STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G026	A. BUILDING _____ B. WING _____	C 03/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
W 331	Continued From page 65 10 Interviewing and Recruitment process for DON position initiated. Although the IJ was removed, noncompliance continues at the exit since the facility has not had an opportunity to fully implement their plan and evaluate it's effectiveness.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 350.620a) 350.700a)1)2) 350.1060a) 350.1060c)1)2) 350.1030d)e)f)g)h) 350.1230c) 350.1230d)1)2)3) 350.1230e) 350.1230f) 350.3240a)b) Section 350.620 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 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or	W9999		

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W9999	Continued From page 66 welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence. Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. 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. f) There shall be a functional training and habilitation record for each resident, maintained	W9999		

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W9999	Continued From page 67 by and available to the training and habilitation staff. g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff. 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. Section 350.1230 Nursing Services c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. 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. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	W9999		

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W9999	Continued From page 68 b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. These Requirements were not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to prevent neglect for 4 of 4 individuals (R1, R3, R4 and R6): 1. Prevent neglect to R1 who sustained a fall, had a seizure the following day (no seizures since 1997) and the next day started vomiting, became unconscious and died. Staff failed to monitor R1's neurological status or notify the physician of her ongoing medical condition over a 3 day period. The facility failed to have systems in place to monitor R1's neurological status and systems for notifying the physician when there is a change in client's condition. Failure of the facility to implement system resulted in serious injury and death. 2. Prevent neglect to R6 who sustained an unknown injury which resulted in a fractured hip. R6 was observed displaying pain, was unable to use his walker and requested the use of a wheelchair. Nursing observed client in pain, and stated he would give him pain medication. No pain medication was given nor did the nurse assess R6 medical condition. R6 was sent to the hospital, and was diagnosed with a fractured hip. 3. Prevent neglect to R4 who sustained an unknown injury which resulted in a fractured arm. R4's fractured arm went unknown by the facility from 2/16/2008 to 2/19/2008. The facility failed to	W9999		

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W9999	Continued From page 69 have a system in place to monitor R4's injury and went 4 days with a fractured arm. 4. Prevent neglect to R3 who had 23 falls in the month of February, 14 for January, and 7 in December. The facility has not implemented a systematic process to prevent recurrent client falls. 5. Ensure that any allegations of abuse, mistreatment or neglect are thoroughly investigated. 6. Ensure the results of investigations are completed within five working days. Findings include: 1. R1's Annual Resident Habilitation Plan dated 1/3/2008 states R1 is a 62 year old female with a diagnosis of Severe Mental Retardation, Seizure Disorder (none since 1997, no seizure medication), Hypercholesterolemia, Anemia, Tachycardia, Bipolar Disorder, Mixed, Severe Specific with Psychotic Behavior. R1 has an IQ - 28 and an Adaptive Behavior Score of 3 - 11. Speech Language and Communication Evaluation dated 1/19/2008 states her primary mode of communication is verbal. R1 is ambulatory and able to communicate her needs. R1 has adequate hearing and vision. R1's State of Illinois Certificate of Death dated 2/12/2008 states R1, on February 7, 2008 died (no time given) from (immediate cause) Aspiration Pneumonia. Review of facility Serious Incident/Accident dated 2/7/2008 written by E1, Administrator, states R1	W9999		

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W9999	Continued From page 70 on "2/7/2008 at 11:20 a.m. ...required 911 when unresponsive." The incident report documented "at 11:10 a.m. resident (R1) had a moderate amount liquid emesis. Color pale. Temperature 97.4, BP 100/70, respirations 40/minute (no pulse rate documented)...11:10 a.m. due to resident's emesis and incontinence of stool, resident was taken for a shower. (At) approximately 11:20 a.m. the nurse contacted the Medical Director regarding emesis and loose stool. Dr. to return call. Within a few minutes staff with resident in shower called for nurse because resident was not responding. Resident color extremely pale but nurse able to palpate radial pulse of 60 but not responsive. 911 called approximately 11:28 prior to arrival resident was transferred from shower chair to floor - CPR was to commence when paramedics arrived. Resident still non-responsive but noted some cardiac activity on the heart monitor as she was being transported to ... advised by hospital chaplain upon arrival that resident had been pronounced dead at approximately 12:10 p.m. Medical Director informed. Medical Director signed Death Certification." Upon review of R1's nurses' notes dated 2/5/2008 written by E15, LPN, "Hab Aid notified of incident where R1 (resident) fell in shower room. Stated she slipped, (up) with assist x1. Body (check) done (no) evident injuries noted." Nurses note dated 2/6/2008 written by E15, LPN, stated "Seizure episode witnessed by hab aid around 6:30 p.m., lasted about 1 minute (resident in bed when incident occurred. Incontinent of bowel during seizure. Breathing heavily afterwards. B/P (blood pressure) 103/56, P (Pulse) 100, R (respirations) 30, Temperature	W9999		

