STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)
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DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

MEADOWS — Facility Name
0594930 — I.D. Number

3250 SOUTH PLUM GROVE ROAD, ROLLING MEADOWS, ILLINOIS 60008
Address

Reviewed By
INCIDENT INVESTIGATION OF 10/06/05
Type of Survey

December 13, 2005
Date 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. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

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):

350.620a)
350.1060e)h)
350.1230b)
350.1230d)1)a)
350.3240a)

Section 350.600 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1060 Training and Habilitation Services .

e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.
h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

MEADOWS | **0594930**
Facility Name | I.D. Number

350.620a)
350.1060e)h)
350.1230b)
350.1230d)1)a)
350.3240a)
(Cont'd.)

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Section 350.3240 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)

These regulations were not met as evidenced by the following:

1. R2 is a 58 year old male whose diagnoses included Moderate MR, Anemia, Depression, Ataxia and Bipolar Disorder. R2, per observations and interview is verbal. R2 is currently utilizing a wheelchair for mobility. Per observations R2 is capable of propelling his wheelchair and moving about the facility.

Per review of the facility's Incident Reports, on 10/5/05 R2 had a colonoscopy due to loose stools. The Incident Report notes the following:
The colonoscopy revealed, "distal end wooden foreign (body)." Foreign body in rectum, which perforated colon.
Emergency surgery performed - foreign body removed - unable to identify object. Resident has temporary colostomy.

The surgical pathology report measured the foreign body at 15.0cm X 1.5cm X 0.3cm with a fragment measuring 2.5cm X 0.2cm. The operative report (10/6/05) identified the foreign body as consistent with a very large tongue depressor.

E2 (DON) was interviewed 11/22/05 at approximately 10:40am. E2 explained that R2 was having many episodes of loose stools and anemia. On 10/5/05 R2 was seen by a gastroenterologist. R2 had a colonoscopy at which time a large foreign body was noted. Emergency surgery was performed and the foreign body was removed. R2 has a temporary colostomy, with reversal scheduled for January 2006.

E2 stated the tongue depressor was in R2's rectum for an undetermined amount of time. E2 stated skin had grown over the wooden tongue depressor.

E2 stated staff have been trained after the surgery on the following (regarding R2):
- room checks daily in the morning
- no small objects in R2's bedroom
- no objects in R2's garbage can

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Included in the facility's investigation is a Special Staffing dated 10/10/05. The staffing was held 10/6/05 and was attended by E1 (Administrator), E2 (DON) and E4 (QMRP).

The staffing noted the following:

Problem Area:
R2 stated he found the tongue depressor in his trash can in his bedroom. R2 inserted the tongue depressor in his rectum because he was angry.

Plan of Action:
1. Strip room of all items that can be swallowed or placed in other parts of the body.
2. When showing signs of depression, hourly checks will be done to monitor his behavior.
3. (R2) will have counseling sessions with his QMRP five days out of the week to help his mood and improve his self-esteem.
4. Workshop will be informed not to give him small objects to return home with and to monitor him closely while using the restroom to avoid him using work utensils to harm himself.

A memo dated 10/10/05 written by E4 (QMRP) notes, "all small swallowable objects should be kept out of his room." The memo also notes when R2 is in a depressive mood he will receive hourly checks.

On 11/22/05 R2 was interviewed at 11:05am. R2 verified he was recently hospitalized, "for my bag." R2 stated he, "put wood in my bottom." R2 was asked why he did this and he stated, "I don't know."

On 11/22/05 at approximately 11:35am R2's bedroom was observed. R2's night stand top drawer was opened. In the drawer there were approximately 20 to 30 items (most of which were small - less than 2 to 3 inches).

E4 (QMRP) was interviewed 11/22/05 at 11:55am. E4 stated he was not previously aware of all of the small items in R2's drawer. E4 stated R2 is to have room checks 1X per week (Wednesday). R2 is also to be monitored hourly by nursing and/or direct care staff.
E4 provided surveyor a copies of the "Hourly Check Sheet" that was to be completed by

nursing and/or direct care staff.

The "Hourly Check Sheet"(s) were dated:

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- 10/10/05 thru 10/20/05 - 11 of the 11 sheets had incomplete checks (there were no staff initials or documentation the checks were completed)
- 10/23/05 thru 10/30/05 - 8 of the 8 sheets had incomplete checks (there were no staff initials or documentation the checks were completed)
- Other "Hourly Check Sheet" (s) were dated: 11/1/05, 11/5/05, 11/6/05, 11/7/05, 11/8/05, 11/9/05, 11/12/05 and 11/22/05 - These 8 sheets also had incomplete checks.

E4 was interviewed 11/22/05 at 11:55am and was asked why the "Hourly Check Sheet"(s) were incomplete and days of data was missing. E4 did not answer as to why the data was missing. E4 did verify there was missing data for specific days and for specific time frames. E4 did state nursing staff are responsible for the "Hourly Check Sheet" in the morning and direct care staff are responsible in the afternoons.

On 12/2/05 at 12:45pm R2's bedroom was again observed. R2's night stand top drawer contained a large wooden tongue depressor, 3 straws and some sports medals. On R2's walker was a material like bag that was observed to contain a 2 inch toy, some cassette tapes and at least 4 lapel pins (size approximately 3/4 inch). E4 verified the above noted objects were not to be in R2's bedroom or on his possession. E4 stated R2's room checks would be increased from 1 - 2 times per week to hourly.

The facility failed to ensure R2's health and safety needs were met. The facility, after recommending all "swallowable" objects were to be kept out of R2's bedroom, failed to ensure this procedure was implemented.

On 11/22/05 surveyor received a copy of the facility's policy titled "Resident Abuse." E1 was asked if the facility had a policy regarding Neglect. E1 stated, 11/22/05 at approximately 2:40pm, the facility's policy titled "Resident Abuse" also included their policy on Neglect. This policy is dated 3/28/05. The facility's "Resident Abuse" policy notes, "No Resident will be mentally or physically abused or neglected by any facility personnel, Resident or visitors." The facility failed to ensure R2 was free of neglect.

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STATE OF ILLINOIS
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(Continuation Page)

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STATE OF ILLINOIS
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(Continuation Page)

Facility Name | I.D. Number

STATE OF ILLINOIS
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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

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