Continued From page 1 following:

1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.

2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:

4) If the identified offender is on probation, parole, or mandatory supervised release, the facility shall contact the resident's probation or parole officer, acknowledge the terms of release, update contact information with the probation or parole office, and maintain updated contact information in the resident's record. The record must also include the resident's criminal history record.

i) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.

These requirements are not met.
Based on record review and interview, the facility failed to ensure a Criminal History Background Check was requested within 24 hours of admission, failed to notify the Department of State Police of a resident identified offender, R75; failed to arrange for a fingerprint based criminal history record inquiry for a known identified offender, R75; and upon decision to retain R75 as a resident, failed to consult with the medical director and law enforcement to address R75’s needs in an individual plan of care. R75 is one of one resident reviewed for criminal background checks on the sample list of 64.

Findings include:


R75’s Physician Order Sheet, dated September 1-30, 2020, documents diagnoses of: Psychosis, Paranoid Schizophrenia, Schizoaffective Disorder and Major Depression with Recurrent with Severe Psychotic Symptoms.

R75’s Illinois State Police Criminal History Record Report was requested on 7/7/20 and received on 7/8/2020, documents R75 as having been found guilty of aggravated battery/great bodily harm on 11/12/20 and battery/bodily harm on 11/12/12.

There was no fingerprint based background check ever requested or obtained and were not on file for R75. There was no waiver issued by the Director of the Department of Public Health that stated the facility was exempt from obtaining a fingerprint based background check on file in R75’s record.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Arcadia Care Danville  
1701 North Bowman  
Danville, IL 61832

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<tr>
<th>ID PREFIX TAG</th>
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<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Complete Date</th>
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<td>S9999 Continued From page 3</td>
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On 10/1/2020 at 8:50 AM, V1, Administrator, stated the facility is unable to provide a background check that was completed within 24 hours of R75’s admission and that the background check dated 7/8/20 was the only background check available. V1 stated the Identified Offender Report and Recommendation Report was never obtained and therefore recommendations were never implemented on R75’s Care Plan. V1 stated R75’s fingerprints were never obtained and R75 was never sent out of facility to obtain fingerprints.

The facility policy titled 'Abuse Prevention and Reporting-Illinois', revised 1/22/19, documents the following:

"For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender’s plan of care including the security measures listed. Reports should be documented and a record kept of the documentation."

(B)

2 of 2

300.1210 b)  
300.1220 b3)  
300.3240 f)

Section 300.1210 General Requirements for Nursing and Personal Care  
- 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
   3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.

Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
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.

These regulations are not met as evidenced by:

Based on record review and interview, the facility
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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<td>S9999</td>
<td>Continued From page 5 failed to prevent the abuse of three residents (R34, R67, R128) perpetrated by a resident (R75) with known history of physical assault. This failure resulted in R75 physically assaulting three medically compromised residents causing mental anguish, intimidation, and injury. Findings include: R75's undated Census Report documents admission date of 4/15/2020. R75's Illinois State Police Criminal History Record Report, dated 7/8/2020, documents R75 as having been found guilty of aggravated battery/great bodily harm and battery/bodily harm on 11/29/12. On 10/1/2020 at 8:50 AM, V1, Administrator, stated R75 has severe mental health history and also history of physically aggressive behaviors. V1 stated the facility is unable to provide a background check that was completed within 24 hours of R75's admission on 4/15/20, and that the name-based background check, dated 7/8/20, was the only background check available. R75's Physician Order Sheet, dated September 1-30, 2020, documents diagnoses of: Psychosis, Paranoid Schizophrenia, Schizoaffective Disorder and Major Depression with Recurrent with Severe Psychotic Symptoms. R75's Minimum Data Set (MDS), dated 9/22/20, documents R75 as requiring limited assistance with transfers and supervision for walking in corridors. R75's Nurse Progress Notes document R75 having aggressive behaviors on 5/7/20 by punching R67 while holding R67 down; 8/19/20 by throwing a computer, papers, and desk phone at staff; 8/22/20 by attempting to throw a plate cover at R128, and then on the same date grabbing R128's leg attempting to pull R128 out</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X3) COMPLETE DATE</th>
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<tr>
<td>S9999</td>
<td>Continued From page 6 of bed; 9/6/20 by throwing a computer at staff, and again on 9/22/20 by hitting, kicking and pulling R34 out of wheelchair onto floor, where R75 continued to hit and kick R34. R75's Care Plan, dated 9/8/20, documents R75 as having a history of criminal behavior, is an identified offender, and has history of verbal/physical aggression towards staff and other residents. This same Care Plan does not document any new behavior interventions for behaviors noted on 5/7/20, 8/19/20, 8/22/20, 9/6/20 and 9/22/20. Last new intervention documented was dated 3/5/2020 for this same Care Plan.</td>
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1. R67's Undated Face Sheet documents diagnoses of: Malignant Neoplasm of Bladder, Artificial Opening of the Urinary Tract, Schizophrenia and Epilepsy. R67's Care Plan intervention, dated 3/18/19, documents to provide R67 with a wheelchair in moments of weakness.

R67's Minimum Data Set (MDS), dated 8/12/20, documents a Brief Interview for Mental Status score of 12/15 (cognitively intact). This same MDS documents R67 as requiring limited assistance of one staff member for transfers.

R67's Hospital records from 4/23/20 stay document R67 had a Nephrostomy Tube that had dislodged and not replaced. R67's Hospital record, dated 5/8/20, document R67 is at risk for infection due to Neutropenia.

