

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2014
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NAME OF PROVIDER OR SUPPLIER H & S CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3RD & CARPENTER, P.O. BOX 376 TAMMS, IL 62988
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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 1452083/IL69789 - 330.785 b)2) c), 1-5 d) 1452096/IL69803 - 330.710 c)2) 330.780 b) 330.785 b)2)c)1-5d) 330.1110 f) 330.4240 b)d)f)	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 330.710a) 330.710c)2 330.780b) 330.785b)2) 330.785c)1-5) 330.785d) 330.1110f) 330.4240b) 330.4240d) 330.4240f) 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. c) The written policies shall include, but are not limited to, the following provisions:	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services.</p> <p>Section 330.780 Incidents and Accidents</p> <p>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>Section 330.785 Contacting Local Law Enforcement</p> <p>b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:</p> <p>2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability;</p> <p>c) The facility shall develop and implement a policy concerning local law enforcement notification, including:</p> <p>1) Ensuring the safety of residents in situations requiring local law enforcement notification;</p> <p>2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;</p> <p>3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>4) Seeking advice concerning preservation of a potential crime scene;</p> <p>5) Facility investigation of the situation.</p> <p>d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).</p> <p>Section 330.1110 Medical Care Policies</p> <p>f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition.</p> <p>Section 330.4240 Abuse and Neglect</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act)</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on Interview, observations and record review the facility failed to: Implement written policies for notifying physicians, emergency medical personnel, and social services; Notify the residents physician of R2's injury and R3's behavior; Notify the Regional Office within 24 hours of an incident involving 2 residents (R2, and R3) reviewed for abuse; Contact local law enforcement authorities when a resident (R3) physically abused another resident (R2); Train staff at the facility of notification policies for resident to resident abuse for two residents (R2 and R3).</p> <p>These failures resulted in R2, being hit in the head with a flashlight, being sent to a local hospital emergency room, transferred to a larger acute care facility and according to Z4 (Emergency Room Nurse Manager), R2 received multiple facial fractures, right eye lid laceration (lower margin), right conjunctiva hemorrhage and right maxillary sinus mildly displaced due to a nasal septum fracture.</p> <p>On May 13, 2014 at 7:45 PM E3 provided a resident census sheet that indicated the facility has 21 residents in the facility with one resident in the hospital with a bed being held.</p> <p>Findings include:</p> <p>1) R2 is 52 years old based on the Admission Record, and based on interview and observation</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>appears alert and oriented to person place and time, independent in activities of daily living, and able to make needs known.</p> <p>R3 is 40 years old based on the Admission Record, and based on interview and observation appears alert and oriented to person place and time, independent in activities of daily living, and able to make needs known.</p> <p>On May 14, 2014 at 10:00 AM R2 reported "I refused to go to the hospital or doctor to get my eye seen about when I got into a fight with my room mate" R2 told this writer he "did not want to talk about it, its over and I don't want to bring it up again."</p> <p>On May 13, 2014 at 7:30 PM, R3 reported "In the early morning hours of May 10, 2014, R2 came over to my bed and started hitting me with a flash light after I had asked R2 to turn the radio down around 5 different times. I took the flash light away from R2 and started hitting R2 with it until it broke into pieces. I stopped hitting R2 when I saw blood on R2's face. R2 refused to go to the hospital to get the eye taken care of, E5 (Aide / Housekeeping) wanted to call an ambulance but R2 refused".</p> <p>On May 13, 2014 at 8:10 PM E2 (Facility Manager) reported the facility has no policy for notifying the local police or the residents physician regarding behaviors. "If it is after hours I sometimes come out to talk with them or talk to them over the phone, most of the time I can settle them down. If someone gets hurt staff is to notify the ambulance first, me next then E1 (Administrator / Owner). Usually we don't notify the doctor we make an appointment for the</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>resident to be seen by their doctor. The staff have been here so long they know how to handle resident behaviors. If the staff or I cannot settle the resident down then I have them call the crisis line at the local community mental health facility to have them come out to see the resident and screen for hospitalization at an inpatient psychiatric facility." When questioned about when the staff need to call an ambulance first or the facilities administrative staff, R2 reported "chest pain, head injury, profuse bleeding, or a seizure lasting over 3 minutes the ambulance would be notified first then they would call me".