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W9999	Continued From page 71 101.9, ...(Tylenol) 650 mg P.O. (by mouth) at 7:30 p.m. Temperature 100.5 at 11:30 p.m. (Tylenol) p.o. given. (increase) fluid intake." Review of nurses' note written by Z4 on 2/7/2008 at 6:30 a.m. states, "T. (temperature), 100.6...no diarrhea noted ...Tylenol 650 given. 7:45 a.m., T 100.2, appears lethargic and weak but no distress." Review of E14's progress noted dated 2/7/2008 at 11:20 a.m. stated R1 was not responding, color extremely pale. 911 called, ...palpate a radial pulse @60 but was not responsive, pupils appeared dilated. Per Interview with E16, CNA, on 2/26/2008 at 5:30 p.m., E16 stated on 2/5/08, R1 was in her group and after her break around 6:30 p.m. she had 4 showers to do and R1 was in the 1 group. E16 stated the floor was wet and also had blood on the floor and R1 was trying to avoid the blood area and fell backwards against the door. E16 stated R1 fell hard backwards against the door and was hard enough for the door to come loose from the magnetic holder and the door hit her in the back. E16 stated R1 hit her shoulders and possibly the back of her head but can't be sure since it has been "awhile ago." E16 stated she shouted for the nurse to come in (E15), and she came right away. She (E15) checked R1's butt, head, back and arms. We (E15 and E16) got her up and R1 left bathroom on her own. E16 stated she had not been sick that day, no temperature . E16 stated on 2/6/2008, she was in the room when R1 had a seizure, R1 had a grand mal seizure. E16 states she has worked for the facility for 4 years and never known R1 to have a seizure. E16 stated R1 was waiting to go to the	W9999		

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W9999	Continued From page 72 bathroom and was sitting on the bed when she had the seizure. R1 fell sideways on the bed and the staff who was assigned to her pulled the call light for the nurse. E15 came in to the room and took R1's vital signs. E16 stated R1 remained in bed the rest of the night. E16 stated she worked a double shift (11-7) and R1 was awake during the night. No lethargy or confusion observed. R1 did not have any emesis at all during the night. E16 states she left duty at 6:45 a.m. When interviewed on 2/26/2008 at 6:10 p.m., E15, LPN, stated on 2/5/2008 (she was called to the bathroom) and observed R1 was on the floor by the door. E15 took her to the treatment room and examined her and she did not have any open areas. E15 stated no one told her if R1 hit her head and I do not remember if I (E15) asked if E15 hit her head. E15 stated she was present in the room when R1 had a seizure on 2/6/08. E15 stated she did not recall her ever having a seizure. Surveyor asked if she notified the physician about R1 falling on 2/5/2008 or seizure activity on 2/6/2008 (since R1's last seizure was in 1997) and she stated "No." E15 stated she notified E3, LPN, DON, regarding R1's seizure activity. When reviewed, R1's record did not produce a seizure record for R1. Surveyor requested a copy of R1's seizure record for 2008 and 2007. The facility was unable to produce this information. Per E2, Residential Service Director, on 2/25/2008, R1 does not have seizures, so no record has been kept. Surveyor asked E2 about R1's seizure on 2/6/2008 but E2 was unable to produce the seizure record. E15 stated she did not notify the physician of R1's fall on 2/5/2008 or seizure activity on 2/6/2008.	W9999		

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W9999	Continued From page 73 Interview with Z1 on 2/28/2008 validated he was not notified that R1 had fallen on 2/5/2008 and that he was not notified of R1's seizure activity on 2/6/2008. When interviewed with E3, LPN, DON, on 2/25/2008 at 2:00 p.m. states, R1 had neuro checks after she fell (on 2/5/2008) initially on examination and they were o.k. E3 stated there is no system at this time to follow up for any changes in the client's neurological status (to determine any changes). E3 was asked by the surveyor how she would know if there were changes in client's neurological status if there was no follow up, E3 was unable to provide a response. During record review, no documentation of initial or follow-up neurological checks could be found. During interview with E1, administrator, on 2/25/2008, surveyor requested the name of the staff who was with R1 when she fell on 2/5/2008. E1 stated she did not know the name of the employee who was with the client when she fell but would find out from E15 when she came into work. On 2/26/2008, E1 noted that E16 was with R1 when she fell in the bathroom. E16 was interviewed on 2/26/2008 and stated she was not interviewed nor did she complete a written statement at the time of the incident. E16 stated she was interviewed 2/25/2008 regarding R1's fall on 2/5/2008. There is no evidence the facility provided documentation that E16 was interviewed during the initial investigation. Confirmed by E1. Upon review of Facility Policy Abuse, Neglect,	W9999		

