DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PETERSEN HEALTH NETWORK, LLC, D/B/A, NOKOMIS REHAB & HEALTH CARE C, Respondent.	)))))))))	Docket No. NH19-S0089

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 18, 2019, at Nokomis Rehab & Health Care C, 505 Stevens Street, Nokomis, Illinois 62075. 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 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: 300.610a), 300.1210b), 300.1210d)5) 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)5) 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 14th day of March, 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:	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 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
	IL6006555	A. BUILDING _____ B. WING _____	R 01/18/2019

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NOKOMIS REHAB & HEALTH CARE CENTER	505 STEVENS STREET NOKOMIS, IL 62075

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S 000	Initial Comments First revisits to Complaint Investigation #1847316/IL107185 of 11/28/18 Annual Certification Survey of 12/13/18 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

300.610a)
300.1210b)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the

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medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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S9999	Continued From page 3 resident These requirements were not met as evidenced by: Based on interview, observation and record review, the facility failed to develop a resident specific pressure ulcer prevention plan, failed to identify, assess, monitor and treat pressure ulcers as ordered for 3 of 4 residents (R100, R300, R26) reviewed for pressure ulcers in the sample of 10. This failure resulted in R100's development of a pressure ulcer that was not identified by the facility until it was unstageable. This failure also resulted in R26's decline to an unstageable pressure ulcer. Findings include: 1.The Minimum Data Set (MDS), dated 12/11/18, identifies R100 as an 81 year old male admitted to the facility with diagnoses of Cerebral vascular Accident, Coronary artery disease and depression in part. The MDS document R100 to have moderate cognitive impairment and requires extensive assist of two for bed mobility and transfer. Hospital Discharge Instructions dated 1/3/19 on R100's readmission documents under Treatment Instructions "Monitor and keep heels elevated due to hx (history) of blisters." It also documents under Additional nursing home report patient info: "Condition of skin: Heels with old blisters-- heel protectors in place." The Nurse Admission Assessment, dated 1/3/19, documents R100 to have no skin issues of any type.	S9999		

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January 2019 Treatment Administration Records (TAR) document R100 a weekly skin check to detect any open areas or pressure areas last recorded on 1/9/19 and none recorded on 1/16/19. The notes document R100 was admitted to Hospice Services on 1/4/19.

The January 2019 Physician's order sheet has no orders for skin treatments and/or preventative measures for skin breakdown.

Nurses Notes reviewed from 1/3/19 through 1/10/19 had no documentation of any areas of concerns for R100 regarding his skin condition. As of 1/17/19, the last entry into the notes is dated 1/10/19.

On 1/17/19 at 9:30am, R100 was in his wheelchair at bedside. At 10:15am, R100 was transferred to bed. R100 was positioned on his back with the head of the bed slightly elevated. At noon, V6, Certified Nurse Aide (CNA), left R100 in the same position and rolled the head of his bed up slightly so she could feed him lunch. R100 then remained in the same position with 15 minute observation intervals until 2:25pm when a skin check was done. R100's heels were not elevated, but lying directly on the mattress. R100 was laying on two cloth incontinent pads and his feet were not elevated. R100's bilateral buttocks, hips and back had deep red/white creases noted throughout and his coccyx area was deep red. R100 was wearing slip on heel pads under his grippy socks. R100's right lateral heel had a large deep purple/red mushy area present with a small fluid filled blister area noted on one end of the discolored area. V5, CNA, stated R100 did not have heel pads on earlier and that the Hospice CNA must have put them on him. Neither CNA indicated at the time that they were

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aware R100 had the heel ulcer.

On 1/17/19 at 2:40pm, V8, Licensed Practical Nurse (LPN), stated she had not worked the hallway for the last 10 days and she was unaware of any type of skin problems with R100. V8 stated she would look at it and provide measurements.

On 1/17/19 at 3:10pm, V8 stated she measured the area as 1 cm (centimeter) x 0.5 cm. When asked what she measured since the area was larger than that, V8 stated she just measured the actual fluid filled blister and not the "discolored area." V8 stated she had informed the physician and a Tegaderm treatment was ordered.

