DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. TWEEDY INC. D/B/A H & S CARE CENTER, Respondent.	)))))))))	Docket No. NH 15-C0234

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF CONDITIONAL LICENSE AND IMPOSED PLAN OF CORRECTION; 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 "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

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 IL76623 conducted by the Department on May 5, 2015, at H & S Care Center, 310 Third Street, P.O. Box 376, Tamms, Illinois 62988. On June 1, 2015, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Sheltered Care Facilities Code, 77 IL. Adm. Code 330 (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.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

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

NOTICE OF CONDITIONAL LICENSE AND IMPOSED PLAN OF CORRECTION

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to H & S Care Center, 310 Third Street, P.O. Box 376, Tamms, Illinois 62988 on March 7, 2015. The Facility's current license number is 0049049. The term of the conditional license shall be from July 2, 2015 to January 1, 2016. It is conditioned upon the licensee's compliance with the Imposed Plan of Correction, attached hereto and incorporated herein as Attachment B. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER SEPARATE COVER. THE LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON JULY 2, 2015 OR UPON RECEIPT IF AFTER THE POSTING DATE.

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 Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License and Imposed Plan of Correction; 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 email the waiver 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.**

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

Dated this 2nd day of June, 2015.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License, provided Respondent substantially complies with the attached Imposed Plan of Correction.

Failure by Respondent to substantially comply with the terms of the attached Imposed Plan of Correction may result in the revocation of the Conditional License in accordance with Sections 3-316 and 3-119 of the Act.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license. However, the Imposed Plan of Correction must be followed.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$12,500.00**, as follows:

- Type A violation of an occurrence for violating one or more of the following sections of the Code: 330.720e)3), 330.1110d), 330.1710f), and 330.4240f).

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.

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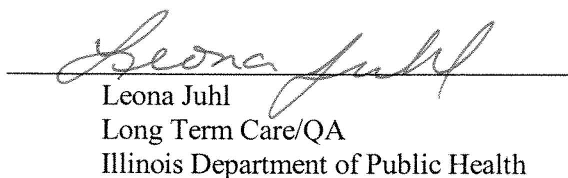
PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License and Imposed Plan of Correction; 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:	Ricky Tweedy
Licensee Info:	Tweedy Inc.
Address:	101 W. Market St, P O Box I Jonesboro, IL 62952

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

AFCI330/15-C0234/H & S Care Center/5-5-15/llj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003883	A. BUILDING: ____ B. WING ____	C 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H & S CARE CENTER	**3RD & CARPENTER, P.O. BOX 376 TAMMS, IL 62988**

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S 000	Initial Comments Complaint Investigation 1552098/IL76623	S 000		
S9999	Final Observations Statement of Licensure Violations 330.720e)3) 330.1110d) 330.1710f) 330.4240f) Section 330.720 Admission and Discharge Policies e) No person shall be admitted to or kept in the facility: 3) Who has serious mental or emotional problems based on medical diagnosis; Section 330.1110d) d) All residents shall be seen by their physician as often as necessary to assure adequate health care. Section 330.1710 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. Section 330.4240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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of that resident as well as the safety of other residents and employees of the facility.

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:
Based on interview, observation and record review the facility failed to ensure that no person with serious mental or emotional problems, based on a medical diagnosis, shall be admitted to or kept in the facility; failed to ensure that a resident with a scheduled psychiatric appointment was assisted with obtaining transportation to the scheduled appointment; failed to establish resident goals for known disruptive and harmful behaviors of agitation and physical aggression towards other residents and failed to determine residents' progress towards or regression from goals for these behaviors for 2 of 7 residents (R1, R7) reviewed for aggressive behaviors in the sample of 7. Further, the facility failed to ensure that a resident who had physically struck a female peer in the face was immediately evaluated to determine the most suitable therapy and/or placement of that individual for 1 of 2 residents (R1) reviewed for an incident of physical aggression in the sample of 7.

