DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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| THE DEPARTMENT OF PUBLIC HEALTH<br>STATE OF ILLINOIS,<br>Complainant,<br><br>v.<br><br>SYMPHONY NORTHWOODS, LLC,<br>D/B/A, NORTHWOODS CARE CENTRE,<br>Respondent. | )<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>) | Docket No. NH19-S0027 |

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 December 14, 2018, at Northwoods Care Centre, 2250 Pearl Street, Belvidere, Illinois 61008. On February 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)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 "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 14th day of February ,2019.

DEPARTMENT OF PUBLIC HEALTH
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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:

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| Registered Agent: | Illinois Corporation Service |
| Licensee Info: | Symphony Northwoods, LLC |
| Address: | 801 Adlai Stevenson Drive<br>Springfield, Illinois 62703 |

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 14th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
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 |
|---|---|---|---|
| | IL6006670 | A. BUILDING: _____ B. WING _____ | 12/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NORTHWOODS CARE CENTRE | 2250 PEARL STREET BELVIDERE, IL 61008 |

| (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 |
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| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>1 of 1 Violation:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These Requirements are not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to ensure residents with cognitive impairment and at a high risk for falls were supervised to prevent repeated falls. This failure resulted in a hospitalization of R81 for a brain bleed and R82 sustaining a fractured upper arm. The facility failed to ensure an electrical outlet cover was in place for a live outlet in a | S9999 | | |

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| S9999 | Continued From page 2<br>confused resident room.<br><br>This applies to 3 of 20 residents (R34, R81 and R82) reviewed for safety and supervision in the sample of 20.<br><br>The findings include:<br><br>1. On December 11, 2018 at 10:48 AM, R81 was sitting in a recliner in the common area with the foot rest up. R81 was restless in the chair, trying to get out of the chair and push the foot rest down. R81's helmet was not on her head or near the recliner.<br><br>On December 13, 2018 at 11:57 AM, V11 (Restorative Nurse) said she is responsible for the fall program at the facility. V11 stated R81 "likes to fall; she falls a lot." V11 said on November 11, 2018 she was notified R81 fell. V11 said she saw R81 lying on the floor on her right side and blood was coming from her head. V11 said V4 (Licensed Practical Nurse - LPN) was holding pressure on R81's head wound.<br><br>On December 13, 2018 at 12:49 PM, V4 (LPN) said she was taking care of R81 on November 11, 2018. V4 said she was in the nurses' station charting and she heard V17 (Certified Nursing Assistant - CNA) yelling her name. V4 said R81 was on the floor of the dining room and stated, "It looked like [R81's] eyebrow was indented and there was blood coming from that area." V4 said when the Emergency Medical Technicians (EMTs) arrived, R81 started nodding off for 30 seconds. V4 said R81 was taken to the closest emergency room, then transferred to another hospital. V4 said she called the hospital to check R81's status and she was told R81 had a subarachnoid hemorrhage (brain bleed) and would be admitted | S9999 | | |

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| S9999 | Continued From page 3<br>to the hospital to monitor the bleeding.<br><br>On December 13, 2018 at 01:35 PM, V17 (CNA) said on November 11, 2018 she was taking a resident to the bathroom and R81 was sitting in a chair in the dining room. V17 said R81 always leans forward, so I pushed her legs back so R81 would be sitting back against the chair with her feet on the floor. V17 said on her way out of the bathroom with the other resident, she saw R81 leaning too far forward and she fell on her head.<br><br>On December 13, 2018 at 02:57 PM, V18 (Nurse Practitioner - NP) she has been R81's NP since R81 was admitted in May 2018. V18 stated, "If I documented R81 had an acute brain bleed after the fall on November 11, 2018, then I'd have to say it (the brain bleed) was new."<br><br>On December 13, 2018 at 02:26 PM, V2 (DON) stated, "the paperwork from the emergency room does show that R81's brain bleed was new from the fall on November 11, 2018."<br><br>R81's records from the local emergency room on November 11, 2018 showed the result of the Computed Tomography (CT) scan of the head was, "Acute intracerebral hemorrhage and subarachnoid hemorrhage. Forehead laceration."<br><br>R81's Nursing Home Visit dated September 27, 2018 does not show nontraumatic subdural hemorrhage, unspecified as a current or historical diagnosis.<br><br>R81's Nursing Home Visit dated November 15, 2018 showed current diagnoses to include: acute nontraumatic subdural hemorrhage, unspecified with a start date of November 15, 2018. This document showed "1. subdural hematoma status | S9999 | | |

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| S9999 | Continued From page 4<br>post (after) a fall..."<br><br>R81's Electronic Medical Record (EMR) on December 13, 2018 showed R81 had thirteen falls from June 11, 2018 to November 25, 2018. R81's Fall Event dated July 16, 2018 showed she was walking, fell and hit her head, resulting in a lump above her left eye brow. R81's Fall Event dated August 29, 2018 showed R81 tried to pick something off the floor, fell and hit her head, resulting in a laceration over her left eyebrow. R81's Fall Event dated October 28, 2018 showed she was walking, fell and hit her head, resulting in a swollen tissue around her left eye. R81's Fall Event dated November 11, 2018 showed R81 was reaching, fell and hit her head, resulting in a laceration above the right eye brow.<br><br>R81's Fall Risk Screen dated November 25, 2018 showed R81 is a High Fall Risk.<br><br>R81's Admission Record printed December 12, 2018 showed R81 has diagnoses to include: generalized muscle weakness, anxiety disorder, and dementia.<br><br>R81's Minimum Data Set (MDS) dated November 28, 2018 showed R81 has severe cognitive impairment; requires extensive assistance of two or more staff members for bed mobility, transfers, walking, dressing, and toilet use; and has had two or more falls since admission.<br><br>R81's Fall Care Plan (revised November 13, 2018) showed R81 has the potential for falls and is at risk for injury from falls. This care plan shows R81 has a soft helmet for ambulation but does remove it herself, ambulates with an unsteady gait, and has weakness and dementia. The interventions include "continue to provide | S9999 | | |

