IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 25, 2019

Marikay Snyder, Registered Agent
Midwest Health Operations, LLC
830 W. Trailcreek Drive
Peoria, Illinois 61614

RE: Complaint #: IL 107502
Survey Date: November 28, 2018
Docket #: 19-C0008
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 Sauk Valley Senior Living.

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
Sauk Valley Senior Living/November 28, 2018/19-C0008/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: SAUK VALLEY SENIOR LIVING COMPLAINT #: 0107502
LIC. ID #: 0053330
DATE COMPLAINT RECEIVED: 11/26/18 10:10:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	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, v. MIDWEST HEALTH OPERATIONS, LLC, D/B/A, SAUK VALLEY SENIOR LIVING Respondent.	)))))))))	Docket No. NH 19-C0008

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 28, 2018 at Sauk Valley Senior Living, 1000 Dixon Avenue, Rock Falls, Illinois 61071. 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 Sauk Valley Senior Living, 1000 Dixon Avenue, Rock Falls, Illinois 61071 on September 25, 2018. The Facility's current license number is 0053330. 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**, 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)2), 300.1220b)8) 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 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 25th day of January, 2019.

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. NH 19-C0008

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:	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 25th day of January, 2019.

Sammye Geer

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
	IL6001929	A. BUILDING: _____ B. WING _____	C 11/28/2018

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 Complaint Investigation 18171612/IL107502	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1220b)8) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. 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 interview and record review, the facility	S9999		

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S9999	Continued From page 2	S9999		

failed to ensure a resident with a tracheostomy tube having difficulty breathing had a patent airway. This failure resulted in R1 experiencing prolonged respiratory distress.

This applies to 1 of 3 residents (R1) reviewed for nursing care and services in the sample of 8.

The findings include:

R1 is a 31 year old resident admitted to the facility after a severe anoxic (without oxygen) brain injury after cardiac arrest following choking on food. R1 required a gastrostomy, colostomy and tracheostomy after the choking episode and was admitted to the facility with these present. R1's MDS (minimum data set) dated August 28, 2018 shows R1 is non-verbal and cannot make herself understood. R1's cognitive skills for daily decision making are severely impaired and R1 is dependent on staff for bed mobility, transfers, dressing, eating, toilet use, hygiene and bathing. R1's care plan dated January 26, 2017 shows she is dependent on staff for repositioning and all ADL (activity of daily living) cares. R1 is unable to express herself and unable to assist with ADL's.

On November 27, 2018, at 11:36 AM, V4 CNA (Certified Nursing Assistant) said on November 24, 2018 around 7PM she was in the hallway outside R1's door and could hear R1 struggling to breathe from the hall. V4 said, "V2 RN (Registered Nurse) was there also and didn't hear a thing. I called for V2 to come into the room. V2 panicked when she saw R1. She put oxygen on her and listened to R1's lungs. Then V2 asked me to listen to R1's lungs. V2 did not check R1's tracheostomy or suction it."

On November 27, 2018 at 2 PM, V2 said when

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S9999	Continued From page 3	S9999		

she entered R1's room on November 24, 2018, R1's chest was not rising and falling. V2 said, "R1 was sweaty and in distress trying to breathe. She breathes through her trach (tracheostomy/airway). I did not suction the trach. I did not remove the tube to make sure it was clear. The first thing I did was put oxygen on her. I listened to her lungs and there was very little lung sounds. I had V4 listen to her lungs too. I left the room to call the doctor to update him and get permission to send her to the ER (emergency room). I have very little experience with trachs. I told the paramedic she was in respiratory distress and it could have been up to an hour she'd been having trouble breathing. All the staff were in the dining room and nobody had seen her in about an hour. If a resident's airway is occluded they could go into a coma, have a lack of oxygen to the brain or become a total vegetable. If I had just checked to see if that cannula was blocked...if I got it cleaned out within 5-10 minutes she would have gotten better and not had such distress."

On November 27, 2018 at 4:20 PM, V9 (ambulance crew care giver) said when he arrived at R1's bedside on November 24, 2018, "R1 was gasping to get air. She was in respiratory distress. Her breathing was labored and she was hyperventilating. I asked the nurse how long she had been breathing like this and she said maybe an hour. She said she only had two CNA's working with her. There was a regular oxygen mask on her not a trach mask and it flipped right off when we moved her."

On November 26, 2018 at 4:20 PM, V6 (local emergency room RN) said when R1 was brought to the ER on November 24, 2018, her trach was completely clogged with blood tinged sputum and hair. The trach was very clogged and dirty. As

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S9999	Continued From page 4	S9999		

soon as V6 changed it R1 was breathing completely normal.

On November 28, 2018 at 8:55 AM, V8 (local emergency room RN) said on November 24, 2018, "R1's trach tube was filthy and gunky. If she was getting suctioned properly her tube wouldn't have been so clogged and dirty. After the tube was removed, she was breathing better."

On November 28, 2018 at 9:00 AM, V7 (local hospital respiratory therapist) said on November 24, 2018, "R1 was breathing very rapidly, working hard and in a lot of distress. I tried suctioning her trach and met some resistance when attempting to pass the suction tubing. I took R1's trach cannula out and it was full of thick dried mucous, basically plugged. You could tell it had not been cleaned or changed for a while. I think doing better trach care would have prevented this ER visit."

On November 27, 2018 at 3:20 PM, V1 DON (Director of Nursing) said she expects the nurses to properly assess a resident's airway and attempt interventions prior to calling 911 if a resident is have respiratory distress. If a resident is not moving air and not breathing they should call 911 without delay and send them out.

R1's communication form dated November 24, 2018 and authored by V2 shows R1 had loud respirations, the abdomen was rising and falling instead of the chest, there were no breath sounds in the lungs, skin was very moist, and R1 seemed to be working hard at breathing. R1's ambulance care report dated November 24, 2018 shows R1 was having extreme difficulty with her breathing, hyperventilating and usage of upper accessory muscles for breathing. When asked how long the

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S9999	Continued From page 5 patient may have been in this condition, the nurse stated she thought maybe for the last hour. R1's emergency room physician notes dated November 24, 2018 shows the patient is nonverbal at baseline and has a tracheostomy with inner cannula noted to be completely obstructed. R1's tracheostomy was congested. On arrival, the patient's trach site was suctioned and inner cannula was changed with significant improvement in her symptoms and she was no longer in any respiratory distress. R1's ER discharge diagnosis was inner cannula obstruction. R1 was discharged back to the facility. V8's ER triage note shows R1 was short of breath for an hour at the facility and this was concerning for neglect. R1's November 2018 Treatment Administration Record (TAR) shows a current orders to provide trach care daily and as needed (prn), suction the trach as needed, and to change the trach inner cannula daily and as needed (prn). The facility's Tracheostomy Care Policy dated January 16, 2012 shows residents who have a tracheostomy will have trach care done daily, or when needed to keep the airway clean and unobstructed. The facility's Emergency Transfer to Acute Care Setting Policy dated December 22, 2017 shows in the event a resident requires emergency care beyond the scope of that provided by the staff of a long term care facility, that resident shall be transferred to an acute care setting. In extreme emergencies implement "911" for immediate assistance as indicated by the injury or condition. (A)	S9999		