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
	IL6001671	A. BUILDING: ______ B. WING ______	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT CORNER S C	905 WEST CHESTNUT STREET LOUISVILLE, IL 62858

(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 2150833/IL130788	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.720 b) 330.720 e)1) 330.720 e)3) Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care. e) No person shall be admitted to or kept in the facility: 1) Who 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; 3) Who has serious mental or emotional problems based on medical diagnosis; (Source: Amended at 31 Ill. Reg. 6072, effective April 3, 2007) The requirement is NOT met as evidenced by: Based on interview and record review, the facility failed to transfer out a resident in need of 24 hour nursing care for one of three residents (R2) reviewed for level of care needs in the sample of 5.	S9999	Attachment A Statement of Licensure Violations	

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

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Findings include:

On 02/09/21 at 11:30am, V5, Ombudsman, stated she was concerned that the facility is unable to provide the appropriate level of care for R2. V5 stated R2 has recently experienced a decline in level of functioning, possibly due to his chronic mental illness, has been confused, and was found wading in a nearby creek looking for his sister's house. V5 stated she is concerned R2 will accidentally harm himself if this behavior continues. V5 stated she has had several conversations about this with V1, Administrator, who has failed to either seek a different placement or to provide one to one supervision for R2.

A 12/05/20 Social Service Note authored by V9, Assistant Administrator, documented, "(R2) is not his normal go getter self. He is on constant every 30 minute watch.(R2) is very confused and his frustration is getting high.(He is) unsure of his wherabouts. (Has had) a few (emergency room) hospital visits, always sent back with no improvement."

On 02/09/21 at 2:55pm, V9 stated R2 has eloped from the facility twice, on 02/02/21 and 02/04/21. V9 stated both times R2 was found wading in a creek about a block away, stating he was trying to get to his sisters house. V9 stated R2's sister resides in New Jersey. V9 stated R2 has decompensated over the last several weeks, and has had numerous visits to his primary care provider, the emergency room, and V8, his Advanced Practice Nurse psychiatric care provider. V9 stated the facility has been trying to get R2 placed in an inpatient psychiatric unit, but each time they sent him to the emergency room for that express purpose, they have been told he

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S9999	Continued From page 2 does not meet criteria, and he has been sent back to the facility. V9 stated R2 was put on every thirty minute checks, but acknowledged that he is in need of one to one supervision. V9 stated on 02/08/21, R2 was found to have ingested cologne, was experiencing a change in level of consciousness, and was sent to the emergency room. V9 stated R2 is currently in an inpatient medical unit on observation. An Emergency Room Physicians Assessment Note, dated 02/08/21, stated, "Patient is from a group home. He has been intentionally spraying cologne into his mouth this evening. EMS (Emergency Medical Services) was called. In route, the patient's heart rate decreased into the 30's, with Narcan given by EMS, which corrected the bradycardia. Patients pupils are dilated and he is just staring straight ahead with no expression." On 02/09/21 at 3:15pm, R1 was alert and oriented to person, place, time, and purpose. R1 stated he and some of the other residents had been asked to help supervise R2 because he had eloped. R1 stated on 02/08/21, R2 got a hold of cologne and drank it. R1 stated he felt that R2 needs constant supervision due to his behaviors. On 02/09/21 at 3:50pm, V6, Aid, stated that R2 has decompensated in the past month or so and has shown behaviors such as thinking he hears dogs barking, believing his sister lives across the creek and eloping to try to get to her, and dumping an unknown substance in a carafe of coffee when he thought nobody was watching. V6 stated R2 is on every thirty minute checks, but he has had to ask higher functioning residents to help supervise R2 as there is only one staff member on shift. V6 stated on 02/08/21, R2	S9999		

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ingested cologne on his shift and had to be sent to the emergency room. V6 stated R2 needs to be in a placement where he will receive 24 hour care, "and it probably needs to be a locked unit."

On 02/10/21 at 11:00am, V3, Aid, stated he was working the evening of 02/04/21 when R2 eloped. V3 stated he had to go to the West Building for supplies, and asked R1 to watch R2 while he was gone. V3 stated he returned about five minutes later to discover R2 had eloped. V3 stated he found R2 wading in the creek, stating he needed to get to his sisters house. V3 stated R2 requires constant one on one supervision and that the facility cannot provide that.

A 01/19/21 Progress Note authored by V8 stated, "Thoughts disorganized. Forgetful at times. Complains of increased paranoia. Poorly groomed and disheveled. Pressured speech. Orientation confused. Concentration distracted. Orders: Will (increase) Vistaril (and)...Risperdal."

On 02/10/21 at 2:15pm, V8 stated R2 is diagnosed with Bipolar Disorder, has decompensated in the past several weeks, and she has adjusted his psychiatric medications in an attempt to stabilize his behaviors. V8 stated she has been working closely with R2's primary care provider, as R2 has had a urinary tract infection as well as some kidney issues, which may have contributed to his decompensation. V8 stated she and the facility have been trying to get R2 placed in an inpatient behavior unit, but there are few such units, and when R2 has been screened for emergency hospitalization through the emergency room, he did not meet criteria and was discharged back to the facility. V8 acknowledged R2 is in need of 24 hour monitoring and nursing care to address his

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S9999	Continued From page 4 psychiatric and physical conditions. V8 stated she did not discuss with facility staff the possibility of a transfer to a skilled nursing facility, but she would have approved of such a transfer.V8 stated she has been in contact with hospital staff and R2 will probably transferred to a local inpatient behavioral health unit. An undated Admission Transfer Discharge Policy stated, "Categories for accepted residents: Residents not in need of immediate nursing care.Residents with little or no signs of Psychosis.Categories of residents not accepted to the facility: Residents with a high risk of self inflicting injuries. Residents with a high risk of elopement. Residents with a recent history of elopement." On 02/11/21 at 8:45am, V1 acknowledged R2 is currently not appropriate for shelter care level of care. V1 stated the facility had been working toward getting R2 an inpatient psychiatric placement via emergency room visits and therefore did not consider placement in a skilled nursing facility with a behavioral health unit. V1 stated it is the emergency room staffs responsibility to try to obtain a transfer to a more restrictive level of care, not the facility's. V1 stated had he refused to readmit R2 after an emergency room visit, he believed the facility would have been liable for improper discharge. V1 stated the facility has recently lost several staff members and stated it would not have been possible to call staff in to supervise R2 one on one. (B)	S9999		