These failures resulted in R1 attacking both R2 and R3 on 4/21/2015 between 5:30 and 6:00 pm. R2 and R3 sustained serious injuries that required immediate transfer to a medical facility. R2 was attacked with a sharp object and stabbed several times and required hospital admission and emergency surgery. R3 was attacked and struck above the right eye, receiving 2 lacerations that required several stitches. (Universal Progress Notes dated 4/21/15 and hospital records of 4/21/15.) These failures also resulted in R1exhibiting physical aggression towards R5 on 2/21/15 by hitting R5 in the face, causing a

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S9999	Continued From page 2 minor injury with swelling and bruising. The Findings are: 1. R1's 4/21/2014 Admission Form identified R1 as being 41 years of age. It included diagnoses of Schizophrenia-Paranoid Type and Mood Disorder. A Mental Health Treatment Plan Review that was found in R1's record with a Service Date of 4/11/2013, was noted to have a fax transmittal date of 3/28/2014, indicating that the facility had received it prior to R1's admission. This Treatment Plan Review indicated an additional diagnosis of Anger/Impulse Control Disorder. An Adult Diagnostic Assessment dated 11/25/13 indicates that R1 "continues to display poor insight into both his symptoms of Schizophrenia as well as how his disorganized thinking, behaviors and lack of insight contribute...(to) ability to form relationship with others around him..." The assessment also included a history of 7 psychiatric hospitalizations due to "problems with his family" and also a recent discharge from a local in-house mental health treatment center on 9/27/2013. It documented a continuing struggle with suspiciousness, mistrust of others motives, predatory behaviors, boundary issues and threats of eviction. A 5/1/14 Psychiatric note indicated R1 was seen to establish psychiatric care. It indicated that R1 had a significant legal history and that R1 had stated that he had been in county jail multiple times but never prison. E1, Manager and E6, Administrator verified on 4/30/15 at 10:30 am that the above information was made available to the facility prior to R1's admission. E1 stated on 4/28/15 at 10:30 am that the facility checks the IL State Police for the required background checks of all residents at admission as well as other web sites like the sex offender site, as required by the regulations. E6 stated that R1 was admitted through an out	S9999		

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patient mental health center and had been living in some sort of residential setting just before being admitted to the facility. E6 stated that he thought R1 was appropriate for placement at that time.
An Incident/Accident Report dated 4/22/15 by E6 documents an incident date of 4/21/15, 6:00 pm involving R1, R2 and R3. The report indicated that R1 struck R3 with his fist and then attacked R2 with a sharp object. It further notes that R1 was removed from the facility by the police and both R2 and R3 were taken to an out of state hospital.
Review of R1's record found documentation in the Universal Progress Notes (UPN) for 4/21/15 at 8:30 am that R1 was in a bad mood, talking hateful to staff and that staff told him to take his medications and "go on." The next note is again dated 4/21/15 at 5:45 pm and documents that R1 hit another resident in the eye (R3) and she was bleeding a lot so the ambulance was called. It goes on to state that while in the process of calling for an ambulance, another resident (R2) came to staff and said he had just been stabbed in the heart. It noted this resident was bleeding in several places and another call was made for another ambulance, and that E6 was notified. A 6:30 pm note documents that police came and took R1 into custody.
E1 stated on 4/22/15 at 11:00 am that she received a call from E4, aide the night before, about 5:30 pm reporting that R3 had been hit in the face and was bleeding. E1 told her to call an ambulance then a few minutes later got another phone call from E4 that R1 had stabbed R2. E4 told E1 that E4 had called for another ambulance and called the state police, the county police and the local police. E1 stated that on day shift 4/21/15 (no time given) that R1 had cussed her out and told her to get out of his room but that this

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was a typical behavior of R1. E1 stated that she did not know of R1 making any threats and there had been no problems with R1 taking his medications.
A 4/21/15 hospital History and Physical Examination indicates R2 is 56 years old and presented to the emergency department with multiple stab wounds after being attacked by another resident with a sharp object. The wounds are described as a 6 centimeter (cm) laceration in R2's left eyebrow and a smaller 0.5 cm in his mid forehead with three larger lacerations palpated at the bowl of his hair, a jagged laceration near his xiphoid, another approximately 7 cm laceration in his left chest and a similar size laceration in his left upper quadrant and a laceration to his left ventral wrist. The hospital History and Physical Plan stated that the abdominal wounds would require local exploration and possibly laparotomy, the wrist would require exploration, and closure of the face and scalp lacerations would be required, all to be done in the operating room under general anesthesia. A Patient Transfer Form states that R2 returned to the facility on 4/23/15 with an abdominal dressing in place and with 2 follow up appointments at the Trauma Clinic. After being seen by Z3 Medical Doctor on 4/24/15, R2 was transferred to a local long term care/ rehab facility for nursing care where he remains as of 5/5/2015. R2 was interviewed on 5/1/15 at 1:00 pm and stated that he did not see what R1 used when R1 stabbed him. R2 stated that he couldn't recall anything about the 4/21/15 incident. R2 repeated to the surveyor three times "can I go now, I'm going to die."
R3 stated on 4/23/15 at 11:00 am that she would wake up "every night" and R1 would be sitting on her bed looking at roommate R8 and "you know, doing it" R3 was asked if she meant masturbating and replied yes but that he didn't touch R3. R3

