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
	IL6002364	A. BUILDING: ______ B. WING ______	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE DANVILLE	1701 NORTH BOWMAN DANVILLE, IL 61832

(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 Facility Reported Incident of 7/8/23/IL162004	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.615e) 300.615g) 300.615h) 300.615i) 300.615j) 300.625b) 300.625c)1)2) 300.625d) 300.625e) 300.625f)1)2) 300.625g) 300.625i) 300.625j) 300.625k) 300.625n) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the	S9999	Attachment A Statement of Licensure Violations	

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Department of State Police. (Section 2-201.5(b) of the Act)

g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

h) A waiver issued pursuant to Section 2-201.5(b) of the Act shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. (Section 2-201.5(b) of the Act)

i) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the

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resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.

j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

Section 300.625 Identified Offenders

b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.

2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and

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other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.

e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry. (Section 2-201.5(c) of the Act)

f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:

1) The facility shall inform the appropriate county and local law enforcement offices of the identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense who are residents of the facility. If a resident of a licensed facility is an identified offender, any federal, State, or local law

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S9999	Continued From page 4 enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirements of the Sex Offender Registration Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release. (Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care. 2) The facility staff shall meet with local law enforcement officials to discuss the need for and to develop, if needed, policies and procedures to address the presence of facility residents who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense, including compliance with Section 300.695 of this Part. g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part. 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. j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. k) The facility shall incorporate the Identified Offender Report and Recommendation into the	S9999		

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identified offender's care plan. (Section 2-201.6(f) 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 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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their abuse prevention policy by failing to take all steps necessary to ensure the protection of residents while an identified offender report and recommendations were pending. This failure affects three residents (R1, R2, and R4) out of three reviewed for abuse on the sample list of four.

Findings include:

R4's Electronic Medical Record documents R4 was admitted to the facility 11/5/22. R4's Record documented a request submitted for a background check for R4. R4's Record does not document any return information from the Illinois State Police UCIA check indicating if R4 had any criminal history or not.

On 7/25/23 at 2:10 PM, R2 stated, "That lady (R4) called me a (derogatory racist name) and I ain't gonna put up with that."

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On 7/25/23 at 3:30 PM, V6, Licensed Practical Nurse, stated, "I was working when this incident between (R2) and (R4) happened but I was in the front of the building. Some of the staff came and told me they could not get (R2) calmed down." V6 then stated, "When I went to the dining room, (R2) was agitated so I separated the two residents. (R2) was saying that (R4) called him a n***er " R2 and R4's Nurses Notes documented this incident occurred on 7/23/23.

On 7/25/23 at 2:30 PM, V3, Travelling Interim Administrator, stated, (V12, Social Services Director) is responsible for the resident criminal background checks and Identified Offender program."

On 7/25/23 at 2:40 PM, V12, Social Services Director, stated, "I did not do any follow up for (R4's) background check because all those requests at that time were going through (V16, former Business Office Manager) and I was not included in the facility's email group. Usually, when the background checks came back with a hit (criminal offense), they send that background check to me and I submit the resident's name for fingerprinting, then (V15, Illinois State Police Identified Offender Evaluator) comes to assess the resident for a level of risk and makes recommendations for us to put in place."

R2's Electronic Medical Record documents R2 was admitted to the facility 3/1/23, is ambulatory without an assistive device, has medical diagnoses including Psychosis, Dementia with Behavioral Disturbance, and receives medical treatment with the anti-psychotic medication

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Quetiapine 12.5 milligrams twice daily.

R2's CHIRP (Criminal History Information Response Process) report dated 2/23/23 documents R2's UCIA (Uniform Conviction Information Act) name based criminal history check documents R2 had a criminal conviction from 1993 for unlawful use of a blackjack knife.

R2's Electronic Medical Record did not document R2's required fingerprint consent, confirmation of the fingerprint procedure, nor CHAR (Criminal History Analysis and Recommendation) to assess R2's level of risk and recommendations from the Illinois State Police (ISP) Identified Offender Program.

On 7/25/23 at 2:30 PM, V3, Traveling Interim Administrator, stated, (V12, Social Services Director) is responsible for the resident criminal background checks and Identified Offender program."

On 7/25/23 at 2:40 PM, V12, Social Services Director, Stated, "I have been working here about 1 year. The process is when we have a resident who get a a hit on a criminal history report, I send them for fingerprints, then (V15, ISP Identified Offender evaluator) at ISP comes to evaluate the resident, then we get a report about the resident's level of risk and any recommendations we need to put in place for that resident." V12 then stated, "I spoke to (V15) today about the report for R2 and (V15) said that the ISP is behind and he would have to reach out to someone above him to see if they can get the assessment report sent to us." V12 further stated, "I did put R2 in the Illinois Department of Public Health Identified Offender system and I sent the information that (R2) had his fingerprints, and I did accompany

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(V15) when he came and did the assessment with (R2), it's just that we have not received the CHAR report yet." V12 concluded by stating, "I had not done any follow-up with R2's report because I was not included in the facility's email group, those emails were going to (V16, Former Business Office Manager)."

