Illinois Department of Public Health

			OVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COM	PLETED			
IL6005672		B. WING		i i	C 01/20/2015			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MAGNO	LIA MANOR SHELTER	R CARE HM	1100 GRA	ANT DO, IL 6293	0			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
S 000	Initial Comments			S 000				
	Complaint investiga	ation 1550247/I	L74335	ATT CONTRACTOR AND				
S9999	Final Observations			S9999				
	Statement of Licens	sure Violations		Note that the second se				
	Section 330.4300	Fransfer or Dis	charge	Management of the control of the con				
	c) 1) A facility in discharge a resident following reasons:	may involuntari it only for one c						
	C) for the physical the facility staff or facility	ical safety of ot acility visitors.	her residents,					
	d) Involuntary to resident from a facilities discussion required Section and by a middays, except in one	under subsect nimum written	ceded by the ion (j) of this notice of 21					
	1) When an endischarge is ordered physician because oneeds; (Section 3-4)	of the resident's	nt's attending s health care					
	2) When the tramandated by the phresidents, the facility documented in the object transfer Department will immunischarge and reloct transferred or discharge and the Department will transferred or discharge and the Department teams as provided in the prov	y staff, or facilitical record. In contified prior to or discharge. In discharge ation assistant arged under the nent may place.	f other y visitors, as The to any such The transfer, or the to residents is subsection e relocation					

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/04/2015 FORM APPROVED

Illinois Department of Public Health

ILEGOSET2 NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
MAGNOLIA MANOR SHELTER CARE HM 1100 GRANT ELDORADO, IL 62930 INCLIP PREFOX (CACH DESCRICATION OF U.SC. IDENTIFYING INFORMATION) S9999 Continued From page 1 (Section 3-402(b) of the Act) e) For transfer or discharge made under subsection (d) of this Section shall be made as soon as practicable before the transfer or discharge. (Section 3-403(a) of the Act) 2) The fefficitive date of the proposed transfer or discharge. (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to not less than 12-point type, which reads: "You have a right to appeal the facility's decision following the hearing is not in your favor, you generally will not be transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transferer or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharged. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health within the postage paid, preaddressed envelope to the Department, and (Section 3-403(d) of the Act) 5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act) 5) The name, addressed envelope to the Department, and (Section 3-403(e) of the Act) 5) The name, addressed envelope to the Department or option to the course of the Act of the Ac						C	
MAGNOLIA MANOR SHELTER CARE HM SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR ISE OFFICIENCY	***************************************		IL6005672	B. WING	7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	01/:	20/2015
Summer stratement of periodecies Summer stratem	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 1 (Section 3-402(b) of the Act) e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The note required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(b) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility, sou may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or dischargee prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below. "(Section 3-403(c) of the Act) 4) A hearing request form, together with a postage paid, preaddressed envelope to the Department, and (Section 3-403(d) of the Act) 5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act) 4) A copy of the notice required by subsection (d) of	MAGNOLIAMANOR SHELLER CARE HM				0		
(Section 3-402(b) of the Act) e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge, A form to appeal the facility's decision and to request a hearing is tatched. If you have any questions, call the Department of Public Health at the telephone number listed below. ".(Section 3-403(c) of the Act) 4) A hearing request form, together with a postage paid, preaddressed envelope to the Department, and (Section 3-403(d) of the Act) 5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(d) of the Act) A copy of the notice required by subsection (d) of	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
this Continuous Continuo A 400 of U. A. J. U. J.		(Section 3-402(b) of e) For transfer or dissubsection (d), the eshall be made as softransfer or discharge subsection (d) of this prescribed by the Deall of the following: 1) The stated reasodischarge; (Section 2) The effective date discharge; (Section 3) A statement in nowhich reads: "You he facility's decision to you think you should you may file a request Department of Public receiving this notice will be held not later request, and you ge or discharged during following the hearing generally will not be prior to the expiration of the original notice A form to appeal the request a hearing is questions, call the Department; and (Section 2) The name, address the person charged supervising the transpands of the Act) A copy of the notice	f the Act) scharge made under notice of transfer or discharge on as practicable before the e. The notice required by is Section shall be on a form epartment and shall contain In for the proposed transfer of 3-403(a) of the Act) of the proposed transfer or 3-403(b) of the Act) of the proposed transfer or 3-403(b) of the Act) of tless than 12-point type, ave a right to appeal the transfer or discharge you. If d not have to leave this facilities for a hearing with the of Health within 10 days after of than 10 days after your nerally will not be transferred of that time. If the decision of is not in your favor, you transferred or discharged of the transfer or discharged of the transfer or discharge of the	ee			

