DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PETERSEON HEALTH NETWORK, LLC D/B/A FLORA GARDENS CARE CENTER, Respondent.	)))))))))	Docket No. NH 15-C0219

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation for IL76230 conducted by the Department on April 22, 2015, at Flora Gardens Care Center, 701 Shadwell Avenue, Flora, Illinois 62839. On May 26, 2015, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

A Plan of Correction is required to be submitted by the facility within two weeks from the date the violation notice was sent. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice. Please email the Plan of Correction to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$2,200.00**, as follows:

- Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.690a), 300.1210b), 300.3240a), 300.3240d), 300.3240e). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.690a), 300.1210b), 300.3240a), 300.3240d), and 300.3240e).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices. **Please email the hearing request to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.**

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in

exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment). **Please email the waiver to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.**

Debra D. Bryars 19

Debra D. Bryars
Designee of the Director
Illinois Department of Public Health

Dated this 2nd day of June, 2015.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PETERSEON HEALTH NETWORK, LLC D/B/A FLORA GARDENS CARE CENTER, Respondent.	)))))))))	Docket No. NH 15-C0219

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Marikay Snyder
Licensee Info:	Petersen Health Network, LLC
Address:	830 W. Trailcreek Dr.
	Peoria, IL 61614

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 2nd day of June 2015.

Leona Juhl
Long Term Care/QA
Illinois Department of Public Health

BF300/15-C0219/Flora Gardens Care Center/4-22-15/llj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003172	A. BUILDING: _____ B. WING _____	C 04/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	701 SHADWELL AVENUE FLORA, IL 62839

(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	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.690a) 300.1210b) 300.3240a) 300.3240d) 300.3240e) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on interview and record review, the facility failed to prevent episodes of staff to resident abuse for 2 of 2 residents (R1 and R2) from the	S9999		

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S9999	Continued From page 2 sample of 7. On 12-29-14, 4-2-15 and 4-6-15 facility staff had knowledge of situations regarding verbal, mental and/or physical abuse by E1 (Administrator) to R1 and R2. Findings include: 1. During interviews regarding abuse allegations, it was reported to this surveyor that R2 was disruptive in the dining room and E1 (Administrator) removed R2 into the hallway. E1 sat R2 in the floor and spoke harshly to her as follows: a. E12 (Certified Nurse Aide) was interviewed on 4/9/15 at 9:15 am. E12 said she witnessed E1 "physically" place R2 on the floor from her wheelchair. E12 said she is unsure of the date this occurred but thinks it was a "couple of months ago." E12 said the nurses and other residents did not witness this. E12 said R2 was yelling out and squirming but was not attempting to get out of the wheelchair. E12 said E1 pushed R2's wheelchair into the hallway and alone transferred her onto the floor. E12 said she heard E1 "harshly" tell R2, "If you're going to act like a baby you can lay in the floor and have a fit like a baby." b. E11 (Certified Nurse Aide) was interviewed on 4/9/15 at 9:30 am. E11 said she did not witness E1 placing R2 in the floor. E11 said she saw R2 sitting on the floor and heard E1 "rudely" tell R2, "if you are going to act like a baby you can lay in the floor and have a fit like a baby." E11 said the other witnesses to this incident were E10 and E12. E11 said she used a gait belt and assisted E1 to transfer R2 back into the dining room. E11 said she is unsure of the date but this happened a "couple months ago."	S9999		

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c. E14 (Registered Nurse) was interviewed on 4/10/15 at 9:30 am and said E1 told her R2 was yelling in the dining room so she "sat her ass in the floor" and told R2 "if you're going to act like a baby, you can crawl like one."

d. E2 (Registered Nurse) was interviewed on 4/9/15 at 11:55 am and said E1 told her R2 "was throwing a fit and acting like a baby so I put her ass in the floor" and told R2 " if you are going to act like a baby you can sit in the floor like a baby." E2 said E1 told her E11 and E12 seen me do this and I am surprised they didn't throw a fit.

e. On 4/9/15 at 9:55 am, E10 (Certified Nurse Aide) said someone told her she had witnessed the incident where R2 was placed on the floor but she said, I just can't remember anything about it.

