IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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

January 29, 2019

Michele Bush, Registered Agent
Niles Nursing and Rehabilitation Center, LLC
240 Fencl Lane
Hillside, Illinois 60162

RE:	Complaint #:	IL 107436
	Survey Date:	November 27, 2018
	Docket #:	18-C0545
	Violation Type:	A Violation with Fine

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 Niles Nursing & Rehab Center.

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
Niles Nursing & Rehab Center/November 27, 2018/18-C0545/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: NILES NRSG & REHAB CENTER COMPLAINT #: 0107436
LIC. ID #: 0050088
DATE COMPLAINT RECEIVED: 11/20/18 12:31:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
211	SAFETY PROBLEMS	1

✓ 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,	)	Docket No. NH 18-C0545
v.	)	
NILES NURSING AND REHABILITATION CENTER, LLC, D/B/A, NILES NURSING & REHAB CENTER Respondent.	)	

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 Investigation conducted by the Department on November 27, 2018 at Niles Nursing & Rehab Center, 9777 Greenwood Avenue, Niles, Illinois 60714. On January 24, 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 Niles Nursing & Rehab Center, 9777 Greenwood Avenue, Niles, Illinois 60714 on January 7, 2019. The Facility's current license number is 0050088. The term of the conditional license shall be from February 24, 2019 to August 23, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 24, 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: 300.610a), 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 Regulations

Dated this 29th day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. NILES NURSING AND REHABILITATION CENTER, LLC, D/B/A, NILES NURSING & REHAB CENTER Respondent.	)	Docket No. NH 18-C0545

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 Plan of Correction Required; 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:	Michele Bush
Licensee Info:	Niles Nursing and Rehabilitation Center, LLC
Address:	240 Fencl Lane Hillside, Illinois 60162

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 29th day of January, 2019.

Sammye Geer

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

AFCI300/18-C0545/Niles Nursing & Rehab Center/November 27, 2018/kk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003644	A. BUILDING: _____ B. WING _____	C 11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NILES NSG & REHAB CTR	9777 GREENWOOD NILES, IL 60714

(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 Complaint Investigation #1897549/IL00107436	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain the functionality of the alarm system by staff immediately disarming the emergency alarm that alerts all staff of an elopement. This failure resulted in the facility failing to maintain resident safety by not alerting staff of elopement and preventing the elopement of a newly admitted resident. The facility further failed to immediately act to search for the resident who wandered off unsupervised resulting in the resident (R1) sustaining multiple injuries and fractures then emergently transferred to the hospital ER for treatment. This failure affects one (R1) of four residents reviewed for dementia with wandering behaviors in a sample of four residents.

Findings include:

R1 is a 90 year old admitted on 11/17/18 with diagnoses Dementia, Low back and shoulder pain, Age-related Osteoporosis, and recurrent Depressive Disorders.

Nursing progress notes dated 11/17/18 written by V5 (RN-Registered Nurse) states, "Patient is new admitted from other nursing home to here at 1 PM with son. Pt is not used any assist devices. Steady and balanced gait. Alert and Oriented x

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2-3 forgetful. Korean speaks better, Diagnosis: low back pain , Right shoulder pain, Cervicalgia, spondylolisthsis lumbar region, osteoporosis without fracture, Dementia, Depression. Dining room at 1st main. vitals taken. Called attending doctor and left message. Continence on both B/B. Faxed hard script for Oxycodone and Fentanyl patch to pharmacy. Assist pt at time. Endorse to next nurse. Will give PPD at evening shift.

Nursing progress notes written over eight hours later by V3 (RN) at 9:33 PM states,"Incident note: Resident left building exit setting off facility alarms. Search was conducted. Police notified. Medical director notified. Son is aware. Resident currently at hospital as he sustained a fall in the community."