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stated that she had reported it to staff and that staff would tell R1 to stay out of the room. R3 stated that R1 had been acting weird, acting crazy and going off on everybody. R3 stated that R1 would swear up and down that "me and R7" were talking about his mom. R3 stated that on 4/21/15, after supper, she went out to smoke a cigarette and that R1 came outside, "whipped out his dick and shook it at me." R3 stated she told R1 to stop and that was when he "went off on me, hit me while we were on the back steps." R3 stated "it didn't feel like a fist but I didn't see any knife or anything but it felt different." R3 denied being afraid of R1 and stated "I'm still not afraid of him...he just caught me off guard." R3 recalled an incident "couple of months ago" where R1 and R7 got into it and R7 went and got a knife to protect himself."

R3's injury is described in a 4/21/15 hospital triage note as two lacerations to the right side of the face caused by an assault. They are described as a 3 cm laceration to the right eyebrow and a 3 cm laceration mid forehead which required a total of 10 sutures. R3 was discharged back to the facility that same evening. R3 was observed on 4/22/15 at 3:00 pm with bruising and sutured areas above the right eye. R3 stated that it was hurting her quite a bit and she had been sleeping a lot.

E4, aide, stated on 4/22/15 at 3:15 pm that E4 had came on shift at 3:00 pm on 4/21/15 as the only aide, which was per the schedule. E4 stated there was no report to her of any problems with R1 during the day shift. E4 stated that around 5 or 5:30 pm she was "doing drinks" and R4 was helping. R1 was heard to ask R4 "where's my drink" and that R4 gave R1 a drink then reported to E4 that R1 "was starting with me." E4 stated

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she continued doing trays, R1 came to the window for his tray then R3 came to the window for ice and R1 was yelling at R3 "don't talk about me" and threatened to "Eff you up" to R3. E4 stated she walked around to R1 and talked to him, asking him to stay calm while supper was served. E4 noted that R3 pushed her tray back before eating, as if she had lost her appetite. R3 left the dining room, but came back inside to the kitchen area within a couple of minutes with blood running down face, and shirt covered in blood. R3 told E4 "R1 came out and hit me." E4 stated that she immediately tried to stop the bleeding, called for an ambulance, called police and called E1. E4 stated that within 5 minutes, R2 came into the kitchen area, bleeding profusely and hollering "he stabbed me in the heart, the guy in the green hat!" E4 stated she started trying to assess R2's wounds and found 4 stab wounds and noted R1 just standing at the door "smirking." E4 stated she called for another ambulance and called for police again. E4 stated she did not know what type of weapon was used to stab R2 but that the wounds looked jagged. E4 stated that she was aware that after the state police arrived they entered R1's room and handcuffed R1 then removed a box from his room. E4 stated she never saw the weapon and was not told what it was. E4 stated that R1 always had a cocky attitude and that she had not noticed any difference in his mood recently.

An interview with Z4, Illinois State Police, on 5/1/15 indicated that R1 currently remained in custody and awaiting arraignment. Z4 stated that he was unable to disclose any information related to R1's arrest until the reports were finished, reviewed and presented to the State's Attorney.

E3, aide stated on 4/22/15 at 3:30 pm that he

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lives in the boarding house next door and was in the kitchen but not working when he saw R3 run in screaming that she had been punched in the face. E3 stated that he had witnessed R1 in an argument with R4 "over drinks" just before. He noted that R3 was bleeding "everywhere" and he got rags to help clean R3 up when R2 ran into the kitchen part stating "that man just tried to kill me, that "mother f***** (expletive) in the green hat!" E3 stated that they had already called for an ambulance for R3 but then called for another ambulance and called state police. E3 stated that the ambulances arrived before police and stated they could not enter the building without police present so R2 and R3 were taken outside to the ambulances. E3 stated that R1 stood in his bedroom doorway during this time and that E3 and E4 tried to get all the other residents to go outside. E3 stated that police did finally arrive but it seemed like it was 30 - 40 minutes later. E3 stated that R1 was always real quiet and that he hadn't seen any changes in R1's mood or behaviors prior to this incident.

