

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2021
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NAME OF PROVIDER OR SUPPLIER CHESTNUT CORNER S C	STREET ADDRESS, CITY, STATE, ZIP CODE 905 WEST CHESTNUT STREET LOUISVILLE, IL 62858
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(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: 2154277/IL135100	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 330.725 i) 330.725 k) 330.725 l) 330.725 n) Section 330.725 Identified Offenders i) For current residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Police. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act) n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.</p> <p>This Requirement is NOT met as evidenced by:</p> <p>Based on interview, observation, and record review, the facility failed to provide staff supervision for identified offenders as per Identified Offender Risk Recommendations, and to place an identified offender in a private room with a private bathroom for three (R3, R4, R8) of three identified offenders in the sample of ten.</p> <p>Findings include:</p> <p>1. R3's (State Police) Sex Offender Evaluation Risk Assessment, dated 04/18/14, documented, "(R3's) criminal history consisted of convictions for...public indecency/lewd exposure and battery. He is required to be registered as a sex offender in the State of Illinois.Recommendations: (R3 is at) moderate risk (for reoffense)...The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time limited basis."</p> <p>R3's Identified Offender Care Plan, dated 05/2021, documented, "Problem...Public indecency/exposure..Approaches: Follow recommendations given in State Police Identified Offender Report...One to one supervision every 60 minutes, limit to facility, must be with staff."</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHESTNUT CORNER S C

**905 WEST CHESTNUT STREET
LOUISVILLE, IL 62858**

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S9999	<p>Continued From page 2</p> <p>On 06/23/21 at 2:35pm, R3 stated he is allowed to go to the dollar store and ice cream stand, which are within walking distance, without staff supervision. R3 stated he may be gone for more than an hour at times. R3 stated none of the staff have ever told him this was a problem.</p> <p>2. R4's Illinois Department of Public Health Identified Offenders Program Criminal History Analysis/Security Recommendation report, dated 05/12/07, documented, "Convicted and/or registered sex offender...(Reoffense risk determination)High risk: The resident requires a single room in close proximity to the nurses station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes...Specific considerations: (R4) was convicted of aggravated criminal sexual assault...and criminal sexual assault..Both of these charges were against minors."</p> <p>R4's Identified Offender Care Plan, dated 11/2020, documented, "Problem: Criminal sexual abuse. Approaches: Follow recommendations given by State Police Identified Offender Report...one to one supervision every 60 minutes..Restrict to the facility."</p> <p>On 06/24/21 at 2:45pm, R4 stated he goes to the dollar store, within walking distance, without staff supervision. R4 stated he may at times be gone in excess of an hour. R4 stated staff have never told him he could not go alone.</p> <p>3. A Room Roster, dated 06/23/21, documented R8 and R9 residing in the same room.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R8's Illinois Department of Public Health Identified Offenders Program Criminal History Analysis, dated 09/16/16, documented, "(R8's) criminal history consisted of convictions for domestic battery, resisting a peace officer, arson, disorderly conduct, and two counts of aggravated criminal sexual abuse. Recommendation: As a convicted and/or registered sex offender, (R8) must be placed in a single resident room with a private bathroom facility."</p> <p>R8's Identified Offender Care Plan, dated 05/2021, documented, "Problem area: Domestic battery, resisiting officer, arson, criminal (sexual abuse). Approaches: Resident will be in a private room.."</p> <p>On 06/23/21 at 3:30pm, R8 and R9 were in the room they share. R8, who was alert and oriented, stated he and R9 have been roommates for about a year. The room was observed to have no attached bathroom, with a shared bathroom located down the hall.</p> <p>On 06/24/21 at 10:45am, V1, Administrator, stated R3 and R4 have been told not to leave the facility grounds without staff supervision, but he is "not surprised it is happening." V1 did not make any statement as to remediating this situation. V1 stated it was the decision of the owners of the facility to cohort R8 and R9, based on the fact that R8 no longer has to register as a sex offender.</p> <p>(B)</p> <p>2 of 2</p> <p>330.710 a)</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>330.1710 c)1) 330.4210 a) 330.4210 f) 330.4210 g) 330.4210 o) 330.4240 a) 330.4240 c) 330.4240 d)</p> <p>Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.</p> <p>Section 330.1710 Resident Record Requirements c) Record entries shall meet the following requirements: 1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.