On 7/21/23 at 12:15 PM, V6, Licensed Practical Nurse, stated, "I was the nurse working when this incident happened between (R1) and (R2) a couple of weeks ago. I was summoned to this dining room because (R3) said there were 2 residents getting in an argument." V6 further stated, "All I witnessed when I came into the room was a verbal argument between R1 and R2, and I separated the 2 residents." V6 continued to state, "(R2) did have a fork in his hand but I never saw him try to strike at (R1) with the fork." V6 confirmed, "(R1) is not ambulatory and requires a (full body mechanical lift) lift for transfers, and (R2) is ambulatory." V6 then stated, "After I separated the two of them, I noticed (R1) had a pinpoint mark on his neck that had a glistening drop of blood on it."

On 7/21/23 at 12:23 PM, R3 stated, "I did see (R1) and (R2) arguing and it got pretty loud but I did not see either of them swinging at each other." R3 further stated, "I did call to the nurse to come because of the argument because it was getting pretty heated. I did see that (R2) did have a fork in his hand but I did not see him try to hit (R1) with the fork." R2 and R1's Nurses Notes documented this incident occurred 7/8/23.

On 7/25/23 at 2:20 PM, V4, Certified Nursing Assistant, stated, "I was working yesterday when this incident between (R1) and (R2) happened, I had to break it up." V4 continued, "What I saw

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was (R1) and (R2) arguing and cussing at each other, then (R1) took a swing at (R2), then (R2) grabbed a hold of (R1's) arm and wouldn't let go." V4 then stated, "One of the nurses (V13, Licensed Practical Nurse) helped me get the 2 separated and I heard her yell "ouch" while we were trying to separate them." V4 further stated, "After we got (R1) and (R2) separated, (R1) wanted to give me a hug and I noticed there was some blood on my arm so I looked at (R1) and he had blood on his arm, and he had indentations where (R2) had grabbed him." R2 and R1's Nurses Notes documented this incident occurred 7/24/23.

On 7/25/23 at 2:10 PM, R2 stated, "That lady (R4) called me a n***er and I ain't gonna put up with that so I yelled at her and told her I was gonna beat her ass if she did it again."

On 7/25/23 at 3:30 PM, V6, Licensed Practical Nurse, stated, "I was working when this incident between (R2) and (R4) happened but I was in the front of the building. Some of the staff came and told me they could not get (R2) calmed down." V6 then stated, "When I went to the dining room, (R2) was agitated so I separated the two residents. (R2) was saying that (R4) called him a n***er and he wanted to beat her up." R2 and R4's Nurses Notes documented this incident occurred on 7/23/23.

R2's Nurses Notes dated 6/26/23 document R2 had followed a staff member out of the locked unit where R2 resides at the facility.

R2's Nurses Notes dated 7/1/23 document R2 had exited the building from the locked unit where R2 resides.

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S9999	Continued From page 10 R2's Nurses Notes dated 7/6/23 documents R2 was pacing around the unit, exit seeking, and yelling because he was missing work (delusion). Redirection was unsuccessful and R2 continued his pacing, exit seeking, and yelling. R2's Nurses Notes dated 7/8/23 through 7/12/23 document R2 was placed on one to one monitoring by a staff member and had no documented aggressive behaviors during this time period. On 7/11/23 the facility Interdisciplinary Team evaluated R2 and reduced R2's staff monitoring to every 15 minutes. R2's Nurses Notes dated 7/13/23 document R2 was making statements that he had to take food to his kids at school. R2's Nurses Notes dated 7/16/23 document R2 involved in a verbal argument with another (unidentified) resident. R2's Nurses Notes dated 7/18/23 documents R2 had mistaken another female resident (unidentified) as his wife and told her to come out of the room before he beat her ass. The responding nurse (unidentified) and the Nurse Practitioner (V17) attempted to redirect R2 but R2 cornered V17 and threatened to beat her ass too. R2's Nurses Notes dated 7/19/23, 7/20/23, and 7/22/23 document exit seeking behavior by R2. R2's Nurses Notes dated 7/24/23 document R2 was placed back on the one-to-one monitoring by facility staff. R2's current Care Plan did not document R2's Identified Offender status.	S9999		

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S9999	Continued From page 11 On 7/25/23 at 11:50 AM, V9, Psychiatric Rehabilitation Services Director, stated, usually we wouldn't put the Identified Offender status on the care plan until we get the assessment and recommendations from the CHAR." (B)	S9999		