DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. GOOD SAMARITAN SOCIETY - MOUNT CARROLL, D/B/A, GOOD SAM SOC - MT. CARROLL Respondent.	)	Docket No. NH 19-S0038

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 Licensure Investigation conducted by the Department on December 06, 2018, at Good Sam Soc - Mt. Carroll, 1006 North Lowden, Mount Carroll, Illinois 61053. On January 31, 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 Good Sam Soc - Mt. Carroll, 1006 North Lowden, Mount Carroll, Illinois 61053 on August 17, 2017. The Facility's current license number is 0007344. The term of the conditional license shall be from March 02, 2019 to September 01, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 02, 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
525 West Jefferson, 5th Floor, Quality Assurance
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 "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 1st day of February, 2019.

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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:	CT Corporation System
Licensee Info:	Good Samaritan Society - Mount Carroll
Address:	208 South LaSalle Street, STE 814 Chicago, Illinois 60604

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 1st day of February, 2019.

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

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001515	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNT CARRC	1006 NORTH LOWDEN P.O. BOX 111 MOUNT CARROLL, IL 61053

(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 FRI of 11-29-18/IL107870	S 000		
S9999	Final Observations Statement of Licensure Violations 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 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

Based on observation, interview, and record review, the facility failed to ensure the safety of a resident with dementia exhibiting exit seeking behaviors by not increasing supervision to prevent elopement. This resulted in R1 exiting the facility unknown to staff on November 29, 2018. R1 was unable to be located for approximately two hours and fifteen minutes before emergency responders and the canine unit located him approximately a quarter of a mile from the facility in a farmer's field and was transported to the hospital for treatment.

This applies to 1 resident (R1) in the sample of 4 reviewed for elopement risk.

The findings include:

On November 29, 2018, R1's electronic medical record showed R1 was an 89 year old male that was admitted to the facility on November 20, 2018 from another long term care facility with diagnoses of dementia, heart failure, chronic ischemic heart disease, ischemic cardiomyopathy, hypertension, atrial fibrillation, and chronic obstructive pulmonary disease. R1's nursing notes from the previous facility that were provided to the current facility upon admission showed a note dated November 19, 2018 at 7:30 AM, "Resident up independently wandering facility with coat on. Exit seeking tendencies noted..." R1's nursing admission assessment dated

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November 20, 2018 showed R1 to be alert and oriented to person and place, required no assistive devices for mobility, had a history of wandering, and was an elopement risk. R1's admission MDS (Minimum Data Set) dated November 26, 2018 showed R1 had severe cognitive impairment and had wandering behavior.

R1's current nursing progress notes showed two entries on November 22 regarding R1 wandering. The 3:15PM note showed R1 "insisting on walking up and down the halls while pushing his wife in a wheelchair." The 3:27 PM note showed R1 was "found in between 2 outside doors in the break room, wander guard alarm sounding. Earlier in shift, resident was following a group of visitors toward the front door with wife in wheelchair." A nursing note dated November 24 at 10:40 AM showed, "Front door alarm sounding. [R1] had followed a guest out the front door with wife in wheelchair." R1's nursing note dated November 25, 2018 at 5:21 AM showed, "during the evening hours [R1] asked a visitor if they would give him and his wife a ride to [a neighboring town]. Another staff member overheard it and reported it to nursing staff; resident walked up and down the halls for several hours tonight pushing his wife in her wheelchair walking mostly to the door at the end of 100 hall ..." An MDS note dated November 26, 2018 at 2:24 PM showed, "Cognition score of 3 indicates severe impairment .....He does pace the halls while pushing wife in wheelchair and has exhibited exit seeking behaviors ...."

On November 29, 2018, at 2:30 PM, V14 (R1's son) said R1 had a history of dangerous behaviors at home including a "bad habit of leaving at night." V14 said R1 has dementia and

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just does not know or understand what he is doing.

On November 29, 2018, at 12:45 PM, V4 RN (Registered Nurse) said the staff keep an eye on R1 because he wanders. V4 said R1 has dementia and has tried to go out of the doors before. V4 said R1 has told others he wanted to leave and he wanders down the halls looking out the windows. V4 said when she was working on Thanksgiving day she found R1 to be between two exit doors near the employee break room attempting to leave the facility. V4 said a couple of days later R1 was pushing his wife in her wheelchair when he attempted to follow a visitor out of the front exit.

On November 29, 2018, at 1:33 PM, V9 CNA (Certified Nursing Assistant) said R1 is someone who she would keep an eye on. V9 said R1 would talk to the staff about wanting to look for his brothers and thought they were in the parking lot. V9 said she caught R1 trying to go out the door with a visitor before.

On November 29, 2018, at 1:50 PM, V5 CNA said R1 was an elopement risk.

On November 29, 2018, at 10:09 AM, V1 Administrator stated, "This morning at approximately 6:10 AM it was noticed that [R1] was not in the building. The staff called me right away and after a thorough search of the building staff called 911. He was seen 15 minutes prior to them noticing he was gone walking the halls. I was able to get on my computer at home and view the security cameras. I was able to track him on the security camera and narrowed it down to him going into room 315 [an unoccupied resident room] and he did not come out of that room. I

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called and let them know and they checked the room and the window was open, the screen was able to be pushed away, and they saw footprints outside of the window in the snow. The staff immediately let the fire and police department know which window it was and they found him at 8:16 AM. He was about a quarter mile away out in the field. He was a little scratched up and he had one shoe in his hand. He was wearing his coat which he always has on, pants, shirt, socks and a shoe. The temperature outside this morning was about 30 degrees." V1 said R1 was wearing a wander guard device that alarms if he attempts to go out of an exit door as a precaution because he would talk about wanting to leave. V1 said the facility did not think he would attempt to leave without his wife but V1 said "well this morning he did."