E5, aide stated on 4/23/15 at 12:50 pm that R1 would normally be quiet but could get aggravated and had punched holes in walls before. E5 recalled incidents involving R1 having injured R13 last year and R5 a couple months ago. E5 stated that R1 had made sexual advances towards her and that she would just ignore him and report it. E5 stated she didn't feel threatened by R1.

Observations were made on 4/22/15 at 1:00 pm of 2 areas in the hallway just outside of the kitchen/dining room where the sheet rock had been broken through. E5 indicated these were areas that R1 had recently punched, causing the damage. Both areas were noted to be larger than 1 foot in length and about 6 to 8 inches across.

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R11 stated on 4/23/15 at 10:00 am that R1 had hit him in the mouth last week and dozens of times in the dining room; R11 provided no other details.

R4 stated on 4/23/15 at 10:10 am that he and R1 "just had words" and that one time R1 had thrown a dinner tray at R4. R4 stated that R1 made him a little nervous and that he thought there had been a change in how R1 was acting lately, more upset. R4 stated that he saw R2 come in the kitchen on 4/21/15 (after dinner) with blood on him and it looked like a horror show.

R10 stated on 4/23/15 at 10:50 am that recently R1 had thrown a tray at R4 and had also knocked several holes in the walls awhile ago. R10 stated that R1 had hit R11 one time and had really scared him. R10 stated that she was not afraid of R1 but that R1 had a lot of problems with everybody here and it had been happening for awhile.

E1 stated on 4/28/15 at 10:25 am that about a month ago there was an altercation involving R1 and R7 in the dining room and that it was verbal, not physical.
E1 stated on 4/22/15 at 11:00 am "we have had problems with R1 and aggression" and noted that R1 had hit one resident in the eye with a flashlight (last year) and that resident (R13) had required hospitalization. E1 stated that after the R13 incident (5/10/14), R1 was set up with appointments with Z2, Physician Assistant at the local behavioral clinic. E1 recalled another incident, this time involving R1 and R5 approximately 2 months ago where R5 had thrown a shoe at R1 because he was in her room. R1 hit R5 in the face and R5 was taken by E6 to

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	IL6003883	A. BUILDING: ______ B. WING ______	C 05/05/2015

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H & S CARE CENTER	**3RD & CARPENTER, P.O. BOX 376 TAMMS, IL 62988**

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the emergency room to be evaluated and returned the same day. E1 stated that R1 was seen by the crisis counselor that same day but that the facility was told they couldn't do anything, it was a behavior and couldn't do anything. E1 stated that R1 did see Z2 sometime afterwards and Z2 increased some medications. E1 stated that E6 had tried to find other placement for R1 but had not been able to.

R8 stated on 4/23/15 at 11:15 am that before dinner on 4/21/15 she had talked to R1 about some money he owed her and that R1 started cussing at her and told her to "f****** (expletive) shut up" and to leave him alone or he was going to snap. R8 stated that she noted at dinner that R3 wouldn't eat and walked out of the dining room then came back in a few minutes later yelling and then saw R3 in the kitchen bleeding with E4 helping her. E8 stated that then R2 came into the kitchen bleeding all over, ripped his shirt open to show them and R8 saw several stab wounds on R2. R8 stated that she wasn't really afraid of R1 and that she and R1 had dated when she had lived here before. R8 stated that she would see him at times, sitting on her roommate's (R3) bed, across from her own bed and that R1 would tell her that he was watching her. R8 denied ever seeing R1 masturbating when sitting there. R8 stated that in the last few days R1 seemed to get worse with "talking to someone that wasn't there, getting really aggressive and causing everyone to yell at him which just made him more mad."

R5 was interviewed on 4/22/15 at 3:30 pm and stated that R1 had punched her in the face a couple of months ago and she had went to the emergency room but nothing was broke, just got a black eye. R5 stated R1 had accused her and

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her boyfriend of talking about his mother. R5 denied being afraid of R1 and stated that she thought "we were friends" but not anymore, not after what R1 did to R2.

E1 provided an Accident/Incident Report dated 2/21/15 that stated R1 and R5 had got in a verbal altercation which resulted in physical aggression where R5 threw a shoe at R1 and R1 hit R5 in the face, causing a minor injury with swelling and bruising. The report stated that R5 was taken to the emergency room and evaluated.