f. E7 (Licensed Practical Nurse) was interviewed on 4/9/15 at 8:30 am. E7 said she has never heard of or seen abuse in the facility. After receiving the final investigative report on 4/16/15 from the facility indicating E7 was a witness to the incident, E7 was interviewed again by telephone on 4/16/15 at 12:45pm. E7 said she had been in the dining room when R2 was "acting up". E7 said R2 was trying to hit her head on the table. E7 said she later went to the nurse desk near the dining room and witnessed E1 trying to ambulate R2 in the hallway but R2 was lifting her feet up so E1 sat her in the floor. E7 said she "did not go over there." E7 said she heard E1 tell R2, if you are done throwing a fit we can go to your room and discuss this. E7 said she only heard some of the conversation and there may have been a lot more going on. E7 said what she did see she did not consider abuse.

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g. On 4/10/15 at 3:00pm, E16 (Social Service Director) said she initiates the behavior tracking for the residents. E16 said she reads all completed behavior tracking and nurse notes related to R2. E16 said she has never seen a behavior of R2 attempting to throw herself in the floor in the dining room except for this "isolated" event documented on the Behavior Tracking by E1.

h. On 4/10/15 at 10:35 am, E1 (Administrator) said she sat R2 in the floor because she was attempting to throw herself out of the wheelchair in the dining room. E1 said she told R2, "Stop acting like a child. If you're acting like a child you are going to be treated like a child" and told her to act like an adult. E1 said R2 didn't have any more behaviors on this day.

i. During the investigation an attempt to interview R2 was made four times. The first time on 4/10/15 at 10:00 am. R2 would not make eye contact with this surveyor and did not converse. The second time was with E2 present(who was identified by staff as having a good relationship with R2) on 4/10/15 at 10:10 am, R2 placed a blanket over her head and did not respond to questions or conversation. The third time on 4/14/15 at 2:50pm with R2's grandmother present. Staff indicated R2's grandmother may make R2 more comfortable during the interview. R2 was tearful. R2 did not carry on a conversation with this surveyor but did say "no" when asked if she has ever been mistreated and "no" when asked if she remembered ever being sat on the floor. Then R2 asked for her medication. The fourth time on 4/15/15 at 9:40 am. When asked if she could remember ever being sat in the floor R2 said "no." R2 had visible tremors and did not make eye contact or carry on

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S9999	Continued From page 5 a conversation with this surveyor. 2. During interviews regarding allegations of abuse it was reported to this surveyor that E1 (Administrator) crushed candy and placed it in applesauce then gave it to R2 and told her to shut up because she was yelling out, as follows: a. On 4/10/15 at 9:30 am, E14 (Registered Nurse) said E1 told her R2 was yelling for her medication so she placed candy in applesauce and when R2 started to yell again she put it in her mouth and said "now, shut up." E14 said she observed E1 come from R2's room and E1 walked directly to her (E14) and told her (E14) this. E14 said she was attempting to give R2 her medication after this incident and R2 told her she had already taken her medicine. E14 said she had to explain to her she had taken candy and encourage her to take her pills. E14 said this happened on Thursday, April 2nd 2015. b. On 4/9/15 at 3:20pm, E2 (Registered Nurse) said on Thursday, 4/2/15 she heard R2 cursing and yelling for her medicine. E2 said E1 told her she crushed some candy and put it in applesauce then when R2 opened her mouth to yell she gave it to her and told R2 "shut up." c. On 4/10/15 at 10:35 am, E1 (Administrator) said she did put candy in applesauce and give it to R2. E1 said R2 is demanding and yells out so she gave her the candy and R2 stopped yelling. E1 said she did not tell R2 that it was her medicine and she did not tell R2 to shut up but she told her to "hush, stop yelling." R2's April 2015 Physician's Order Sheet documents a diagnosis of Limbic Encephalitis and Emotional Liability. www.johnhopkins.org	S9999		

