IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 11, 2019

Marilyn Dunn, Registered Agent
PA Peterson at The Citadel, LLC
55 West Monroe Street, STE 2400
Chicago, Illinois 60603

RE: Complaint #: IL00107184
Survey Date: November 13, 2018
Docket #: 18-C0536
Violation Type: Level A

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as PA Peterson at The Citadel.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
PA Peterson at The Citadel/November 13, 2018//RegAgent/S.Geer

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: PA PETERSON AT THE CITADEL COMPLAINT #: 0107184
LIC. ID #: 0054635
DATE COMPLAINT RECEIVED: 11/08/18 11:24:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
409	POLICY AND PROCEDURES	2

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PA PETERSON AT THE CITADEL, LLC, D/B/A, PA PETERSON AT THE CITADEL Respondent.	)))))))))	Docket No. NH 18-C0536

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 Complaint IL0107184 Investigation conducted by the Department on November 13, 2018, at PA Peterson at The Citadel, 1311 Parkview Avenue, Rockford, Illinois 61107. On January 10, 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 PA Peterson at The Citadel, 1311 Parkview Avenue, Rockford, Illinois 61107 on July 01, 2018. The Facility's current license number is 0054635. The term of the conditional license shall be from February 10, 2019 to August 09, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBUARY 10, 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
P.O. Box 4263
Springfield, Illinois 62708

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 11th day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. PA PETERSON AT THE CITADEL, LLC D/B/A, PA PETERSON AT THE CITADEL Respondent.	)))))))))	Docket No. NH 18-C0536

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:	Marilyn Dunn
Licensee Info:	PA Peterson at The Citadel, LLC
Address:	55 West Monroe Street, STE 2400 Chicago, Illinois 60603

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 11th day of January, 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
	IL6007041	A. BUILDING: _____ B. WING _____	C 11/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA PETERSON AT THE CITADEL	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

(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 IL#107184/1817313 Statement of Licensure violations	S 000		
S9999	Final Observations 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/26/18

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S9999	Continued From page 1 These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise a resident at high risk of falls to prevent repeated falls. This failure contributed to R1 falling out of bed and sustaining bilateral leg fractures. This applies to 1 of 3 residents (R1) reviewed for falls in the sample 3. The findings include: R1's face sheet shows R1 was admitted to the facility on January 22, 2018 and has diagnoses that include: chronic kidney disease stage 4 (severe), major depression, and hypertension. R1's electronic medical record (EMR) showed that R1 has a moderate cognitive deficit. The EMR showed that R1 had unsteady gait and required extensive assistance of at least one staff for bed mobility, transferring in and out of bed and the wheelchair, and required the use of a walker for additional support to transfer or ambulate. R1's February 4, 2018 Fall Scale (fall risk assessment), showed that R1 had fallen before, had a weak balance, forgets her limitations, and was a high risk for falls. R1's September 10, 2018 nursing progress note shows that R1 was exhibiting behaviors of transferring herself in and out of the wheelchair without assistance and becoming combative with staff. R1's September 16, 2018 nursing progress note shows that R1 was having increasing delusions and she was requesting to move out of	S9999		

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S9999	Continued From page 2	S9999		

the facility. R1's September 18, 2018 nursing progress note shows that R1 was "very confused" refused her medications, was being monitored closely in the dining area, and was started on an antibiotic for a urinary tract infect infection.

R1's September 22, 2018 1:22 PM nursing progress note shows that R1 was stating that she wanted to go home and was given Lorazepam (anti- anxiety) medication for anxiety/agitation. R1's September 22, 2018 2:20 PM progress notes show that R1 had fallen out of her wheelchair and was observed on the floor in the common area and had sustained a laceration to the left side of her head. R1's progress note shows that the facility's restorative manager was notified of R1's fall.

On November 13, 2018 at 10:10 AM, V17 Registered Nurse (RN) and V18 Licensed Practical Nurse (LPN) stated R1 had been increasingly agitated the week leading up to her fall. R1 had a urinary tract infection, and as a result they were having R1 stay in the dining area for closer supervision and she should not be left alone in her room. V17 stated she called the facility's fall prevention nurse after the fall on September 22, 2018.