</p> <p>On May 14, 2014 at 10:35 AM over the phone E5 reported R6 came to the kitchen and said there was a lot of commotion coming from R2 and R3's room. E5 stated "I went to the room and found R2 and R3 standing face to face with each other, the fight was over. I asked R2 what happened since he was holding his eye and R2 said R3 hit R2 in the eye with a flashlight after R3 asked R2 to turn down the radio and R2 said 'I'm a grown man and I did not have to do what R3 said'. E5 called E2 and reported the altercation and that R2 was refusing medical treatment. E2 told me to call an ambulance and when I told R2 an ambulance was going to be called R2 said he was a grown man and he did not have to go so I did not call the ambulance". E5 reported the flash light was about 1 foot in length, yellow plastic and the kind that takes 2 "C" batteries". The flash light was broke in several pieces so I swept it up and threw it in the trash. I did not call the police, the fight was over and I brought R3 down to the kitchen to talk for about an hour to make sure he was ok before letting him go back to bed."</p> <p>Z3 (Registered Nurse at local emergency room hospital) reported there were three people with</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>R2 when R2 brought to the emergency room on May 13, 2014 around 2:00 PM, a sheriff's deputy, a community mental health crisis worker, and a H & S Care Center worker. R2 reported to Z3 at that time an antibiotic cream was being used by R2 on the eye injury prior to coming to the emergency room.</p> <p>On May 14, 2014 at 3:00 PM, Z2 (Licensed Practical Nurse for R2's physician) reported R2's physician had not been notified of an eye injury.</p> <p>On May 16, 2014 at 4:50 PM Z1 (Clinical Supervisor for a local community mental health provider) reported the local community mental health's crisis line had been notified twice regarding evaluating R2 at the facility due to R2 refusing medical care for an eye injury. The first call came in on May 11, 2014 at 10:15 AM, a crisis counselor responded, met with R2 and said R2 was willing to go to a hospital in a surrounding state. The facility again called the crisis line on May 13, 2014 at 11:45 AM and the crisis counselor responded again and escorted R2 to the local hospital for medical treatment due to failure to care for self.</p> <p>On May 15, 2014 at noon, E1 reported being notified of R2 and R3's altercation on May 13, 2013. E1 reported "I called the States Attorney's office and requested assistance to make R2 obtain treatment for the eye injury, the nurse (E4) had called the local community mental health facility for a crisis worker to evaluate R2 again and E3 (transporter) was told to keep trying to get R2 to obtain medical treatment. The facility policy for calling an ambulance or the police is ' if the situation is not life threatening call the manager and R2 has the responsibility to go to the facility to see what is going on'. If it is a medical issue</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>the manager knows to call the Registered nurse consultant (E4)."</p> <p>On May 15, 2014 at 10:41 AM E4 reported not completing an investigation or notifying Illinois Department of Public Health and stated "I was notified May 11, 2014, not sure of the time and was told R2 threw a flashlight at R3 and R3 started hitting R2 with the flashlight. The staff tried to get R2 to go to the hospital but R2 refused. The local community mental health facility was called but they wouldn't make R2 obtain treatment since they felt R2 had a right to refuse and it was a medical issue and not a psychiatric issue."</p> <p>On May 16, 2014 at 1:10 PM E6 reported no memory of the facility staff notifying E6 regarding E3's physical altercation with R2.</p> <p>On May 16, 2014 at 1:07 PM E2 brought in a document dated May 12, 2014 listing an Incident/Accident report where R2 was "in an altercation with another peer and R2's right eye has been hurt" and checking the Regional Office file for reported incidents from H & S Care Center, no incidents were found as being reported for R2 or an eye injury as a result of a resident to resident altercation.</p> <p>Review of R2's Universal Progress Notes reveals: A resident to resident altercation occurred on May 10, 2014 at 2:30 AM, E2 was notified and R2 refused to be taken to the hospital; On May 10, 2014, at 9:00 AM E2 called the facility and R2 was continuing to refuse medical care; On May 10, 2014 at 3:30 PM R2 refused to talk to E2 during a visit to the facility; E4 (Registered Nurse [RN] consultant) was notified and came to the</p>	S9999		