On 1/18/19 at 7:20am, R100's heel was again observed to be mushy, deep tissue injury with a deflated blister area on one end. There was no tegaderm on R100's heel.

At 10:15am on 1/18/19, V2, Director of Nurses (DON), stated the Tegaderm order was not appropriate for R100 and she told the nurses to remove it last night. V2 stated she was going to reevaluate it herself again today, but agreed that it was unstageable and a deep tissue injury. V2 stated she received the Hospice Notes from the CNA visit from 1/17/19 am and confirmed that it did not refer to R100's heel ulcer. V2 stated the Hospice note from the nurse dated 1/15/19 also does not identify any ulcers to R100's heels.

On 1/18/19 at 1:32PM, V13, Nurse for V14 (R100's Physician), stated the doctor would expect them to monitor for skin issues, report it and to follow discharge instructions for heel bows.

The Care Plan, dated 1/11/19, documents the Problem/Need as "at risk for pressure ulcer per

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Braden Risk Assessment" with risk factors identified as "requires staff assist to help turn and position." The list fails to identify R100's history of heel blisters, but does document the ulcer found on 1/17/19 as a "reddened area noted to R (right) posterior heel." Interventions include: off load pressure to areas of concern, assess skin - if open or bruised areas noted, report to MD (Medical Doctor) and responsible party, Skin check daily during cares and during bath/showers, with no interventions added regarding his heels until 1/17/19 when "float heels when res (resident) allows" in part was added.

Nurse Notes, dated 1/18/19 entered by Hospice, documents R100's heel ulcer measured 3cm x 2cm with an area of dark inside it measuring 1cm x 2cm. No other measurements were documented by the facility.

On 1/18/19 at 3:00PM, V14, R100's Physician, stated that he doesn't remember being notified on yesterday's date in reference to R100's pressure ulcer. V14 also stated he relies on the home to make their own prevention measures and that he hasn't seen R100 since he returned to facility. When asked if R100's pressure ulcer should have been identified by the facility before it was unstageable, V14 stated he didn't know the facility's policies, but he would expect them to follow them.

2. The Admission Record documents R300 as an 81 year old male admitted to the facility on 1/11/19.

Hospital Discharge Instructions, dated 1/11/19, document R300 to have a "evolving" pressure ulcer on his left buttock described as "non-intact, shallow ulcer stage 2 no depth, no slough" with a

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scant amount of serous drainage with no odor. The treatment was foam dressing.

Labs, dated 1/11/19, document R300 to have a low Albumin of 2.8 (normal 3.5-5) and a normal Total Protein of 7.1 (normal 6.5-8.5).

Admitting Orders included an order for treatment to the left buttock daily and PRN (as needed) cleanse with wound cleanser and apply Allevyn Foam, change dressing daily and "skin checks daily." There were no orders for R300 to receive any Protein Supplement.

On 1/17/19 at 9:55am, R300 was sitting in his wheelchair at the nurses station and stated he did not have a treatment on his buttocks and hasn't had one on for the last 24 hours. R300 stated the area was about closed. R300 remained in his wheelchair for the remainder of the morning and during lunch with observations being done on 15 minute intervals.

On 1/17/19 at 12:25pm, R300 requested to use the urinal and be transferred to his recliner. R300 had no dressing on his buttock pressure ulcer which was small, round and beefy red. He was transferred to the toilet then to his recliner. No treatment was put on it.

The January 2019 TAR documented no treatment done on 1/16/19.

On 1/18/19 V8, LPN, stated at 12:35pm that R300 refused his treatment and therefore they didn't do it.

On 1/18/19 at 10:45am, R300 stated he never refused his treatment, but he did tell the nurses that they were not very comfortable given the

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location of the ulcer. R300 stated the nurses would tell him that he needed it to be put on and he would allow it. R300 stated on the day before yesterday, they didn't have the treatment to put on and they just let it go. R300 stated the ulcer was painful in the beginning and was from him sitting in one position too long.

The Interim Care Plan, dated 1/11/19, documents R300 to require the assist of two staff for transferring, but includes nothing regarding his pressure ulcers and his need to reposition.

The Braden Scale, dated 1/11/19, identifies R300 as only at moderate risk for developing pressure ulcers even though he was admitted with one and currently has one.