</p> <p>Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. f) The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. g) The facility shall develop procedures for investigating complaints concerning theft of</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>residents' property and shall promptly investigate all such complaints.</p> <p>o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.</p> <p>Section 330.4240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the department.</p> <p>Based on interview, observation, and record review, the facility failed to protect residents from financial misappropriation and to investigate an allegation of financial misappropriation for three (R2, R6, R10) of four residents reviewed for financial misappropriation in the sample of ten.</p> <p>Findings include:</p> <p>1. On 06/23/21 at 2:15pm, R1, who is alert and oriented, stated he has never been a victim of abuse or financial misappropriation while residing at the facility, but a former resident has been. R1 stated that a former employee, V4, former Office Assistant, was caught withdrawing money from a</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>residents account using the residents debit card, and was subsequently terminated. R1 stated he heard about this in passing, but he does not know which resident it concerned.</p> <p>On 06/24/21 at 10:45am, V1, Administrator, stated in early June 2021, there was an incident involving V4 stealing R6's funds. He stated R6 discharged himself from the facility, and later admitted himself to a different facility. Staff from the new facility brought R6 to get his belongings, and R6 brought bank statements showing withdrawals were made from his bank account using his debit card. V1 suggested to R6 that R6 needed to go to his bank. V1 stated the next day, the sheriff came to the facility and said they were investigating the theft, and V4 was seen on the bank's surveillance camera withdrawing the funds. V1 stated somehow V4 must have gotten the card and pin code from R6. V1 stated he did not know how much money had been taken, but apparently there had been several withdrawals over the course of days. V1 stated V4 had no history of similar behavior, and had a clear background check. V1 stated the sheriff told him V4 said R6 gave her permission to make the withdrawals. V1 stated V4 was subsequently terminated. On 06/25/21 at 1:10pm, V1 stated the facility did not investigate the financial misappropriation because the sheriff was investigating it. When the Surveyor pointed out that other residents could have been affected, V1 stated there was "Nobody else(residents) she(V4) could have done it to."</p> <p>2. On 06/23/21 at 10:45am, V4 (former Office Assistant) stated although R2 was discharged from the facility several months ago, the facility is continuing to receive Illinois Public Aid payments on R2's behalf, and to charge R2 for room and</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>board. V4 stated , in her capacity as Office Assistant, she asked V1 if they should do discharge paperwork for R2 after R2 had been gone for several months, to which V4 stated V1 replied, "Not as long as we're getting paid for (R2)."</p> <p>On 06/24/21 at 10:45am, V1 stated R2 has been on a home visit from the facility since sometime in January of 2021. V1 stated R2 has not been discharged, and is still a resident, since R2 still has belongings at the facility. V1 stated the facility tried calling the residents family, but the phone was disconnected and there was no other contact information. V1 stated the facility did not attempt to reach R2 by mail at the family members address he provided. V1 stated V8, Accounting /Payroll Staff, is responsible for accounts and billing, so V8 would know if R2 was being billed for room and board, but he stated he does know R2's \$30 per month spending money is being kept in an envelope in the facility's safe. V1 stated since they do not know where R2 is, there is no way of forwarding his funds.</p> <p>On 06/24/21 at 10:45am, V8 stated he does account billing based on the room roster submitted to him by V1. He stated R2 is still listed on the roster as a resident, so the facility is receiving his Illinois Public Aid benefits which go toward room and board, and he is being billed for room and board. V8 stated he is of the understanding R2 has been on home visit since January or February 2021. V8 stated V9, Illinois Department of Human Services Casework Manager, Medical Field Operations, is the staff they deal with in regard to the residents Illinois Public Aid billing.</p> <p>V8 provided a form titled "Statement: To (R2)"</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>dated 06/24/21, documenting the following:</p> <p>12/01/20: Monthly Service(amount due): \$1283.00 12/23/20: Payment(from) IPA(Illinois Public Aid): \$1,320.00 01/01/21: Monthly Service(amount due): \$1283.00 01/14/21 Payment(from) IPA:\$1320.00 02/01/21:Monthly Service(amount due):\$1283.00 02/22/21 Payment(from) IPA: \$1320.00 03/01/21 Monthly Service(amount due):\$1294.00 03/25/21: Payment(from) IPA: \$1320.00 04/01/21: Monthly Service(amount due): \$1294.00 04/27/21: Payment(from) IPA: \$1320.00 05/01/21: Monthly Service(amount due): \$1294.00 05/21/21 Payment(from) IPA: \$1330.00 06/01/21: Monthly Service(amount due): \$1294.00 06/18/21: Payment(from) IPA: \$1330.00</p> <p>On 06/24/21 at 12:45pm, V9 stated the facility has not notified her office R2 was on an extended home visit. R2 stated even though the facility does not know the whereabouts of R2, they should have notified her so that payments on behalf of R2 could have been stopped. V9 stated she sent re determination paperwork to the facility on 05/05/21, which they completed and sent back on 05/11/21. V9 stated in the documentation, the facility stated R2 still lived at the facility and they had evaluated R2 on 05/03/21 to re determine his care needs. She stated for all of 2020 and 2021, the facility has been receiving monthly benefits on behalf of R2.