Interview with V9 (weekend receptionist) on 11/21/18 at 1:23 PM states, "I was with V8 (CNA-Certified Nurse's Aide) at the reception desk. V8 was looking at his schedule which is posted at my desk. We were monitoring (R1). I saw the resident come back in the building from the yard. It was cold and he was wearing only a sweater and sweat pants. He went back inside from the backyard entrance. All of a sudden he disappeared from the security camera around 5:50 PM. It was dark outside already. The emergency alarm rings in the front at my desk. I told V8 to go look for him. 3-5 minutes pass and I got a bad feeling so I called V3 (Weekend Nursing Supervisor) and told her we might have a resident that left the building. I decided to call a code purple (missing resident). We continued to monitor the situation and we had called every floor.

Asked if the emergency alarms go off on the floors, V9 stated, "No just at my desk. I turned

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them off right away because V8 was standing there and I just told him to go out back and look."

Asked what he was supposed to do when the emergency alarms go off, V9 stated, "I'm supposed to call a code green, It's when a resident escapes. I know I didn't but I thought he (R1) might have just gone back upstairs."

Asked if a code green was ever called so that staff would immediately come down to search outside, V9 stated, "Well they started later after doing the code purple and about six CNA's'. came down to look for him on the main level."

Asked when the staff went outside to conduct the search, V9 stated, "I guess it was 30-40 minutes later. V9 went outside this time and walked around the building but didn't see R1 but by then we got a call from the hospital saying (R1) was there."

Facility's undated policy titled "Resident elopement and missing resident policy" states, "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken. Procedure: In the event of resident elopement, every reasonable effort will be made to return the resident to the unit. The following will be implemented: A. Code Green will be announced with the exit door that the resident has used. (This also includes all instances of an exit door alarm that goes off and there is nobody seen exiting through that exit door.) B. Staff must respond to the code and go to the exit location that was announced. If a resident is found and redirected back inside, then Code Green will be canceled by announcing

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"Code Green all Clear", If there was no resident upon searching outside, then proceed to C: Do head count and make sure all residents on your floor are accounted for. D. When all residents are accounted for, Code, Green will be canceled.

Missing Resident Procedure: Code Purple is initiated on the overhead paging system to alert staff of a missing resident. Contact administrator or designee and Director of Nursing or designee immediately. Initiate coordinated, organized search of the facility grounds, maintain on to two people on each unit to attend to resident's needs during the search. If the resident is not located after the building and the grounds have been searched, call in other department heads, the responsible party or POA, physician, and the police and expand the search to the local neighborhood. Search the facility and the grounds again.

Interview with V8 at 11/21/18 at 11:15 AM states, "He's a new resident (R1). I came around 3 PM when my shift starts and went to the dining room around 5 PM and served the food tray to (R1) I was assigned to. I saw him in the day room up to 5:50 PM. I took all the meal trays and cart to the kitchen door. I redirected (R1) to the elevator then I went to the reception desk and checked my schedule. At that time (R1) came back to the reception area. Then he went outside the patio doors to the yard and V9 saw him on camera."

Asked what it was like outside, V8 stated, "It was cold out and already dark outside."

Asked what R1 was wearing V8 stated, " He was wearing a T-shirt and pants so he went back inside the other door. I went to check and R1 wasn't there. I didn't hear the emergency alarm.

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There is no alarm here (at security door) just at the desk. I then went upstairs and told my nurse and another CNA that I was going outside to look. I searched for 10-15 minutes probably starting around 6:30 PM."

Asked to show surveyor the security door (R1) exited from, V8 walked out to the patio and back inside the back of the building and to the security door in question. On the security door read a sign saying "door alarmed". V8 opened the door but no alarm rang.
Asked about this, V8 stated, "I don't know sir, I think it just rings in the front (reception)."

Interview with V5 (RN) on 11/21/18 at 11:30 AM states, "I admitted (R1) around 1:00 PM. I went with V6 (RN) because I don't speak Korean. I did a head-to-toe assessment and I checked his gait and he walked by himself with a steady gait. He seemed aware and I did an elopement assessment and he was ok. He was pretty much calm."

