

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
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CHESTNUT CORNER SC

0029108

Facility Name

I.D. Number

905 WEST CHESTNUT STREET, LOUISVILLE, IL 62858

Address, City, State, Zip

02658

MARCH 26, 2008

Reviewed By

Date of Survey

INCIDENT OF MARCH 16, 2008

09038

Type of Survey

Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE:

THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

“A” VIOLATION(S):

330.330
330.720e)1)
330.1120a)
330.4240A

Section 330.330 Definitions in part:

Abuse means: Physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means and that required (whether or not actually given) medical attention.

Personal Care - assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual.

Section 330.720e)1) Admission and Discharge Policies

No person shall be admitted to or kept in the facility that is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation.

Section 330.1120a) Personal Care

Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

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Section 330.4240A) Abuse and Neglect

An owner, Licensee, Administrator, Employee or agent of a facility shall not abuse or neglect a resident.

These standards are not met as evidenced by:

Based on record review and interviews, the facility failed to adequately monitor, assess, and develop a plan to provide for personal care needs including daily supervision for homicidal ideations, behaviors, mood changes, and medication refusals for 1 of 1 resident (R1) who was assessed by a psychiatrist as having homicidal ideations. The facility also neglected to provide safety for 1 of 1 resident (R2) by failing to ensure that R2 had an environment that was free from physical abuse. R2 was physically abused by another resident, R1, causing physical harm and death.

The findings include:

R1 is a 25 year old resident with diagnoses that includes Seizure Disorder and Psychotic Disorder according to his physician's order sheet dated 03-01-08 through 03-31-08. R1's nutritional assessment dated 03-15-07 documents that he is 5 feet 5 inches tall and R1's medication administration record dated March 1-31, 2008 documents that R1 weighs 247 pounds.

Review of R1's medication administration record for February, 2008 and March, 2008 documents that R1 frequently refused his morning medications which included Lexapro 20 mg by mouth at 8am and Risperdal 2 mg by mouth at 8 am and 8 pm. R1 refused his Lexapro and Risperdal 10 times in February, 2008 and 5 times from March 1 through March 16, 2008. E5, Aide, stated during an interview on 03-20-08 at 11:05 am that R1 did not like to get up in the mornings so he would miss his morning medications. E5 also stated that she did not call the physician to let him know R1 was not getting up in the mornings and therefore was not taking his medications. E1, Administrator, stated during an interview on 03-20-08 at 2:50 pm that Z3, physician, sees the medication administration record when he sees R1 so there was no need to notify him of R1's refusal to take his Lexapro, an antidepressant, and Risperdal, an antipsychotic medication. There was no documentation that the facility attempted any type of behavior interventions to encourage R1 to take his morning medications. Z5, physician's assistant, stated during a telephone interview that he did not know R1 was not taking his antipsychotic medications.

According to the admission data sheets, R1 was first admitted to this facility on 04-01-05 and was readmitted to the facility on 06-30-06. A psychiatric evaluation completed by Z1, psychiatrist, on 07-12-06 documents that R1 has a diagnosis that includes Psychotic

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CONT. Disorder and was recently readmitted to the facility after an altercation with his sister. This 07-12-06 evaluation states, "Pt (Patient) tried to push sister out window and his father intervened. Now Pt is disrespectful to staff; profane and obstinate."

On 09-06-07, R1 saw Z1. The progress notes from this visit document his mental status as "Having homicidal thoughts X (times) 2 mos. (months)." And homicidal ideation is circled to indicate his thought content during the visit. There is no documentation that Z3 or Z5 were notified of this psychiatric evaluation or that the facility developed a plan to increase supervision and protect the other residents in the facility.

On 10-30-07, R1 again saw Z1. The notes state, "still with homicidal thoughts." and the category homicidal ideation is circled to indicate his thought content during the visit. There is no documentation that Z3 or Z5 were notified of this psychiatric evaluation or that the facility developed a plan to increase supervision and protect the other residents in the facility.