</p> <p>R2's November 2020 Medication Administration Record documented R2 was given medications on 11/24/20. The remainder of the spaces have</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>"HV"(home visit) written in.</p> <p>On 06/25/21 at 11:25am in the Main Office, a locked file cabinet was observed to contain 7 envelopes, all with R2's name on them. The envelopes were labeled February, April, May and June, with three undated. All contained \$30 cash with the exception of one undated envelope which contained \$27 cash. V1, who was present, stated R2 may have borrowed \$3 at some point, and it was taken out to be paid back.</p> <p>On 06/25/21 at 11:40am, the East Building medication cart was observed to contain R2's February 2021 and March 2021 medication cards from the pharmacy.</p> <p>An undated Contract Between Resident and (Facility) Form documented, "The resident may terminate the contract and all obligations under it upon thirty days written notice. The resident and/or residents responsible party shall be responsible for all charges and fees for all services performed up to the date of termination. The resident shall have all charges pro rated as of the date the contract terminates and the excess shall be refunded to the resident or the residents responsible party. As a condition of admission, the resident or personal representative agrees that they must give a 30 day notice of their intent to vacate. If the 30 day notice of intent to vacate is not given, the facility is entitled to retain future monies to cover this period of time. In the event a resident, who has depleted their funds for the current for the current period is admitted, (of admission), the facility is entitled to receive funds from subsequent checks after the resident is discharged. This contract will terminate with seven days notice if the resident dies or is compelled by a change in physical or</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>mental health to leave the facility."</p> <p>3. On 06/29/21 at 9:05am, R10, who is alert and oriented to person and place, but not time, stated V1 took his federal benefits prepaid debit card and pin number when he was admitted to the facility about six months ago. R10 stated he is not sure how much money was on the card at that time. R10 stated his \$850 SSI(Supplemental Security Income) check was loaded onto the card each month. R10 stated during the course of his stay, he asked V1 several times to give him the card back, but V1 refused. R10 stated he discharged himself from the facility in March 2021, at which time he asked V1 for the card, and was told by V1 it could not be found. R10 stated when he later accessed the account, he found that \$1600 was missing.</p> <p>On 06/29/21 at 9:40am, V1 stated he did not get a card nor pin number from R10 at any time during his stay. When asked if V4 could have gotten the card and pin number, he stated this was not possible as R10 would have had his SSI directly deposited and he did not believe R10 had a debit card. V1 did not offer to investigate the matter in light of the above referenced theft.</p> <p>On 06/29/21 at 10am, the surveyor reported to V11 , General Manager/Co Owner, the allegation R10 made against V1. V11 stated he did not believe the allegation, and asked the surveyor what she wanted him to do about it. When the surveyor asked if the facility had a policy addressing misappropriation of resident funds, V11 stated he would have V1 check and see if they had one, as he was not sure, and V11 stated he was driving. V11 made no mention of investigating the allegation, nor of removing V1 during an investigation.</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>On 06/29/21 at 11:30am, V1 was still present in the building. V1 presented a form titled, Part 330, Sheltered Care Facilities Code Section 330.4240 which V1 stated the facility utilizes as it policy for resident financial abuse, which documented, "An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident...when an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that an employee of a long term care facility is the perpetrator of abuse, that employee shall be immediately barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution, or disciplinary action against the employee."</p> <p>On 06/29/21 at 12:50pm, V11 stated he had begun investigating the allegation. V11 stated V1 was at home for lunch, and he would direct V1 to remain out of the facility pending the results of the investigation.</p> <p>A Resident Rights Policy with a review date of 10/11 stated, "You have the right to safety and good care. You must not be abused by anyone-physically, verbally, mentally, financially, or sexually."</p> <p>(B)</p>	S9999		