R1's record included a 2/27/15 progress note from Z3, Medical Doctor. This note did not make mention of the 2/21/15 incident with R5 and indicated that R1 was stable. Z3 stated on 4/28/15 at 3:00 pm that he had been notified of the 2/21/15 incident involving R1 and R5. Z3 stated he had saw R1 but not until 2/27/15 and did not recall any concerns, that R1 looked good and that R1 never appeared psychotic at facility visits. Z3 stated that he felt R1's actions were behaviors rather than a manifestation of a psychotic state. Z3 indicated that he was not aware of any increase in R1's behaviors. Z3 indicated he had also seen R1 on 3/27/15 during a facility visit and had not noted any concerns.
R1's record included documentation in the Universal Progress Notes of a physical altercation with R13 on 5/10/14 which resulted in a serious injury to R13. A 7/8/14 note documented an incident where R1 had purchased a knife at a local store and the store employee had called the facility to report it. The 2/21/15 physical altercation with R5 was also documented in the Universal Progress Notes.
R1's Universal Progress Notes dated 3/9/15 (no time) documents that R1 was taken to see Z2 to "let her know all the things that have been going

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on with him" (R1). An Encounter Summary dated for 3/9/15 by Z2 notes that R1 presented with staff and that staff reported that R1 had been aggressive toward other clients, punching one in the face, easily agitated and constantly fighting with others, punching holes in walls, having verbal aggression towards staff and hard to re-direct. Z2 documented "Patient has apparently been causing a lot of dispute in the home with other clients." Z2 noted a past history of mental illness with a diagnosis of Paranoid Schizophrenia Mood D/O (Disorder). Z2 described R1 as hypertalkative and disoriented to situation but oriented to time , place and person and stated that R1 does not seem to understand the seriousness of the situation that he is in. Z2 indicated R1 did not report any hallucinations but described R1 as "Thought Content: delusions." Z2 increased R1's antipsychotic medication, Zyprexa from 15 mg to 20 mg a day and indicated a followup appointment in 1 month where Z2 would increase another of R1's psychotropic medication, Trileptal, at that followup. The note indicates an appointment was scheduled for R1 to return on 4/6/15 at 1:15 pm. Z2 also documented a diagnosis of Antisocial personality disorder at this visit.
The record did not reflect that R1 went to Z2 for the 4/6/15 appointment. E1 stated on 4/22/15 at 11:00 am that she thought that the Dr. office had called and rescheduled because Z2 wasn't going to be available. E1 looked in a calendar book and noted that R1's next appointment was scheduled for 4/30/15.

Z2 stated on 4/23/15 at 1:15 pm that R1 was always a little delusional but wasn't ever overtly agitated when she would see him, but he was difficult to reason with. Z2 verified the 3/9/15 Encounter Notes regarding R1. Z2 stated that

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office records indicated that the facility had called on 4/2/15 and rescheduled R1's appointment for 4/16/15 and then called again on 4/16/15 and canceled that appointment and rescheduled for 4/30/15. Z2 stated that she was available on both 4/6/15 and 4/16/15 and did not know why the appointments were canceled. Z2 stated she felt the 1 month followup appointment she had requested on 3/9/15 was important because she had planned to increase his Trileptal medication, as her 3/9/15 note stated.

E1, when questioned again on 4/28/15 at 10:25 am about the 4/6/15 canceled appointment, recalled then that there was some kind of a problem with another residents appointment being that same day and then indicated that the other resident's appointment couldn't be rescheduled as it was a surgery follow-up so R1's was rescheduled for 4/16/15. E1 stated that on 4/16/15 she called to confirm R1's appointment for that day and was told by Z2's office staff that there was no appointment scheduled for R1 for 4/16/15 but that a 4/30/15 was scheduled.

R1's record did not include any established goals for addressing R1's behaviors of physical aggression.

E1 stated on 4/28/15 at 10:25 am that there were no established goals to address R1's physical aggression, either after the 5/10/14 physical altercation with R13 or after the 2/21/15 altercation with R5. E1 stated that the facility did not establish goals for residents and did not have a written plan to address behaviors. E6, Administrator and E2, Quality Assurance verified this on 4/30/15 at 10:30 am.

