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
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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 #1650827/IL83382	S 000		
S9999	Final Observations Statement of Licensure Violations 330.780a) 330.780b) 330.780c) 330.4240d) 330.4240f) Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 1	S9999		

phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 330.4240 Abuse and Neglect

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)
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)
These requirements were not met as evidenced by:
1.) Based on observation, interview and record review the facility failed to investigate report of peer to peer incidents of abuse and to notify the department of the actual abuse for three residents (R2, R4, R5) in a total sample of 6 residents reviewed for abuse and neglect.

2.) Based on observation, interview and record review the facility failed to notify the Regional office within 24 hours of a reportable incident or accident for two residents (R1, R6) in a total sample of 6 residents reviewed for accidents and

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
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 2	S9999		

injuries

Finding Include:

1a.) On 2/17/16 at 11:10 AM, R4 was by medication cart and had laceration and raised area over left eyebrow with black, blue and dark purple discoloration. When R4 was asked what happened stated last night (2/16/16) during the evening that R2 and R5 had been arguing over a shirt. R4 stated he tried to stop the fight and he (R4) and R5 ended up in the floor fighting. R4 stated during the fight, R5 had struck him in the head with his cane.
1b.)On 2/18/16 at 10:00 AM, E1 Administrator, stated she had seen R4 ' s actual injuries for the first time the same time the surveyor had yesterday on 2/17/16 at 11:10 AM. E1 stated E5(caretaker) had called her yesterday evening and told her that R2 and R5 had gotten into a fight and R4 had stepped in to break it up and as a result had a small abrasion on his eye. E1 stated what E5 described to her on the evening of the incident (2/16/16), as to what R4 actual injury were, are not what was observed on 2/17/16 at 11:10 AM. E1 stated as far as she knew E5 did not do an Accident and injury report for the injury on R4. E1 stated E5 should have done an Accident and injury report for R4 and should include what happened and what the injury actually was. E1 stated R4' s injury did not match E5' s verbal description given over the phone that night. E1 stated E5 should have checked R4 ' s vital signs, checked his pupils and done the proper documentation in R4 ' s chart. When E1 was asked if this was a peer to peer and if actual injury had occurred E1 stated yes. When E1 was asked if she had done any investigation she stated she had not done anything formal and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 3	S9999		

just spoken with R2, R4 and R5 to make sure it didn' t happen again. When asked E1 if she was supposed to notify IDPH about possible abuse with this incident, E1 stated she wasn ' t sure. Upon further discussion and review of the facility policy and procedure E1 stated that abuse had occurred and IDPH should probably have been notified but, she hadn ' t as of this time. E1 stated she was not sure what the policy was about peer to peer altercations and reporting to IDPH.
R4 ' s nursing notes dated 2/16/16 with no time shows resident trying to break up a fist fight and one of the other residents hit resident and cut him by his left eye. Resident was checked. Does not need stiches or to see a doctor. This is signed by E5 (caretaker)
R5 ' s nursing note dated 2/16/16 done by E5 with no time shows, Resident got into an argument with another resident over a shirt, tried to stop the argument and resident hit him. Resident and other resident began to fist fight. Another resident tried to break up fight. Writer kept trying to grab residents cane so staff was not hit with it. Writer finally got the cane and restrained resident. Other staff restrained other resident. One resident ended up with a cut near his eye and resident ' s mouth was bleeding. Writer checked everyone involved ok. No stiches needed to go to the hospital. Resident said his knee hurt but it ' s from falling on it.

1c.) R2 ' s nursing note from 12/27/15 shows resident verbally cursing another resident off and on and writer was called outside to break up a physical altercation with this resident and another resident. This writer broke up the fight and separated both residents, signed by E3 (caretaker). On 2/18/16 at 2:00 PM, E1 stated this altercation was also with R4. E1 stated she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 4	S9999		

not report this to IDPH because she did not know she was supposed to. E3 stated she wrote the note and did not do accident and injury report and did not notify IDPH and has not received any education regarding abuse and neglect or what to do with peer to peer altercation besides to document and notify the administrator.
On 2/18/16 at 10:00 AM, E1 stated she had not reported this to IDPH because she did not know she was supposed to. E1 stated after looking at the facility policy a nurse's note is to be written and an Accident and Injury report done. E1 stated E5 did not do report.
On 2/18/16 at 2:00 PM, E1 stated the main issue with the recent physical aggression was R2. E1 stated R2 is very antagonizing. E1 stated they have been trying to place him somewhere else for a while but have not been able to . E1 stated they have tried to place at different facility due to the fact he has caused multiple assults on other residents and likes to cause fights and argues. E1 states she doesn ' t bother calling the local police because they won ' t do anything and if she were to send R2 to the local hospital they would just send him right back because no one else will take him.

