change clothes before going to bed? Don't remember, can go back and try to find their statements. How much snow was on the ground that early morning, was it snowing? There was a blanket of snow but you can walk through the snow. It was not snowing at the time of elopement, it was very cold. Which exit did R6 take to leave the fenced area of the building? R6 walked through the north gate toward next residential building (on campus), walked through the main driveway (of the campus). (The two buildings are approximately 150 feet away). Which side of the road on Routes 1 and 17 was R6 found? Police report did not say either way. Was nurse notified at time of return to facility? They called Director, E1, who is a nurse. Did E1 give directions to supervisor about getting vitals on R6? Don't know, you would have to speak with E1.	Z9999		

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Z9999	Continued From page 8 Did you interview E1? Probably not. Was there staff documentation on R6's skin status upon return to facility? Our policy says to have person returned to nursing for assessment. (Nursing starts at 6:00 AM). What was the distance from facility R6 resides in and the point on Routes 1 and 17 police picked up R6? It's not included in the report. Why did the report not state that this was a case of neglect? E19 and E20 were terminated for not maintaining supervision of R6. Per our policy, unattended residents is grounds for termination (of liable staff). The facility did not identify the lack of immediate medical assessment, nursing personnel notification and lack of staff assessment of skin, temperature and pulse of R6 who eloped and walked about a mile in 9 degrees weather condition. Current Elopement policy does not address what action to take when a client who eloped returns to facility during times when there is no nursing staff on campus. (B)	Z9999		