On November 30, 2018, at 8:45 AM, V16 (R1's granddaughter/caretaker) said R1 has a history of being confused and delusional at home. V16 said R1 has been getting progressively more confused. V16 said when she spoke with R1 at the acute care hospital on November 29, 2018 after the emergency services found him R1 told her he pushed the screen out from the window and once he got out of the window he just started running. The facility provided a time line of the events surrounding R1's elopement on November 29, 2018 which showed "Resident was last seen walking down the 300 hall wing at 5:54 AM and he was found at 8:16 AM and being transported to the local hospital for evaluation."

The document titled Pre-hospital Care Report provided by the transporting ambulance service dated November 29, 2018 showed they were dispatched to the facility at 6:30 AM. The report showed, "after a two hour and fifteen minute

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search the patient was spotted near a fence line one quarter mile north northeast of the nursing home by a deputy and canine unit. He was brought to the road by a utility vehicle. Patient presents in no acute distress with no primary deficits noted. He is wearing a fall weight jacket, a heavy sweatshirt underneath, slacks and socks. He has one shoe on and is carrying the other. Unsure how long he had been walking without the one shoe on. Patient placed on cot ... removed jacket and covered patient with several blankets after turning heat up inside cabin. Left scene, temperature 94.1 degrees. Hands and feet are both extremely cold. Hands wrapped in blankets. Shoe and socks removed. Feet dried then placed on blankets with warm packs, then wrapped in aluminum foil followed by more blankets ...."

The Assessment and Plan history and physical from R1's admission to the acute care hospital dated November 29, 2018 showed acute cold exposure, acute hypothermia, and acute myocardial infarction.

On November 30, 2018, at 11:47 AM, V3 CNA stated she last saw R1 at around 6:00 AM on the morning of November 29, 2018. V3 said R1 was close to the sitting area near the 300 wing and it looked like he was getting ready to walk down the 300 hallway. V3 said, "[R1] walks around all the time pushing his wife in her wheelchair from hall to hall. It caught me off guard because I'm not used to seeing him up that early and dressed so it stuck out 'like a sore thumb.' [R1] would normally be in his room in bed or at least in the recliner. I had never seen him out of his room and dressed at that hour. It was out of the ordinary for [R1] to be out and [R1's spouse] still in their room. I had never seen him walk the halls by himself before; he was always with his wife."

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On November 29, 2018, at 12:50 PM, V8 CNA said they have to "keep an eye" on R1 because of his exit seeking behaviors which he has had since admission to the facility. V8 said R1 has been having exit seeking behaviors, wandering, pushing on all the doors, and asking visitors for a ride. V8 said she triggered the search for R1 when she went into R1's room to assist his wife with getting dressed and noticed R1 was not in the room. V8 said R1 does not usually go anywhere without his wife so she knew something was not right.

On November 29, 2018 at 2:05 PM, V7 CNA said when she reported for her shift starting at 6:00 AM during report one of the other CNAs was asking if anyone knew where R1 was. V7 said everyone started looking for R1 and she looked down the 300 hall. V7 said the door to room 315 was closed and when she opened it the room felt very cold. V7 said she noticed the window was open and thought someone had probably just left it open. V7 said she closed the door and continued searching for R1.

On November 30, 2018, at 8:58 AM, R1 was observed at the acute care hospital. R1 had numerous significant scratches to bilateral hands, wrists, and arms, top of his head and bilateral lower extremities.

On November 30, 2018, at 8:58 AM, R1 stated he remembered being out in the cold but he did not remember what he was doing. R1 said, "I think I stepped out a window. I thought my wife was outside and crying ...I wanted to be with her. I wanted to go home."

On November 30, 2018, at 8:34 AM, V13

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(Emergency Room Physician) said R1 was brought into the emergency room on November 29, 2018. V13 said the ambulance staff had already started warming R1 during the transfer to the emergency room but he was still cold. V13 said R1 had scrapes on his head, hands, and feet. V13 said the blood tests done in the emergency indicated R1 had a cardiac event. V13 said it is difficult to say if being exposed to the cold environment caused the cardiac event but he went on to say R1 was attempting to climb over a fence when was found by emergency responders and the physical exertion of walking through the field and climbing the fence is more likely to have caused the myocardial infarction than the cold environment. V13 said R1 is confused and requires supervision. V13 stated it is not safe for R1 to be in the cold or unsupervised.

The national weather service website showed on November 29, 2018 from 5:55 AM to 8:15 AM during the hours
R1 was outside of the facility the temperature was 27 degrees Fahrenheit in Mt. Carroll.

The facility's policy and procedure for elopement with revision date of April 2016 showed the purpose of the policy to "assess and identify residents at risk for elopement ...to minimize risk for elopement through individualized interventions ...to provide protection for residents at risk for elopement." The policy showed, "all residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. Each location will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. The policy defines elopement as, "When a resident who needs supervision leaves

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S9999	Continued From page 8 the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so." R1's electronic care plan initiated on November 20, 2018 for potential for elopement related to history from prior facility and last revised on November 26, 2018 showed a goal of "resident will not leave facility unattended" with interventions to include: attempt non-pharmacological interventions, offer hot chocolate, watch TV in fireplace area and personal alarm (wander guard) used to alert staff to resident's movement and to assist staff in monitoring movement. (A)	S9999		