DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PETERSEN HEALTH NETWORK, LLC, D/B/A, CHARLESTON REHAB & HEALTH CC, Respondent.	)))))))))	Docket No. NH19-S0053

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; 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 Charleston Rehab & Health CC, 716 Eighteenth Street, Charleston, Illinois 61920. On February 27, 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 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 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 FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$2,200.00,** as follows:

Type B 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, 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 "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. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

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 Regulation

Dated this 27th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. PETERSEN HEALTH NETWORK, LLC, D/B/A, CHARLESTON REHAB & HEALTH CC, Respondent.	)	Docket No. NH 19-S0053

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:	Marikay Snyder
Licensee Info:	Petersen Health Network, 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 27th day of February, 2019.

Sammye Geer
Administrative Assistant I
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
	IL6001358	A. BUILDING: _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CARE CENT	716 EIGHTEENTH STREET CHARLESTON, IL 61920

(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 Incident Report Investigation to incident of 12/15/18/IL108334	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d) 6) 300.3240 a) 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. Section 300.1210 General Requirements for Nursing and Personal Care d) 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001358	A. BUILDING: _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CARE CENT	716 EIGHTEENTH STREET CHARLESTON, IL 61920

(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
S9999	Continued From page 1	S9999		

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to physically stabilize a high fall risk resident (R1). This failure resulted in R1 sustaining a fracture of the left shoulder after falling out of a standard shower chair. R1 was one of three residents reviewed for falls in the sample of three.

Findings include:

On 1/2/19, V1 Administrator presented a Final Report Regarding Injury to resident (R1) which documents R1 experienced a fall on 12/15/18 in the shower room and sustained a fracture of the left humeral head. This report also documents R1 was transferred by staff from wheelchair to shower chair by mechanical lift. R1 was unhooked from the mechanical lift and began sliding in the shower chair and was gently lowered to the floor when R1's left arm got hung up on the armrest of the shower chair.

R1s diagnoses include: Lewy Body Dementia, Parkinson's Disease, Dementing illness with behaviors, Multi Infarct Dementia, and Agitation with psychotic features.

R1's Minimum Data Set (MDS) dated 12/11/18, documents R1 as not cognitively intact, totally dependent on two plus staff for transfers and showers, is not able to walk, is not steady, can only stabilize with staff assistance with surface to surface transfer between bed, chair and wheelchair, totally dependent with all ADL's (activities of daily living) including a mechanical lift for transfers, and uses a wheelchair with total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001358	A. BUILDING _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CARE CENT	716 EIGHTEENTH STREET CHARLESTON, IL 61920

(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
S9999	Continued From page 2	S9999		

staff assistance for locomotion.

R1's Care Plan dated 12/15/18, documents R1 is unaware of R1's safety needs related to Parkinson's Disease and advanced dementia. R1's care plan also documents R1 has current interventions that include reclining wheelchair for positioning due to lack of trunk control. This care plan documents R1 is unable to safely transfer or ambulate by self. This same Care Plan also states R1 is nonverbal and unable to follow verbal cues or directions, and ensure R1 is in an upright position and proper alignment while out of bed.

R1's Fall Risk Assessment dated 12/11/18, documents R1 is a high fall risk having decreased muscle coordination and loss of sitting balance. R1's Range of Motion Assessment dated 12/11/18, documents R1 as "serious" for mobility, functional ability, and mentation. On 1/3/19 at 12:00 PM, V5 MDS Coordinator stated "serious" means R1 is fully dependent on staff for care, cannot move self in wheelchair, and can't do anything for herself.

R1's Nurse's Notes dated 12/15/18, documents notified MD (medical doctor) V11 of left shoulder being swollen. V11 gave order for x-ray, results came back stating a humeral fracture and V11 gave a new order to put arm in a sling.

R1's portable x-ray report, dated 12/15/18 and electronically signed by V12, Medical Doctor documents the reason for the x-ray as: swelling, patient slid in the shower, and the impression is confirmed as a humeral head fracture of the left shoulder.

On 1/3/19 at 10:00 AM, V3 Certified Nursing Assistant (CNA) stated R1 was in a regular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001358	A. BUILDING _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CARE CENT	716 EIGHTEENTH STREET CHARLESTON, IL 61920

(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
S9999	Continued From page 3	S9999		

shower chair and there were no foot rests on the shower chair when R1 slipped out. V3 stated when R1 was sliding out of the shower chair, R1's left arm got caught between the left arm rest and the seat and V3 had to lift R1 up some to get R1's arm from being caught in the shower chair. V3 also stated R1 leans to the side when sitting up in the shower chair. V3 stated there is no specific chair care planned for R1's use in the shower. V3 stated R1 now has a shower chair that tilts back, has foot rests, is more narrow and there are grips in the shower chair.

On 1/3/19 at 10:51 AM, V4 Physical Therapy Assistant (PTA), stated no one in therapy assesses residents for shower chair use and R1 has never been assessed by PT for a shower chair.

On 1/3/19 at 1:00 PM, V5 Licensed Practical Nurse (LPN)/ MDS Coordinator (previous floor nurse) stated V5 is not sure the exact date R1 started using the tilt back wheelchair, but it was before V5 started as MDS Coordinator so it had to be the middle of 2016. V5 stated the tilt back chair was a nursing intervention. V5 confirmed R1 is in the tilt back wheelchair due to poor trunk control. V5 stated also stated, "(R1) would need a tilt back shower chair as well."

On 1/3/19 at 2:51 PM V2 Director of Nursing (DON), stated R1 should have been ordered a tilt back shower chair at the same time R1 was ordered a tilt back wheel chair.

(B)