3. R26 has a admission date of 12/7/2017 with the following diagnosis; incisional hernia, dementia, hypertension, impaired mobility & activities of daily living (ADL), confusion, benign colon polyp, depression, dermataphytasis, edema, hyperglycemia, hyperlipidemia, lumbar cancal stenosis, osteoarthritis, TIA, pathologic fracture of vertebral, urinary incontinence and vertebral compression.

R26's MDS, dated 11/06/18, documents a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment. R26's MDS also documents that R26 is dependent on two staff assistance for all ADL's, is frequently incontinent for urine and occasionally incontinent of bowel.

On 01/17/19 from 1:10 PM to 3:30 PM, R26 was observed lying on the left side lying position. R26 was very restless and rolling her bed linens into knots. At 3:30 PM, a skin check of R26 was done

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with V6, CNA. When R26 was rolled to the right side, a loose dressing was observed on the left hip. There was red edematous skin surrounding the dressing.

On 01/18/19 from 8:30 AM to 9:50 AM, R26 was observed up in her wheelchair sleeping in the hallway. At 9:50 AM, V5 and V9, CNA's, were observed during transfer and incontinent care for R26. When R26 was rolled to the right side lying position, the dressing on the left hip was dangling only taped on one end. An open unstageable pressure ulcer was observed with a black center surrounded by a layer of yellow slough and reddened edematous outer edge. The open area was approximately 3 cm x 3 cm. The dressing had a small amount of bloody drainage.

On 01/18/19 at 10:05 AM, V10, LPN, performed wound care for R26. V10 had said prior to the procedure that the orders are for every three days and it had been replaced yesterday (01/17/19). V10 removed the dressing and V2, DON, was present and said to not put skin prep on until after she spoke with the doctor about the change in the condition of the pressure ulcer.

R26's Physician Order Sheet, dated 12/29/18, documented a telephone order, "Apply duoderm left hip change every three days and as needed (prn) until healed."

R26's Wound Evaluation and Management Summary, dated 12/31/18, documented the left hip pressure ulcer was unstageable and measured 1 cm x 1 cm. It documented treatment plan of hydrogel and Gauze Island with border foam once daily for 30 days.

R26's Wound Summary, dated 01/15/19,

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	IL6006555	A. BUILDING: _____ B. WING _____	R 01/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOKOMIS REHAB & HEALTH CARE CENTER	505 STEVENS STREET NOKOMIS, IL 62075

(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 10	S9999		

documented the pressure area had improved and new orders to apply skin prep with foam dressing every three days.

R26's Wound Summary, dated 01/18/19, documented the pressure area had not changed since 12/31/18 and to keep the same order of hydrogel and gauze island border foam.

The Treatment Assessment Record (TAR) for R26 documented the area had dressing changes daily, even though the new order was for every three days. There are no measurements or documentation on the TAR describing the left hip pressure ulcer. There are no nurse's notes that describe what the area looked like on initial assessment.

The care plan, dated 05/04/18, documented under high risk for pressure ulcer development a Braden score of 12 with risk factors including impaired mobility and prolonged sitting. It also documented R26 was often unable to communicate discomfort other than moaning or increased restlessness.

R26's lab report, dated 8/17/2018, documents in part; Protein L 5.8 g/dl (normal range 6.4-8.9g/dl) and Albumin, Serum L 3.3 g/dl (normal range 3.5-5.7g/dl).

The facility's plan of correction with the completion date of 1/11/2019 documents in part: "The following systematic measures have been implemented to ensure the alleged deficient practice does not recur. The DON/Designee will conduct random observations of licensed staff performing treatments to ensure proper identification, assessment, treatment and monitoring of skin conditions. The DON/Designee

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S9999	Continued From page 11 will conduct random checks of TARs to ensure proper treatments as ordered." The Facility's policy/procedure entitled Pressure Ulcer Prevention Guidelines, dated 1/2018, documents the policy as: It is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. The interventions include turn and reposition every two hours, range of motion, incontinence care, and care plan entry for both risks. For High risk, a special mattress will be put in place along with daily skin checks. (B)	S9999		