

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2007
NAME OF PROVIDER OR SUPPLIER BIG MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LONGMOOR SAVANNA, IL 61074		
(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) COMPLETION DATE	
F 323	Continued From page 7 policy changes before they were allowed to continue to work with the residents. All staff will be in-serviced on the new policy and procedure prior to the start of their shift.	F 323			
F9999	3. On 12/15/07 at 10:00 AM a new Pre-Admission Screening Form was initiated to ensure that new admissions are appropriate for the facility's program. 4. Care plans were reviewed and updated for 15 residents identified by the facility as having an increased risk for abuse and neglect. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a 300.1210b)4) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. b)4) Personal care shall be provided on a 24-hour, seven-day-week basis. These Requirements were not met as evidenced by:	F9999			

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F9999	<p>Continued From page 8</p> <p>Based on Observation, Interview and Record Review, the facility failed to supervise R2, a confused wandering resident with known aggressive behaviors. This failure allowed R2 to enter other residents' rooms leaving them unprotected from R2's aggressive behavior. One resident (R1) received multiple facial injuries after being struck by R2, and needed evaluation at a local hospital.</p> <p>This applies to 1 aggressive resident (R2) and 3 residents (R1, R3 and R5) at risk for abuse.</p> <p>Findings include:</p> <p>On tour 12/14/07 at 8:30 AM, R1 was observed walking in the hallway. R1 was noted to be of petite stature with extensive discoloration noted to the right side of her face and neck. The Minimum Data Set (MDS) dated 10/30/07 shows R1 is a 71 year old female who stands 4 feet 9 inches tall and weighs 125 pounds. The Physician Order Sheet (POS) dated 12/07 shows R1 has diagnoses of Alzheimer Type Dementia with Psychosis and Depression.</p> <p>R2 was observed lying in his bed at 9:00 AM on 12/14/07 and to be of average stature. The MDS dated 11/27/07 shows R2 is a 66 year old male who stands 5 feet 8 inches tall and weighs 140 pounds. The POS dated 12/07 shows diagnoses of Senile Dementia with Depressive Features secondary to Coronary Artery Disease (CAD) and Generalized Anxiety.</p> <p>On 12/14/07 at 8:30 AM, R1 was observed walking in the hallways. This surveyor noticed extensive discoloration to the right side of her</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>face and neck and a large firm hematoma to her right cheek bone. R1 proceeded to show this surveyor a smaller hematoma with obvious discoloration to left side of the back of her head.</p> <p>On 12/14/07 at 8:30 AM, R1 was found to be alert and orientated to person, place, time and surroundings. R1 stated two Sunday's ago, R2 was trying to get into her room and she told him no. R2 then struck R1 to the right face and jaw area causing R1 to fall and hit the back of her head on the floor.</p> <p>On 12/14/07 at 10:25 AM, E4 (Physical Therapy Aide) stated she was in an office four doors away from R1's room. E4 said she heard nothing prior to a "thud" then came out of the office to see what happened. E4 stated she saw R1 pushing herself up off the floor in the doorway of her room and R2 was standing over her. R1 began yelling at R2 and told E4 that R2 hit her in the face and knocked her down. E4 directed R2 away from R1's room. E4 denies any yelling, arguing or other commotion was heard prior to the "thud noise."</p> <p>The Physician's Notes dated 12/3/07 show R1 was "punched in the face" by another resident and was complaining of a headache, pain behind the right eye and some nausea. The physician also documents her neurological exam as "not completely normal." R1 was sent out for a Brain CT.</p> <p>Z3's psychiatric notes dated 6/14/07, 7/31/07 and 8/30/07 show R1 has known fears of "someone" trying to get into her home which resulted in nailing her doors shut, covering her windows, and using three dead bolt locks for protection. The</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>facility nurses notes dated 10/31/07, 11/1/07, 11/3/07, 11/4/07 and 11/5/07 document R1's barricading behaviors by placing furniture in front of the doors of her room. The nursing notes and R1's care plan identify R1 has fears of someone entering her room.</p> <p>According to nursing notes and care plans, R2 has a long documented history of wandering into other residents' rooms and many documented episodes of aggressive and violent behaviors towards staff and peers. Nursing Notes dated 9/5/07 at 2:00 PM show R2 was found in a female residents room after the Maintenance Staff heard her screaming. Upon arrival to the room, both R2 and R3 were "swinging their arms and hands at each other." The Incident Report List dated 12/2/07 at 6:45 PM, shows R2 was again found in R3's room. At this time, R2 and R3 were found to be on the floor with extremities entwined. On 12/8/07 at 4:00 PM, Nursing Notes show R2 "pulled another resident (R5) out of his wheelchair" and "hit" R5 in the head "knocking his glasses off." Z2 (Geriatric Psychiatrist) Notes dated 1/4/07, 6/14/07 and 12/4/07 all show R2's wandering behavior and his interactions with other residents have been a problem while at this facility.</p> <p>Altercations with R2 have occurred with 3 of the 15 residents identified at risk for abuse during the past 3 months. (R1, R3 and R5).</p> <p>(A)</p>	F9999			