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. NH19-S0041

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 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 January 03, 2019, at Parkview Home - Freeport, 1234 South Park Boulevard, Freeport, Illinois 61032. On February 27, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Sheltered Care Facilities Code, 77 Ill. Adm. Code 330 (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.

PLAN OF CORRECTION

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 **$ 1,100.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 330.1120a.

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
Attn: Sammye Geer
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 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 Regulations

Dated this 27th day of February, 2019.

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

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 27th day of February, 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 01/03/2019

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 Facility Reported Incident of 12/30/18 IL108347	S 000		
S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 330.1120a) Section 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure personal attention and care was given in order to ensure resident elopement did not occur. This applies to 1 of 3 residents (R1) that were reviewed for safety and supervision in the sample of 3. The findings include: R1's Elopement Assessment dated 12/18/18 shows R1 is at high risk for elopement. R1 is physically able to leave the building on her own or follow someone exiting the building, disoriented to place, has impaired decision making, has a diagnosis of dementia, has symptoms of delirium or delusions, displays persistent anger at family, staff, current placement or other residents, has a history of exit seeking, and has a current behavior	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

of exit seeking.

R1's MDS 2.0 (Minimum Data Set) dated 12/26/18, shows R1 wanders-moved with no rational purpose, seemingly oblivious to needs or safety and has short and long term memory problems.

R1's Service/Functional Assessment dated 3/14/18, shows, "resident wanders and loses sense of direction...Resident/Family Concerns: Safety-due to dementia, getting lost inside the building or getting out of the doors and getting lost."

R1's Physician Order Sheet for 1/1/19-1/31/19 shows R1 was admitted to the facility on 8/25/18 with diagnoses including: hypertension, reflux, dementia with mild memory loss, and osteoarthritis.

R1's Communication Order Sheet date 12/5/18 shows, "resident striking out at staff, barricading staff in her room, pounding on glass windows to get out..."

R1's current care plan shows "Safety: wanderguard (device used to monitor if a resident exits the door) on walker, do 1/2 hour checks... (R1) has a diagnosis of dementia/Alzheimer's and will have behaviors on occasion. (R1) will wander and ask to go outside and try to leave the facility. (R1) may climb into wardrobes, wander into other resident rooms, and try to barricade herself into her room...maintenance to fix window in staff bathroom so window can only open a crack....Admin to check on key pad entry for (employee) bathroom door and other doors such as the bathing/spa room, linen closet etc."

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S9999	Continued From page 2	S9999		

The facility's initial Report of Incident dated 12/31/18 shows, "Date of Incident: 12/30/18. Type of incident: Missing Resident-Memory care resident found a way to bypass locks and safety mechanisms on memory care employee restroom window. She broke out the screen and climbed out the window. When nurse checked on her she saw her outside of window. Police and fire department called to help encourage resident to come back into the building."

On 1/2/19 at 8:42 AM, V1 Administrator stated (V5) RN (Registered Nurse) called me. (V5) was the nurse on duty. R1 was in the employee restroom. (V5) checked on (R1) and saw her outside the window. 911 was called. The shade was opened in the bathroom, the window was unlocked and the screen was broke. At 8:58 AM, V3 CNA (Certified Nursing Assistant) said, "I got here at 5:15 PM. The Nurse told me (R1) was in the bathroom. (R1) had locked herself in the employee bathroom. The bathroom is supposed to be our employee bathroom, residents go to their rooms to use the bathroom. When the nurse went to the bathroom, the door was unlocked and the window was opened all the way, (R1) was outside across the parking lot. The nurse yelled my name and I went outside, (R1)was waving at the cars. It took the police 45 minutes to get here. (R1) was refusing to come back into the building. She wanted to go to the hospital but as soon as the ambulance guys got out the stretcher, she wanted to come back in the building." At 11:00 AM V5 said, on 12/30/18, (R1) was anxious and wandering around. V5 knew R1 was in the bathroom. V5 went to get R1 for supper and saw "the window was wide open, the screen was on the ground, and (R1) was running across the parking lot. I yelled for her to stop. 99% of the time I am on the unit by myself. (V3) ran outside

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S9999	Continued From page 3	S9999		

to stop (R1) from getting to the street. I called 911 and called upstairs for more staffing, then I went outside. (R1) uses the employee bathroom every once in awhile. We have a tool to unlock the door from the outside. (R1) has expressed verbally that she wants to leave." At 10:26 AM, V2 DON (Director of Nursing) stated she was not in the facility at the time of the incident. V5 called her and reported that (R1) went outside. "I heard she had gotten out through the employee bathroom. Residents do not typically use the employee bathroom. (R1) is a wanderer and sometimes stands by the door." At 8:58 AM, V4 LPN (Licensed Practical Nurse) said that (R1) has locked her self in the bathroom before. "When she locked herself in the bathroom before we got the tool to be able to open the door from the outside." At 9:30 AM, V7 Dietary Aid stated that residents don't use the employee bathroom. They would use their own bathroom in the room or the spa bathroom. At 9:39 AM, V6 CNA stated that residents don't use the employee restroom unless they just go in there by themselves.

On 1/2/19, an observation was made of the employee bathroom. The window was near outside ground level. There is a lock on the window easily unlocked. There is a clip on each side of the frame of the window that prevents the window from opening all the way but only needs to be pushed down in order to open window all the way. There is now a screw in one of the clips preventing it from being pushed down. The street was approximately 30-45 feet from the bathroom window. The street is busy.

The facility's Philosophy of Care Policy dated January 2017 shows, "Our memory unit is secured by a locked unit and monitored by a wanderguard system..."

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S9999	Continued From page 4 The facility's Policy and Procedure to Prevent Accidents dated 5/22/14, shows, "When it is determined a hazard or risk exists, specific interventions will be put in place to try to reduce a resident's risk of an accident." The Facility Missing Residents and Elopements Policy and Procedure not dated shows, "All residents are afforded supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk for elopement...residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: A code alert type safety device that will notify staff when the resident has attempted to leave the building or designated safety zone without supervision...staff supervision, either by visual contact or by video camera, of facility exits...unless otherwise identified in a plan of care, all residents who are at risk for safety concerns who leave the facility property shall be accompanied by a responsible party and shall sign the resident out of the facility on a resident sign out sheet." (B)	S9999		