STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

MARKS SUNSET MANOR	0011312
Facility Name	I.D. Number
1044 WHITTLE, OLNEY, IL 62450	
Address, City, State, Zip	
30200	2-7-2011
Reviewed By	Date of Survey
COMPLAINT INVESTIGATION 1150161	05397, 11373
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

330.715a)
330.715c)
330.715e)
330.715f)
330.720e)4)
330.725f)
330.726d)1)2)3)
330.780a)
330.785b)2)
330.785c)1)2)3)4)5)
330.785d)
330.4240a)

Section 330.715 Request for Resident Criminal History Record Information

a) A facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [210 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police.

c) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check.....

e) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility.....

f) If the results of a resident's criminal history background check reveal that the resident is an identified offender... the facility shall immediately fax the resident's name and criminal history to the Department pursuant to the requirements.

Section 330.720 Admission and Discharge Policies

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

4) Who is an identified offender, unless the assessment requirements of Section 330.715 for new admissions and the requirements of Section 330.725 are met.

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Section 330.725 Identified Offenders

f) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history information to the Department. (Section 2-201.5(c) of the Act)

Section 330.726 Discharge Planning for Identified Offenders

d) A facility that admits or retains an identified offender shall have in place policies and procedures for the discharge of an identified offender for reasons related to the individual's status as an identified offender, including, but not limited to:

1) The facility's inability to meet the needs of the resident, based on Section 330.725 of this Part and subsection (a) of this Section;

2) The facility's inability to provide the security measures necessary to protect facility residents, staff and visitors; or

3) The physical safety of the resident, other residents, the facility staff, or facility visitors

Section 330.780 Serious Incidents and Accidents

a) The facility shall notify the Department of any incident or accident which has, or is likely to have significant effect on the health, safety, or welfare of a resident or residents. ...

Section 330.785 Contacting Local Law Enforcement

b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:

2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability;

c) The facility shall develop and implement a policy concerning local law enforcement notification, including:

1) Ensuring the safety of residents in situations requiring local law enforcement notification;

2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;

3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;

CONT.

4) Seeking advice concerning preservation of a potential crime scene;

5) Facility investigation of the situation.

d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).

Section 330.4240 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)

These regulations are not met, as evidenced by the following:

Based on record review and interview the facility failed to request a criminal history background check within 24 hours for 3 residents. (R1, R2 and R3) and failed to request a fingerprint-based check for 1 resident (R2) and failed to take action including notification and discharge for 1 resident (R1) who has disqualifying crimes.

Based on interview and record review, the facility failed to discharge an identified offender when the requirements of Section 330.715 were not met.

Based on record review and interview the facility failed to submit the required notification to the Department for serious incidents on 11/23/10 and 1/12/11 involving residents including R1 who was identified as an Identified Offender (R1).

Based on record review and interview, the facility failed to notify local law enforcement about an incident in which R1 assaulted R2 with injury.

Based on record review and interview the facility failed to have the required staff training as required for contacting law enforcement for all 14 staff employed at the facility.

Based on interview and record review, the facility neglected residents of the facility by failing to protect them from harm by R1.

The findings include:

Based on a review of admission records and facility background check records, it was found that R1 was admitted to the facility on 9/27/10 and the background check was requested on 10/8/10 and returned with multiple hits on 10/29/10. The background check hits included Felony convictions including Aggravated Battery / Victim >60. The facility could provide no information to show that they did anything further to notify the Department. R1 continued to live at the facility until 1/12/11 after stabbing two staff members and being arrested.

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According to the admission records R2 was admitted to the facility on 10/14/10 and left on 10/15/10. R2 was readmitted on 10/27/10. The background check documentation found R2's background check was initiated on an unknown date and conducted on 12/1/10. The background check returned with "Multiple Hits - fingerprints requested." Interview with E2 (Administrative Assistant) on 1/19/11 at 11:00 am found that the facility has not requested any further background checks. After the 1/19/11 discussion E2 indicated the fingerprint for the background check would be taken on 2/1/11.

R3 was admitted to the facility on 12/29/10 and the background check was requested on 1/12/11. No results were available at the time of the survey.

R1 continued to live at the facility until 1/12/11 after stabbing two staff members. Review of R1's facility records found no documentation that discharge was planned for R1 prior to R1 stabbing two staff members of 1/12/11.

R1's criminal history, lack of notification and failure to discharge the resident were confirmed with E1 (Administrator) on 1/31/11 at 2:50pm.

A review of a facility incident report dated 11/23/10 found R1 and R2 were involved in an altercation regarding E3 (LPN). R1 was hitting E3 and R2 stepped in to assist E3. R1 continued to beat R2, who received two black eyes and an abrasion on the left ear. R2 was sent to the emergency room and police were notified. There was no indication that this incident report was submitted to the Department as required.

A review of a facility incident report dated 1/12/11 found R1 had an altercation with E3 on 1/12/11 at 12:15PM that resulted in R1 stabbing E3 and E4 (maintenance man) repeatedly. The report indicated R1 had multiple knives and the police were called immediately. R1 was apprehended by the police in the area and remains in police custody at this time according to interviews with E3, E4 and E1 on 1/19/11. There is no indication that report of this stabbing was submitted to the Department as required.

Interview with E1 on 1/19/11 at 2:45pm confirmed that the incidents on 11/23/10 and 1/12/11 were not reported to the Department.

The facility could provide no training information regarding contacting local law enforcement for review. This was confirmed with E1 on 2/7/11 at 9:15am.

Review of R1's records with the facility found no documentation of discharge planning for R1. Interview with E3 on 1/19/11 at 1:35pm found that due to R1's behaviors alternative living arrangements were needed for R1. E3 indicated that she had tried to find other placement for R1 but no other facilities would take R1. E3 indicated before the stabbing incident of 1/12/11 that R1 was requested to go to the psychiatric unit but that R1 would not go. There is no record of follow-up to attempt to provide help for R1 on the day of the incident. Further review of incident reports finds a statement made by E4 that states R1 was told by E3 prior to the stabbing

CONT. that R1 would have to go to the "Psych ward or a hotel" because of R1's behaviors and incidents of the morning of 1/12/11 with stepping on a visitor.

Several confidential resident interviews on 1/19/11 and 1/31/11 found that the residents were intimidated or scared of R1. The interviews found since the stabbing incident of 1/12/11 that the facility is much calmer and less problematic without R1 as a resident.

Interview with E1 and E2 on 2/7/11 at 9:15am found the facility attempted to find alternative placement for R1 without success. E1 and E2 indicated at that time that R1 had numerous behaviors and that he had altercations with R2. R2 was beaten by R1 on 11/23/11 and from that time until the arrest on 1/12/11, no involuntary discharge was sought for R1.

(A)