On November 13, 2018 at 11:40 AM, V6 (fall prevention nurse) stated that he was notified of R1's September 22, 2018 fall and he asked hospice to get R1 a low reclining wheelchair that will help with trunk support. V6 stated that he recommended that R1 be supervised and not left in her room alone if she was awake.

R1's September 24, 2018 3:24 PM nursing progress notes show that V17 (RN), was called into R1's room by a CNA and, "observed patient

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S9999	Continued From page 3	S9999		

(R1) lying on her left side on the floor, alert and responding verbally, noted left leg twisted and discolored (2 days after the previous fall). Patient complained of pain to the left leg. Noted resident's bed in the highest position and bed remote on top of the bed ..." R1's progress note shows 911 was contacted for transport and R1 was sent to a local community hospital.

On November 13, 2018 at 2:15 PM, V17 (RN) stated that before R1 had the change in behaviors R1 would sometimes lay down in the afternoon. During the period when R1 fell between the first and second time R1 was supposed to be monitored and not to be left alone. V17 stated that a hospice CNA had come into the facility and had given R1 a bath that afternoon in her room and left R1 in her room unsupervised. V17 stated "as far as I know the hospice CNA knew about R1's behaviors, I don't know what possessed the hospice CNA that day to leave her laying down in bed. I didn't know she was in bed ..." V17 said she found the resident on the floor with the bed in the highest position and the bed controller dangling on the side of the bed.

On November 13, 2018 at 2:25 PM, V18 (LPN) stated "I was so upset that day when she fell, the hospice CNA should have told us she was lying her down. We would have told her not too lay her down because, she (R1) was not taking naps then. She (R1) was too upset and trying to get up on her own ..."

On November 13, 2018 at 11:40 AM, V6 (fall prevention nurse) stated the hospice CNA should not have left her (R1) alone in her room that day of the fall on September 24, 2018. V6 said that sometimes when residents have urinary tract infections it can cause them to be even more of a

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S9999	Continued From page 4	S9999		

fall risk.

On November 13, 2018 at 12:45 PM, V2 Director of Nursing (DON) said that she was in the building on September 24, 2018 when R1 had the second fall. V2 said that a hospice CNA had given R1 a bed bath and did not tell anyone that she left R1 alone in bed. V2 said when staff found R1 the bed was raised all the way up and it was not typical of R1 to maneuver the bed remote controller herself. V2 said that R1 had a urinary tract infection and was even more confused in the days prior to the fall.

On November 13, 2018 at 1:45 PM, V19 Certified Nursing Assistant (Hospice CNA) stated that R1 was having issues and was very upset the day of the fall on September 24, 2018. V19 said she gave R1 a bath and left her in her room alone in bed with the bed remote controller out of R1's reach. V19 stated that she was unaware that R1 was not supposed to be in her room alone.
R1's September 24, 2018 History and Physical (H&P) from a local community hospital showed that R1 presented to the Emergency Room (ER) after a fall for evaluation. R1 was noted to have bilateral femur fractures, and orthopedics was consulted. R1 was sent to the operating room for a surgical procedure. The H&P showed that the facility reported to them, "The patient (R1) fell out of her bed while it was at the highest position..." The H&P showed that (R1's) Prognosis is poor and guarded.

R1's September 24, 2018 Radiology report showed R1 was admitted to the hospital following a fall from bed, at a nursing facility and had distal femur fractures to both of her legs. The report showed "Markedly comminuted (break or splinter of the bone into more than two fragments) and

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S9999	Continued From page 5 angulated (the normal position of the bone has been altered) as well as displaced (the bone breaks and moves so that the two ends are not lined up straight), and mildly impacted fracture of the left distal femur ..." and "comminuted, displaced and angulated fracture of the right distal femur..." R1's care plan shows that R1 was a high risk for falls. R1's Care Plan shows that on September 22, 2018 an intervention was added to keep R1 in a highly visible area when awake in chair. R1's care plan shows that a floor mat, and room checks every 30-60 minutes, were not added until September 24, 2018. R1's Care Plan shows that on October 2, 2018 (9 days after R1's first fall), and after R1's second fall, an intervention was added to not leave resident alone in room while awake. R1's nursing progress notes show that R1 returned to the facility on October 1, 2018 and is now not able to bear weight, and requires the use of a mechanical lift for all transfers. (A)	S9999		