On 4/29/15 at 2:00 pm, E1 was asked about the

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7/8/14 incident where it was reported to the facility that R1 had purchased a knife. E1 stated that a store employee had called the facility and notified them and when R1 returned to the facility R1 was asked about the knife and admitted to purchasing it. R1 was told that he wasn't allowed to have any kind of weapons. He apologized and gave the knife to them. E1 was asked if there was any plan developed to ensure R1 did not try to obtain or possess a knife in the future. E1 stated that they reported the incident to R1's mother but there was not a plan established. E1 provided an untitled facility policy that included a section titled Operators Rights. This section stated that "periodic thorough inspections of all rooms, including closets, drawers, boxes etc. for the purpose of keeping everything clean, neat and sanitary... Any objects found that are conceivably harmful to the resident or others will be removed, (such as guns or knives)." E1 did not indicate that any inspections of R1's room and belongings had occurred after the earlier incident of 7/8/14 where R1 had purchased a knife.

2. R7 is a 39 year old male admitted on 3/24/2010, as noted on the facility Admit Form. An Encounter Summary by Z2 dated 4/29/2015 lists diagnoses that include Intermittent Explosive Disorder and Anti social Personality Disorder. The April 2015 Physician Order Sheet includes diagnoses of Impulse Control Disorder and Schizophrenia.

Documentation in the Universal Progress Notes includes an incident on 10/10/2014 where R13 was in an altercation with a peer, pushing him and calling him (derogatory) N word. Documentation for 1/25/15 notes that R7 was trying to get cigarettes from a female peer and when he was told he couldn't have any, R7 got in

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peers face screaming and pushing her down the hall and threatening her. A 2/13/15 note documents an incident with a peer where R7 jumped through the kitchen 'pass through' window with a knife and pinned peer down. Staff intervened before any further harm occurred. It stated that the police and the crisis center were both notified.

R7's record does not include any established goals to address R7's aggressive behaviors. As indicated earlier, E1 stated that the facility does not have a written plan to address specific resident behaviors.

3. R5 was interviewed on 4/22/15 at 3:30 pm and stated that R1 had punched her in the face a couple of months ago and she had went to the emergency room but nothing was broke, just got a black eye. R5 stated R1 had accused her and her boyfriend of talking about his mother. R5 denied being afraid of R1, and stated that she thought "we were friends" but not anymore, not after what R1 did to R2.

E1 provided an Accident/Incident Report dated 2/21/15 that stated R1 and R5 had got in a verbal altercation which resulted in physical aggression where R5 threw a shoe at R1 and R1 hit R5 in the face, causing a minor injury with swelling and bruising. The report stated that R5 was taken to the emergency room and evaluated. There was no indication that R1 was immediately evaluated after this incident.

R1's record included a 2/27/15 progress note from Z3, Medical Doctor. This note did not make mention of the 2/21/15 incident with R5 and indicated that R1 was stable. Z3 stated on 4/28/15 at 3:00 pm that he had been notified of the 2/21/15 incident involving R1 and R5. Z3 stated he had saw R1 but not until 2/27/15 and did not recall any concerns, that R1 looked good

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S9999	Continued From page 15 and that R1 never appeared psychotic at facility visits. Z3 stated that he felt R1's actions were behaviors rather than a manifestation of a psychotic state. Z3, Psychiatric Physician Assistant did not assess R1 until 3/9/2015. (A)	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: H & S CARE CENTER

Attachment B
Imposed Plan of Correction

DATE AND TYPE OF SURVEY: May 5, 2015, Complaint 1552098/IL76623

Section 330.720 Admission and Discharge Policies

e) No person shall be admitted to or kept in the facility:

3) Who has serious mental or emotional problems based on medical diagnosis;

Section 330.1110 Medical Care Policies

d) All residents shall be seen by their physician as often as necessary to assure adequate health care.

Section 330.1710 Resident Record Requirements

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.

Section 330.4240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of a 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.

This will be accomplished by:

I. All policies and procedures related to Admissions and Discharges will be evaluated and revised as needed to ensure compliance with Illinois Sheltered Care Facilities Code.

II. The facility will ensure that all residents have access to medical appointments as necessary to assure adequate health care.

III. The facility will establish resident specific goals and maintain resident record including progression toward and regression from established resident goals.

IV. The facility will conduct an investigation of incidents of resident to resident abuse and take appropriate actions. These actions will include, but are not limited to, the notification of all required entities; a thorough assessment of each involved resident's condition, therapy, placement, and safety measures; and the safety of other residents of the facility. Resident specific interventions will be established and implemented in order to reduce or remove the threat of harm that places other residents at risk of abuse.

V. Documentation of in-service training, assessments, investigations, policy and procedure review, and related follow up actions will be maintained by the facility.

VI. The Administrator and Director of Nurses will monitor items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 10 days of receipt of this Imposed Plan of Correction.