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S9999	Continued From page 8 facility on May 11, 2014 to examine R2's eye, R2 refused to allow E4 to examine the eye; On May 11, 2014 the local community mental health facility was called and came to the facility to examine R2 but due to not meeting mental health criteria, they could not force R2 to obtain medical care, but did report R2 would be willing to go to an out of state hospital; E2 came to the facility to transport R2 to the out of state hospital and R2 refused to go; On May 12, 2014 at 8:00 AM, E3 went to R2's room and requested R2 go to the primary doctor, R2 told E3 the eye was getting better, the swelling had gone down and it was not hurting as it was before; On May 12, 2014 at 10:30 AM R2 allowed E3 to examine the eye and E3 told R2 to allow E3 to transport R2 to the doctor and R2 reported "God was going to heal it"; On May 12, 2014 at 4:30 PM E3 requested R2 go to the Emergency room and again R2 refused; On May 13, 2014 R2 allowed E3 to examine R2's eye and again E3 insisted R2 go see a doctor and R2 said no it was getting better due to the eye itching. E3 notified E1 and E4. E4 said to call an ambulance. Once the Emergency Medical Technician (EMT) got to the facility R2 allowed the eye to be examined but refused to go with the EMT's to the hospital. E4 came to the facility R2 refused to allow E4 to examine the eye or discuss the injury. E4 called the local community mental health facility crisis worker again to screen the R2 for lack of self care and after the evaluation the crisis worker called a deputy sheriff to pick R2 up and transport to a local hospital for evaluation. A review of prior Universal Progress Notes indicate R2 has been refusing the antipsychotic medications on several occasions, getting into different types of altercations with other peers at the facility pushing other peers on two occasions, screaming or arguing with peers on 5 different occasions,	S9999		
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S9999	<p>Continued From page 9</p> <p>pouring ice water on peers on two different occasions and got into a fight with another peer once since January 21, 2014.</p> <p>On May 17, 2014 at 2:10 AM, R5 reports notifying R2 when resident to resident altercations occur since it takes the police so long to respond, and "once they do respond, they awaken the residents, the neighbors are disturbed from the police car lights running, and it is better if I can control the situation to try to do that. Other than the documents put on the bulletin board for review, or the communication book, I have not received any training. I have been here 14 years and I know the residents and when I can handle the situation. I have had to call the police only twice". When E5 was questioned on when to notify the administrator, local law enforcement, or the physicians E5 stated "I just call the manager (E2) and E2 decides what to do". When asked about calling an ambulance R5 reported an example of when an appropriate time to call an ambulance is "when the resident is not breathing".</p> <p>According to the Contacting Law Enforcement policy dated May 14, 2008 local law enforcement will be contacted immediately when a resident is physically assaulted by another resident.</p> <p>On May 14, 2014 at 10:35 AM E5 reported the local law enforcement was not notified on the morning of May 10, 2014 at 2:30 AM when R2 and R3 were fighting.</p> <p>2) R4 is 26 years old based on the Admission record, and according to E2 on May 13, 2014 at 8:10 PM R4 is alert, oriented, independent in activities of daily living and able to make needs</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>known.</p> <p>On May 13, 2014 at 8:10 PM E2 (Facility Manager) reported the facility has no policy for notifying the local police or the residents physician regarding behaviors. "If it is after hours I sometimes come out to talk with them or talk to them over the phone, most of the time I can settle them down. If someone gets hurt staff is to notify the ambulance first, me next then E1 (Administrator / Owner). Usually we don't notify the doctor we make an appointment for the resident to be seen by their doctor. The staff have been here so long they know how to handle resident behaviors. If the staff or I cannot settle the resident down then I have them call the crisis line at the local community mental health facility to have them come out to see the resident and screen for hospitalization at an inpatient psychiatric facility." When questioned about when the staff need to call an ambulance first or the facilities administrative staff, R2 reported "chest pain, head injury, profuse bleeding, or a seizure lasting over 3 minutes the ambulance would be notified first then they would call me".</p> <p>A review of an incident statement by E7 (Aide/housekeeper) indicates on May 9, 2014 R4 was threatening staff with an ice pick, broke out a window in the kitchen door and had to be taken to the local emergency room for care of a hand laceration.</p> <p>On May 12, 2014, The Illinois Department of Public Health Regional Office received an incident notification from H & S Care Center, reporting on May 9, 2014 R4 was admitted in to the hospital.</p> <p>Upon review of R4's Universal Progress notes</p>	S9999		

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S9999	Continued From page 11 regarding the incident occurring on May 9, 2014 no documentation of physician notification or local law enforcement was found in R4's record. <p style="text-align: center;">(A)</p>	S9999		