Illinois Department of Public Health

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PRINTED: 02/04/2015 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
IL6005672		B. WING		C 01/20/2015	
NAME OF PROVIDER OR SUPP	LIER STREET AI	DRESS, CITY, STAT	E, ZIP CODE		
MAGNOLIA MANOR SHE	TER CARE HM 1100 GR	ANT DO, IL 62930			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
shall be transmoresident, the resident, the resident, the resident's care. Title XIX, to the Family Service. j) The planned shall be discust resident's representative and involuntary transfacility administ representative. The content of shall be summathe names of the discussions and clinical record. This requiremed Based on interversident, and involuntary resident, and to an involuntary residents. (R2) in the sample of 3 are sidents. Findings include On 1/16/15 at 1 that R2 was in a behavior episod letter stating R2 outside of the facontinuous more	sident's clinical record and a copy itted to the Department, the sident's representative, and, if the is paid for in whole or part through Department of Healthcare and S. (Section 3-405 of the Act) involuntary transfer or discharge sed with the resident, the sentative and person or agency the resident's placement, and care in the facility. The discussion of the reasons for sfer or discharge shall include the rator or other appropriate facility as the administrator's designee. The discussion and explanation in writing and shall include the individuals involved in the discussion and explanation wrized in writing and shall include the individuals involved in the discussion and explanation writing and shall include the individuals involved in the discussion and explanation writing and shall include the individuals involved in the discussion and explanation writing and shall include the individuals involved in the discussion and resident's section 3-408 of the Act)	S9999			

Illinois Department of Public Health

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
		IL6005672	B. WING		01/2	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAGNO	IA MANOR SHELTER	R CARE HM FLDORAL	ANT OO, IL 62930	1		
044.15	SLIMMADV STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
S9999	Continued From pa	age 3	S9999		danaoonussa a	
		logical Assessment dated e of the letter described above.			A DESCRIPTION OF THE PROPERTY	
	9/24/14, R2 was be admitted to the faci the Physician's Ord diagnoses include I	acility Face Sheet dated orn on 9/26/80 and was lity on 9/2/14. According to ders for January of 2015, R2's Psychotic Disorder NOS (Not d), Mood Disorder NOS, and ury.				
	Assessment dated identified offender variety required "a single runursing station to pumonitoring." Nurse	titled Psychological 11/7/14, R2 is a high risk with a history of violence who oom in close proximity to the ermit ongoing visual as Notes dated 11/29/14 and 22 was experiencing suicidal tions.				
	p.m., R2 left the factors house and called the he did not want to report to Nurse's Notes downwas taken to the erbreathing trouble, a told staff that if he rekill everyone. R2 w	e's Notes dated 1/1/15 at 6:40 cility and went to a neighbor's ne police. He told police that return to the facility. According ated 1/1/15 at 9:20 p.m., R2 mergency room complaining of and in the emergency room R2 returned to the facility he would was then screened by a sequently admitted to a				
	spoken to an (unna services departmen that the owner of th R2 to return to the facility had not sub- involuntary transfer	p.m. E1 stated that she had amed) individual in the social of the hospital and stated ne facility (E2) refused to allow facility. E1 stated that the mitted notification of the to the Department, and that hat such notification was a				

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED			
		IL6005672	B. WING		01/2) 0/2015	
NAME OF	PROVIDER OR SUPPLIER	Lucino servir de la companio del companio de la companio della com	DRESS, CITY,	STATE, ZIP CODE	1		
MAGNO	MAGNOLIA MANOR SHELTER CARE HM 1100 GRANT ELDORADO, IL 62930						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
\$9999	requirement. On 1/20/2015 at 2:0 member, stated tha for 8 years. Z1 stat facility because she longer care for him. unaware until last w hospitalized, and wa would not be allowe On 1/20/2015 at 9:4 any notification was involuntary discharg that she did not, and information E2 had 10:20 a.m., E2 deso which endangered of that he had not provinvoluntary transfer because he did not the facility. E2 also	ge 4 20 p.m., Z1, R2's family the she has been R2's guardian and that she placed R2 at the sis disabled and could no Z1 stated that she was weekend that R2 had been as unaware until today that he ad to return to the facility. 25 a.m., when asked whether provided to R2 regarding his ge from the facility, E1 stated at that she was unsure what provided. On 1/20/2015 at cribed behavioral problems other residents, and stated wided any notification of to R2 or other relevant parties expect R2 to come back to acknowledged that Z1 had the involuntary discharge. (B)	\$9999				

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