Asked if she heard any alarm go off when R1 triggered the security door, V5 stated, "No."

Asked if she went outside to do a search, V5 stated, "I didn't go".

Asked if she was responsible for supervising R1, V5 stated, "Yes, he was my resident."

On 11/21/18 at 11:45 AM, V1 (Administrator) was asked to show surveyor where R1 exited the building, V1 showed the back exit doors and opened the door for the surveyor. A loud shrieking alarm and flashing strobe lights went off and numerous staff came down the back of the stairs.

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S9999	Continued From page 6 Asked why the same alarm did not go off during V8's demonstration earlier, V1 stated, "Receptionist must have turned them off." Interview with V6 (RN) on 11/21/18 at 12:11 PM states, "I helped assess (R1). He was alert, spoke Korean and he knew who he was. He had diagnosis of dementia but he was not on our locked unit. Asked if she helped search for R1 outside, V6 stated, "No. There was no alarm but I did a head count on the floor and we couldn't find him." Interview with V1 (Administrator) on 11/26/18 states, "We immediately suspended V9 pending the investigation of this incident and he has now resigned his post. (V9) worked only weekends and was PRN (as needed) basis. This should not have happened. We have installed new alarms and now they ring at all security doors so the receptionist cannot just turn off the emergency alarm." V1 added, "We've been conducting regular tests and in-services but I see we still need some more work." Interview with V12 (Physician) on 11/26/18 at 12:30 PM states, "I got paged that day but I was told of a new admission but that he was already in the ER. I found this out late in the evening probably around 9 or 10, I'm not sure. Sometimes it is hard for me to hear my pager when I am in the hospital you know." Asked to comment about the elopement, V12 stated, "This should not happen but family is usually with resident when they are new and should have stayed with resident."	S9999		

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S9999	Continued From page 7 Asked to clarify statement as to who should stay with the resident, V12 stated, "This happens a lot (elopements). I see it everywhere." Asked how a 90 year old could leave a facility unnoticed, V12 stated, "I don't know, you have to ask administration. He cannot walk fast so I don't know how it happened." Hospital radiology reports 11/17/18 shows, "Findings: Right prefrontal hematoma without underlying calvarial fracture. Minimally displaced left lateral orbital wall fracture. Minimally displaced left inferior orbital floor/rim fracture and left zygomatic arch fracture. Minimally displaced left anterolateral maxillary sinus wall fracture. Fracture of the medial left maxillary sinus wall. Mild bilateral periorbital hematomas. Right prefrontal scalp; hematoma without underlying calvarial fracture." Hospital consultation reports dated 11/21/18 shows, "Consultation: obtained from the medical record. Patient does not follow commands. (R1) is a 90 year old male with dementia who presented as a trauma after he was found wandering the streets with cutaneous manifestations of facial trauma. He lives in a nursing home and per report he left unsupervised. He was transferred due to concerns for unwitnessed fall and signs of facial trauma. He was evaluated in the ED. CT of the face revealed multiple facial fracture for which Plastic Surgery is consulted for definitive management. Ophthalmology is also at the bedside at the time of my evaluation. CT of Head: Extensive intracranial atherosclerosis and moderate intracranial small vessel ischemic disease. Mild to moderate bifrontal temporal volume loss. Large right	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NILES NSG & REHAB CTR	9777 GREENWOOD NILES, IL 60714

(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 8 prefrontal scalp hematoma without underlying calvarial fracture. Left inferior orbital floor/rim fracture. Minimally displaced fracture anterolateral left maxillary wall. All fractures non-operative. While argument may be made for reducing the left zygomatic fracture, given patient's age, I would not recommend any intervention. Appreciate ophthalmology evaluation of the globes bilaterally. Plan of care relayed to Surgery Service. Plastic surgery to sign off. Eye consult: Patient has history of trauma to left side of head with orbital floor fracture being followed by plastics. He is not able to open either eye because of lid swelling." (A)	S9999		