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documents Limbic Encephalitis as "The limbic areas of the brain control many functions including memory, learning, and emotions such as aggression" and "The term "Limbic Encephalitis" (LE) is used when the limbic areas of the brain are inflamed (swollen) or not functioning properly. The symptoms of Limbic Encephalitis include memory loss, seizures, confusion, disturbances of sleep and psychological disturbances such as altered personality or behaviour." R2's Minimum Data Set (MDS) dated 3/31/15 documents R2's Date of Birth as 5/21/89 and an admission date of 9/29/14. The MDS also documents R2 has little interest or pleasure in doing things, feeling down, depressed or hopeless and thoughts that she would be better off dead or of hurting herself in some way. It also documents R2 has verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others)and other behavioral symptoms not directed towards others. (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).
R2's Behavior Monitoring Record dated 12/29/15 documents "trying to throw self out of chair at lunch. Resident to hall with staff. R2 continued to attempt to put self on floor while standing with staff. Staff sat her in the floor. Explained why it was not appropriate to yell at staff and throwing self on floor. R2 walked to dining room. No behaviors the rest of lunch."

3. During interviews regarding allegations of abuse, the allegation was made that E1 (Administrator) sprayed water in R1's face to stop R1 from yelling during R1's shower, as follows:

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a. On 4/9/15 at 9:15 am, E12 (Certified Nurse Aide) said E1 told her when she (E12) is giving R1 a shower and he is yelling out to spray him in the face with water and he will quit yelling.

b. On 4/9/15 at 9:30 am, E11 (Certified Nurse Aide) said E1 told her when she (E11) is giving R1 a shower to spray him in the face with water when he is yelling and he will stop yelling.

c. On 4/10/15 at 9:30 am, E14 (Registered Nurse) said E1 told her she (E1) gave R1 a shower and R1 was yelling so she told R1 if he yelled one more time she would spray him in the face with water. E14 said E1 told her, R1 yelled again so she sprayed him in the face and he didn't yell any more after that.

d. . On 4/9/15 at 11:55 am, E2 (Registered Nurse) said E1 told her she (E1) gave R1 a shower on 4/6/15 and R1 was yelling so she sprayed water in his face and he stopped yelling.

R1's Minimum Data Set (MDS) dated 1/23/15 documents R1 was admitted to the facility on 6/28/2007 and R1's diagnoses include Non-Alzheimer Dementia, Traumatic Brain Injury, Depression and Unspecified Intellectual Disability. R1's Date of Birth is documented as 1/3/58 as documented on the MDS. R1's Care Plan for Behavior dated 3/17/15 and Behavior Monitoring Records from December 2014 through April 2015 do not document yelling out in the shower as a problem. R1's MDS documents R1 has a score of 04 for the Brief Interview for Mental Status indicating he has a Severely Impaired cognitive status. There are no mood or behaviors documented on this MDS. The MDS documents that R1 requires two assist and is totally

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dependent with bathing. R1's Shower/Abnormal Skin Report with the date of 4/6/15 documents 1's initials as the Certified Nurse Aide giving the shower on this day.

4. The following information was obtained during interviews regarding allegations of abuse:

a. On 4/10/15 at 9:30 am, E14 (Registered Nurse) said E1 told her a nurse was working with an expired nursing license and if anyone told this to anyone else she would "burn down their damn house." E14 said E1 is not approachable and the employees are intimidated by her. E14 said E1 calls them names.

b. On 4/9/15 at 11:55 am, E2 (Registered Nurse) said E1 was leaving on 4/8/15 after the abuse investigation was initiated and told her, "you tell the cna's (Certified Nurse Aides) to keep their mouths shut about me or I will kill them and burn their houses down. E2 said all the staff are intimidated by E1 and are scared to tell her things.

c. On 4/9/15 at 1:15pm, E4 (Registered Nurse) said on 4/8/15 E1 was leaving the facility after the abuse investigation was initiated, E1 stepped back into the facility and said tell the cna's if they say anything about me I will kill them and burn down their houses. On 4/10/15 at 10:15 am, E4 said E1 had made a telephone call to her about something and E1 told her it had been a hectic day and R2 had been yelling so she gave her candy in applesauce and told her, "now, shut up."

d. E11 (Certified Nurse Aide) said E1 is uncaring. E11 said E1 had an inservice for all cna's. (Certified Nurse Aides) E1 told them to write their concerns and complaints down on a piece of

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S9999	Continued From page 9 paper. After they were finished writing E1 told them to wad it up and cram it up their butts because she doesn't care about their complaints. (B)	S9999		