R67's Nurse Progress Note, dated 5/7/20 at 1:52 PM, documents R67 reports that R75 gave R67 dirty looks two times, and on the second time R75 put R75's hands on R67's shoulders, then R75
Continued From page 7

punched R67 in the face. R67 acquired abrasion in between eyes, reddened areas under both eyes and complained of pain to right forehead.

2. R128's undated Face Sheet documents diagnoses of: Hemiplegia, Cognitive Communication Deficit, Convulsions, Gastrostomy and Cerebral Vascular Accident. R128's Minimum Data Set (MDS), dated 9/9/20, documents R128 as severely cognitively impaired. This same MDS documents R128 as requiring total dependence of two staff for bed mobility, transfers and personal hygiene.

R128's Care Plan, dated 6/25/19, documents an intervention for staff to pull curtain and allow private time to rest, ensure and provide a safe environment.

R128's Nurse Progress Notes, dated 8/22/20 at 8:09 PM, documents R75 entered into R128's room and pulled R128's leg attempting to pull R128 from R128's bed.

3. R34's undated Face Sheet documents diagnoses of: End Stage Renal Disease, Dependence on Renal Dialysis, Diabetes Mellitus, Methicillin Resistant Staphylococcus Aureus (MRSA), Septicemia, and Mitral Valve Replacement on 8/27/20. R34's Minimum Data Set (MDS), dated 9/16/20, documents a Brief Interview for Mental Status score of 10/15 (moderately impaired cognition). This same MDS documents R34 as requiring one-person physical assistance for transfers.

R34's Care Plan documents a focus area of R34 being a moderate risk of increased susceptibility of abuse due to suspected history of abuse/neglect. This same Care Plan documents
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| S9999       | Continued From page 8
R34 is on antibiotic therapy due to MRSA infection in blood and Septicemia. This same Care Plan documents R34 as having an Arteriovenous (AV) Fistula in upper right arm for Renal Hemodialysis access. This same Care Plan documents R34 should wear an Ankle-Foot-Orthosis (AFO) brace to right leg and should avoid activities that could result in injury. R34’s Physician Order Sheet, dated September 1-30, 2020, documents a physician order for renal dialysis three times every week on Mondays, Wednesdays and Fridays. dated September 1-30, 2020 and October 1-31, 2020 documents a physician order for Rifampin (antibiotic) 300 milligrams (mg) every eight hours until 10/9/20 for Methicillin Resistant Staphylococcus Aureus (MRSA) and Septicemia. This same POS documents a physician order for R34 to maintain sternal precautions for six weeks. R34’s Physician Order Sheet, dated September 1-30, 2020, documents a physician order for renal dialysis three times every week on Mondays, Wednesdays and Fridays. This same POS documents a physician order for Coumadin (anti-coagulant) 4 milligrams (mg) daily. R34’s Laboratory Value for (INR) on 9/21/20 was 3.9 seconds (high). This same report lists therapeutic range as 2.5-3.5 seconds. R34’s Nurse Progress Note documents that R34 was “hit in left side of face, pulled from wheelchair and kicked several times” by R75. Nurse Progress Note, dated 9/22/20 at 11:32 PM, documents returns from hospital “requested to leave facility related to incident” and R34 was “consoled” and agreed to stay. Hospital Records from 8/12/20-9/9/20 hospital | S9999       |
Continued From page 9

stay document R34 had open heart surgery on 8/27/20 that required cardiopulmonary bypass machine for a Mitral Valve Replacement. This same hospital record documents R34's sternum was divided with a sternal saw for the surgery and closed after the surgery with wires, sutures and adhesive strips over the incision site over mid chest. Hospital Emergency Room records for R34, dated 9/22/20, document diagnosis of victim of assault and battery. This same Hospital record documents R34 was examined due to an assault and "someone attacked and tried to harm you (R34)".

On 9/30/20 at 10:00 AM, R34 stated had no previous relationship with and did not know why R75 would want to attack R34. R34 stated asked the facility to call police and have R75 arrested. R34 stated, "I just had this open-heart surgery. He (R75) was hitting me in my chest right in the incision site. I was really scared." R34 also stated R75 is out of facility now "but when R75 returns I am afraid R75 will attack me again".

On 10/1/20 at 9:00 AM, V1, Administrator, stated R34 was involved in an altercation with R75 on 9/22/20, where R34 was hit and kicked several times. V1 stated staff intervened to aide in removing R75 from hitting and kicking R34 any further. V1 stated facility was aware that R75 was an identified offender.

On 10/6/20 at 2:15 PM, V22, Social Service Director, stated V22 was unaware of aggression and behaviors documented in Nurse Progress Notes. V22 stated V22 does review documentation, but only that listed under behavior notes. V22 stated R75's Care Plan had not had any updated interventions from 3/25/20-9/22/20. V22 stated should have updated R75's Care Plan...
Continued From page 10
due to continued aggressive behaviors and history of violent criminal history.

On 10/6/2020 at 3:00 PM, V10, Registered Nurse, stated V10 was aware of R75's aggressive behaviors. V10 stated V10 had personally witnessed R75 yelling, throwing furniture such as bed side tables and wheelchairs and hitting objects. V10 stated R75 was unpredictable in R75's behaviors. V10 stated V10 was very intimidated and scared of R75 due to R75's unprovoked aggressive behaviors.