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| S9999 | Continued From page 5<br>frequent visual monitoring to ensure safety."<br><br>R81's Abnormal Involuntary Movement Scale (AIMS) dated November 14, 2018 showed R81 is a low risk of movement disorder.<br><br>The facility's Fall policy (revised August 2014) showed, "The facility is committed to maximizing each resident's physical, mental, and psychosocial well-being.... the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.<br><br>2. On December 11, 2018 at 12:00 PM, R82 was sitting in the recliner with the feet up. R82 turning side to side in recliner, trying to kick up her leg. V13 (LPN) stopped to talk to R82 briefly, as V13 walked away from R82 she stated to another staff member, "[R82] is rolling around and that's how she gets when she rolls out of those chairs."<br><br>On December 13, 2018 at 12:30 PM, V11 (Restorative Nurse) said on May 14, 2018 12:00 PM, R82 rolled out of bed, fell on her left arm and fractured her humerus. V11 said the fall was unwitnessed. V11 said the CNA that found R82 on the floor was V16 (CNA) and R82's nurse that day was V21 (Registered Nurse - RN).<br><br>On December 13, 2018 at 3:03 PM, this surveyor left a message for V21 (RN). V21 did not return the call.<br><br>On December 13, 2018 at 03:08 PM, V16 (CNA) said she does not remember finding R82 on the floor.<br><br>On December 13, 2018, R82's Electronic Medical Record (EMR) showed R82 had 11 falls in 2018. | S9999 | | |

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| S9999 | Continued From page 6<br><br>R82's Fall Event dated May 14, 2018 showed R82 was found face down, next to her bed, resulting in a left forehead laceration and hematoma. R82's Fall Event dated 5/30/18 showed she was reclined in the recliner and fell, resulting in a 3 cm laceration above her left eyebrow. R82's Fall Event dated July 12, 2018 showed was sleeping in the recliner and fell, resulting in a bloody nose and possible closed fracture of her nose. R82's Fall Event dated November 9, 2018 showed R82 rolled out the left side of the recliner and hit her head on the wall, resulting in a hematoma to her left forehead. R82's Fall Event dated November 21, 2018 showed R82 rolled out of the side of the recliner and hit her head and face on the wall, resulting in bruising to her forehead and nose.<br><br>The facility's Incident Report completed on May 14, 2018 by V2 (DON) showed V16 (CNA) exited R82's room and heard a thud. This document showed "V16 found R82 lying on floor on left side with a 2 cm laceration to her forehead, which was bleeding profusely." This document continued to show "R82 grimaced with movement to left upper extremity (arm); X-ray results reveal left proximal humeral fracture (broken arm)."<br><br>R82's local emergency department records dated May 14, 2018 showed "Diagnosis: Fall; Forehead laceration; scalp laceration; acute left proximal humerus fracture." This document also showed, "[R82] has a moderate sized swollen, raised bruised area to the left side of forehead. R82 has a small skin tear to the area with bleeding controlled. R82 has 2 inch laceration the top of the scalp."<br><br>R82's Admission Record printed December 12, 2018 showed R82 has diagnoses to include: | S9999 | | |

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| S9999 | Continued From page 7<br>Alzheimer's Disease, anxiety disorder, moderate chronic kidney disease, and dementia.<br><br>R82's MDS dated November 28, 2018 showed R82 had severe cognitive impairment; and required extensive assistance of two or more staff members for bed mobility, transfers, walking, dressing, and toilet use.<br><br>R82's Fall Risk Screen dated November 21, 2018 showed she is at "High Risk" for falls.<br><br>R82's Care Plan (revised December 6, 2018) showed R82 has the potential for falls and is at risk for injury due to poor safety awareness/impulsiveness, attempts to roll out of recliner, and stand alone without assistance." The interventions include "continue to provide close visual monitoring when R82 is out of bed" and "provide staff reminders regarding need for constant supervision when R82 is out of bed."<br><br>R82's Abnormal Involuntary Movement Scale dated November 5, 2018 showed R82 is a "low risk of movement disorder."<br><br>3. On December 11, 2018 at 09:25 AM, R34's room was observed to have a electrical outlet approximetley 4 feet off the ground on the wall where the resident's head of bed was located. The electrical outlet was missing it's cover plate and no pieces of the outlet cover were observed in the vacinity of the outlet. R34's bed was plugged into this outlet.<br><br>On December 1, 2018 at 11:04 AM, V16 Certified Nursing Assistant, stated the electrical outlet cover had been missing for a few days and she believed it had been reported. | S9999 | | |

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| S9999 | Continued From page 8<br><br>On December 11, 2018 at 10:49 AM, V15 Maintenence, stated the outlet with the missing cover was live and the purpose of the outlet cover is "to protect the outlet and to keep people from sticking their fingers in it." V15 stated if someone would stick their fingers in the outlet they "would get electrocuted." V15 stated he was not aware of the broken outlet cover.<br><br>On December 11, 2018 at 10:49 AM, the facility's Maintenance Work Order Request log was reviewed with V15 and the missing outlet cover had not been documented at that time.<br><br>On December 11, 2018 at 12:28 PM, R34 was observed in the dining room self propelling herself to the door.<br><br>R34's October 17, 2018 Minimum Data Set showed her cognitive ability to be severly impared. R34's Diagnosis Report, dated December 12, 2018, showed diagnoses to include Alzheimer's and "psychotic disorder with hallucinations."<br><br>(B) | S9999 | | |