2a.) R1' s Admission/Release/Death of Report shows admission as 8/1/85 and date of death as 11/30/15.
R1' s Face sheet with admit date of 8/1/85 shows diagnosis of Organic Brain Syndrome, Schizophrenia, Arthologic Knee
R1 ' s nursing notes with date of 11/30/15 show resident complained about diarrhea and vomiting for past couple of days. Feeling anxious and nervous and complained of not feeling well took R1 to administrator and sat R1 down in chair and had a nose bleed. Administrator called

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
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 5	S9999		

ambulance to take resident to the hospital to get checked out. Ambulance was immediately called and they arrived around 6:50 PM and transported to hospital.
On 2/17/16 at 12:30 PM, E3 (Caretaker) stated she was the one who had written nurses note for R1 the day he went to hospital on 11/30/15. E3 stated that when she was walking with the ambulance attendance out the door, R1 had blood start coming out of his mouth and nose in a large amount and at that time, the ambulance persons " took off " and were in a hurry to get to hospital. E3 stated R1 had died at the hospital later that day.
On 2/17/16 at 3:00 PM, E1(Administrator) stated that R1 had been at the facility for many years and prior to him leaving and going to the hospital on 11/30/15. E1 stated as far as she knew, R1 had no major health problems. E1 stated she had not expected R1 to expire at the hospital on 11/30/15. E1 stated R1 died at the hospital on 11/30/15 but had been in the facility the same day prior to expiring at the hospital on 11/30/15. E1 stated she had not notified IDPH (Illinois Department of Public Health) of R1 death because she did not know she was supposed to because R1 had actually died at the hospital.
2b.)R6' s record with title on "Plastic and Reconstructive Surgery " dated 2/11/16 done by Z1 (Doctor/Plastic and Reconstructive Surgeon) shows patient presents as a follow up for emergency room last night due to a lip laceration on the left upper lip. The patient states that he fell while getting up last night. Patient plan is a complex lip laceration from fall last night brought by nursing home and repair performed today. Procedure: complex repair of left upper lip 4 cm (centimeter) laceration.
R6' s hospital report dated 2/11/16 at 3:40 am shows the care of your problem is not complete.

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
	IL6005672	A. BUILDING: _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR SHELTER CARE HM	1100 GRANT ELDORADO, IL 62930

(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
S9999	Continued From page 6	S9999		

Additional evaluation by another doctor is necessary. Please arrange to be seen by Z1 (plastic surgeon) on or before 2/11/16.
R6' s Accident and Injury report dated 2/11/16 at 1:45 AM shows R6 came to dining room and had fallen in his room in the dark, busted his lip, nose and gums were bleeding and complained of no other injuries. R6 to hospital by ambulance.
On 2/17/16 at 4:00 PM, E2 (office assistant) stated he was the one that had taken care of R6 and transported him to the plastic surgeon on 2/11/16. E2 stated he had went and picked R6 up from the hospital and the hospital emergency room doctor stated they could not take care of R6 ' s injury due to the extent of R6' s injury. E2 stated the emergency room doctor stated he (doctor) had already notified the plastic surgeon and made the appointment and the facility needed to make sure R6 made it to the appointment. E2 stated he had taken R6 to see the plastic surgeon on 2/11/16 according to the hospital doctor instructions. E2 stated he was the one that had dealt with the situation and did not know he was to notify the IDPH with R6' s injury.
On 2/17/16 at 4:00 PM, E1 stated normally she does all the IDPH notification but she was not there or she would have notified us. E1 stated IDPH should have been notified about R6' s injury and accident and had not been.

(B)