E2, Office Staff, was asked about R1's homicidal thoughts during an interview on 03-20-08 at 11:10 am. E2 stated that she did not remember the entry from Z1 and did not think he had any homicidal thoughts. E1, Administrator, on 03-20-08 at 1pm was asked if she knew about R1 having any homicidal thoughts and she stated she did not know of any and R1 may have said that seeking attention. None of the facility staff that were interviewed during this survey were aware that these reports indicated R1 was having homicidal ideations.

E3, Aide, stated in an interview on 03-20-08 at 9:15 am that on 03-16-08, R2 had asked her for a cup so he could get a drink of water. E3 and R2 walked together toward the water fountain then E3 started to enter the laundry. R1 was coming through the area and asked, "Where is (R3)?" E3 continued to enter the laundry. E3 heard R1 accuse R2 of throwing water on him and then heard what she thought was a punch. E3 said she then went running out the door of the laundry. E3 saw R1 punch R2 again on the right side of the face. R2 went down, hit the trash can and then went straight down on his face on the floor. E3 yelled for help and E4, Cook, came. R2 was not moving and was gasping for air.

E4 stated in an interview on 03-20-08 at 9:45 am that E3 yelled that she needed E4 now. E4 stated when she came out the kitchen door she saw R2 on the floor and R1 ranting and raving that R2 had thrown water on him. At this point, E4 told R1 to go back to his side. E4 said that R1 was lying at a funny angle. She tried to talk to him but never got a response. E4 also stated that R1 was not himself. He seemed to her angry and was in a bad mood. She said she has never seen R1 that vicious and did not think he knew what he had done.

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E3 was interviewed on 03-20-08 at 9:15 am and stated that R1 was a "Bully" and would push and shove people. E3 also stated that R1 was "not himself that day."

During an interview on 03-20-08 at 11:05 am, E5, Aide, stated that R1 is "hard core" and always cursing at her. E5 stated that he did not like to follow the rules and that R1 would pick on people and could not keep his hands off others. She stated that in the past R1 had struck several residents but not hard. There was no documentation of these incidents found in R1's medical record which was reviewed on 03-20-08. E5 said she saw R1 last on Friday, March 14th and on that day he was arguing a lot. E5 stated that in her book, "He had a violent temper" and she did not want him behind her. E5 stated that the only behavior tracking that they use is a weekly sheet used to determine who gets to go out to eat on Fridays. E1 was interviewed on 03-20-08 at 1pm and verified that the weekly sheets are used to determine who gets to eat out. E1 also indicated that they do not keep these forms. There is no documentation of any facility interventions to prevent R1's abuse of the other residents.

The facility incident report documents that the altercation between R1 and R2 occurred at approximately 10:45 am on 03-16-08. The sheriff was on the scene within 2-3 minutes and advised staff not to move R2 from the position he was laying. First responders came approximately 2 minutes later and moved R2. They initiated CPR at that time. The ambulance arrived within another 5 minutes and R2 was transported to a local hospital. R2 was then transported to an out of state hospital for a head trauma condition. R1 was taken into custody by the sheriff's department where he remains at this time. This was verified by Z4, Deputy for the Clay County Sheriff's Department at 3:20 pm on 03-21-08 during a telephone conversation.

According to the physician's order sheet dated March 1-31, 2008, R2 was a 79 year old resident with diagnoses that includes Manic Depressive, Schizophrenia, and Hypertension. R2's weight was 132 pounds and his height was 5 feet 4.5 inches according to the emergency room documentation.

After the incident, R2 was admitted to a local hospital for treatment with the chief complaint of Cardiac Arrest after a fall according to the emergency room documentation. A CT scan of the head taken during this admission, documents findings of "Subarachnoid hemorrhage in the frontal lobe, temporal lobe, parietal lobes, per circle of Willis, peribrain stem at the pericerebellum noted. A ruptured aneurysm is a prime consideration." R2 was transferred to an out of state hospital due to need for a higher level of specialty services on 03-16-08 at 5pm by helicopter service. R2 expired on 03-17-08 at 10 pm according to the 03-17-08 nurse's notes for R2.

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According to the Clay County Circuit Clerk web site, R1 has been charged with aggravated battery of a senior citizen over the age of 60 years which is a class 2 felony. Z4 stated during the telephone conversation on 03-21-08 at 3:20 pm that they are waiting on the outcome of R2's autopsy and more charges may be added.

“A”