DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. MIDWEST HEALTH OPERATIONS, LLC, D/B/A, SAUK VALLEY SENIOR LIVING, Respondent.	)))))))))	Docket No. NH18-S0540

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 November 9, 2018, at Sauk Valley Senior Living, 1000 Dixon Avenue, Rock Falls, Illinois 61071. On January 7, 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), 300.1220b)3) 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) 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 "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 Regulations

Dated this 8th day of January ,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 Plan of Correction Required; 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:	Midwest Health Operations, LLC
Address:	830 W. Trailcreek Drive Peoria, Illinois 61614

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 8th day of January, 2019.

Sammye Geer

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
	IL6001929	A. BUILDING: _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUK VALLEY SENIOR LIVING	1000 DIXON AVENUE ROCK FALLS, IL 61071

(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 FRI of 10-28-18/IL107162	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 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 resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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) These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to protect a resident from abuse. This failure resulted in R2 feeling angry and embarrassed. This applies to 1 of 3 residents reviewed for abuse in the sample of 8. The findings include: The facility abuse investigation for the incident on	S9999		

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October 28, 2018 shows R2 alleged that R1 touched her inappropriately while riding the bus to church. This form shows it was reported by the church that provided transportation for R1 and R2 on October 29, 2018.

The November 2018 Physician Order Sheet (POS) for R1 shows a diagnosis of Multiple Sclerosis and impaired balance. The March 8, 2018 Minimum Data Set assessment (MDS) for R1 shows him to have moderate cognitive impairment.

The November 2018 POS for R2 shows her to have a diagnosis of schizoaffective/bipolar type, PTSD and muscle weakness. The August 7, 2018 MDS for R2 shows her to be cognitively intact.

On November 8, 2018 at 8:58AM, R2 was sitting alone outside and when this surveyor approached R2 to ask her some questions R2 responded by saying she could not believe she had to retell the story again. R2 said she was riding on the bus to church when R1 started to unzip her jacket and then fondled her breast and chest area. R2 said that R1 then grabbed her hand and placed it on his crotch. R2 said she told the people at the church and then when she got back to the facility she told the activity lady and the nurse what had happened. R2 said she felt very angry and embarrassed by what happened.

On November 8, 2018 at 8:45 AM, R1 said he did touch R2's breast and took her hand and put it on his penis. R1 said he was not sure why he did but it was a mistake to do it.

On November 8, 2018, at 9:03 AM, V4 (Activity Director) said she had called V1(Administrator in

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Training) on Sunday October 28, 2018 about R2 telling her that R1 attempted to touch her while on the church bus and V4 was told to keep an eye on R1 and keep the two residents separated.

On November 8, 2018, at 10:55 AM, V7 (CNA/Certified Nursing Assistant) said R1 has been known to touch female residents inappropriately and staff. V7 said that is why he is on 15 minute checks and staff never go into his room alone.

On November 8, 2018, at 10:40 AM, V2 (RN/Registered nurse) said R1 has a history of inappropriate comments that are sexual in nature. V2 said she has heard that R1 has inappropriately touched female peers. V2 said R1 is on 15 minute checks while in his room, and must be escorted out of his room and watched at all times for awhile now.

On November 8, 2018, at 12:30 PM, V3 (LPN/Licensed Practical Nurse) said she was working the day R2 came home from church and said, "This is bullsh**; I can't even go to church without getting sexed up." V3 said she was told by V4 (Activity Director) that R2 said R1 touched her breast and took her hand and placed it on his penis. V3 said R1 has a history of being inappropriate sexually with female residents and staff.

On November 8, 2018, at 1:35 PM, V8 (Dietary Aide) said R1 told her he got into trouble while on the bus but R1 wished it had been V8 he got in trouble with rather than the other woman.

On November 8, 2018, at 10:46 AM, V5 (Social Service Director) said R2 told her on Sunday that R1 tried to touch her. V5 said R1 has been on 15

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minute checks for a long time due to sexually inappropriate remarks to staff and because of an issue regarding another female resident's invasion of personal space.

On November 8, 2018 at 9:08 AM, V1 (Administrator) said R1 has been on 15 minute checks and gets constant supervision when out of his room since sometime in 2017. V1 said the need for this supervision is to make sure he is in his own room and not in other resident's space. V1 said R1 has made inappropriate comments to staff. At 2:29 PM, V1 said the facility team felt it was best to leave R1 on 15 minute checks all this time due to R1's history of inappropriate touching and comments to female peers and staff. V1 said the facility felt it was ok for R1 to leave the facility for church because the church would be responsible for him. V1 said she did not know if the church was aware of R1's history of inappropriate touching and his need for constant supervision while in the facility.

On November 9, 2018, at 11:00AM, V9 (Pastor from church) said he was not aware that R1 was on any special precautions for observation of his behavior.

The Nursing progress note for R2 shows on October 28, 2018 R2 returned from church and said R1 had unzipped her coat and fondled her breasts and upper body, then took her hand and placed it on his genitals while on the bus. R2 said she told him to stop several times. The note also shows the nurse tried to call the church with no answer and the social service director who was in the building was told of the allegation and a message was left for the administrator in training.

The facility abuse investigation shows an

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interview with R2 and she reported that she did not feel comfortable telling R1 to stop becasue she had been abused by her brother.

The care plan intervention for R1 dated September 22, 2017 shows resident is on 15 minute checks when in room and close frequent monitoring when in public areas due to noncompliance with personal space towards peers. The care plan last reviewed on September 26, 2018 for R1 shows he will be escorted to meals/activities. Staff will remain with him when in public areas and two staff present during any interaction.

A Physician progress note dated July 11, 2018 shows R1 to have a big problem with behavior. The note shows the need to isolate R1 due to his inappropriate behavior with other residents.

The social service note dated October 4, 2017 shows R1 was placed on 15 minute checks while in his room and when out in public areas; frequent observation to maintain his where about at all times due to continued non-compliance with personal space towards female peers.

The facilities Abuse Prevention Program policy dated 2/2018 shows the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property and exploitation. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by: training on what constitutes abuse, identifying occurrences and patterns of potential mistreatment, exploitation, neglect, abuse of residents and making the necessary changes to prevent further occurrences.

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