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W9999	Continued From page 74 dated May 2007, it states "Neglect means the failure to provide adequate medical or personal care or maintenance, which results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. It is failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Additional review states "the following situations require an Incident/accident report: Fall, Behavioral issues of a resident...injury of unknown origin. Medical issues requiring transfer to emergency dept and/or admission to the hospital, (and) abuse/neglect. ...Incident/Accident report is to be completed; The form is to be completed by any staff member who encounters an incident; as a direct witness of the situation or who is informed of the situation....The nurse and/or designee may initiate interviews with staff members who have possible knowledge of the situation in an effort to determine cause and/or background...Incident/Accident report must be faxed to IDPH within 24 hours of the incident...A summary of the Incident is to be completed and faxed to IDPH...within 7 days... The facility was not able to provide evidence that the incident report was completed and faxed to IDPH (Illinois Department of Public Health). Nursing staff failed to recognize changes in signs and symptom of R1's neurological status after she fell on 2/5/2008, then had a seizure on 2/6/2008 (last seizure 1997), and episodes of vomiting on 2/7/2008 which resulted in R1 becoming unconscious and eventual death. There is no evidence that nursing provided increased monitoring of R1 following a fall on	W9999		

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W9999	Continued From page 75 2/5/08. There also is no evidence that E15 fully interviewed E16 following R1's fall to evaluate the nature of her injury for assessment of and care for R1's health/medical needs. There is no evidence that nursing staff recognized symptoms of head trauma (seizure, lethargy, vomiting, altered vital signs) and reported them to the physician. 2. According to information provided by the facility, there were 98 residents on 2/25/08. Twenty six of the individuals require adaptive equipment for ambulation. Two individuals are in need of total assistance requiring position changes every 2 hours. 19 individuals function in the Profound range of Mental Retardation, 47 individuals function in the Severe range of Mental Retardation, 27 individuals function in the Moderate range of Mental Retardation and 5 individuals function in the Mild range of Mental Retardation. Review of Accident/Incident log provided by the facility for December 2007, January 2008 and February 2008 indicated: December 33 total falls including falls during seizures. January 46 total falls including falls during seizures. February 43 total falls including falls during seizures. E1, Administrator, E2, Residential Services Director (RSD), and E3, Licensed Practical Nurse - Director of Nursing, were asked about falls and other serious incidents during the daily status meeting on 2/25/08 at 3:15 p.m. Surveyor asked about the level of supervision for individuals who	W9999		

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W9999	Continued From page 76 have fallen or have other medical issues. E2 said the level of supervision an individual needs is conveyed by "word of mouth." E1 said individuals have not been assessed to determine the level of supervision they need. E1 said the facility has been struggling with staffing. Staff is not always assigned to specific residents. E1, E2 and E3 confirmed that all individuals are on general supervision. Levels of assistance for toileting have been identified for individuals who have bowel and bladder needs. E1 said individuals have not had assessment for fall risks and there is no fall prevention plan in place for individuals who have frequent falls. 3. According to the 1/2/08 IPP, R4 is a 64 year old male, whose diagnoses include, Severe Mental Retardation, Blind right eye, Bipolar Disorder, Psychotic Disorder NOS, Seizure Disorder, Mood Disorder, and constipation. R4's IQ is 30 and his adaptive score 3 years 5 months. R4 was referred to a neurologist on 10/10/07 for a history of unsteady gait and falling per physician progress note dated 9/16/2007. According to incident report, R4 sustained a fracture to his finger during a fall on 10/17/07. R4 sustained an unobserved fracture to his humerus, which was discovered on 2/19/08. The facility investigation states: "On 2/19/08 Hab Aide giving shower to resident @ approx 8:30 p.m. noted a bruise to (left) upper arm - also some difficulty in movement. Reported findings to LPN who assessed resident: Bruising on (left) tricep & bicep approx 6 (inches) in diameter. (No) evidence of broken skin. Entire arm is grossly edematous from shoulder to digits...	W9999		

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W9999	Continued From page 77 non-displaced fracture of the left humerus." The facility investigation states: "incident reviewed regarding (fracture) humerus. Investigated - falls/incidents. Resident had several falls on 2/16 (with) no injury and one incident (with) eyebrow injury - as reported by roommate. Roommate reported resident fell on a "dresser drawer" Nurse assessment: 2 - 1cm parallel lacerations (above) (left) eyebrow..." "RSD, DON and Administrator looked over residents rm to (check) if fall in rm. (on dresser drawer) as stated by roommate could have been the cause resulting in the (fractured) humerus. Attempted to re-enact "a fall." In that resident's injury was (left) sided (i.e. eyebrow and arm) and in view of furniture location (i.e. dresser) it would be feasible that as he fell he hit his eyebrow area first and then as he went (down) he hit his arm. Until 2/19 when the bruising was noted - resident offered no complaints and no guarding of (left) arm was noted. Staff was interviewed (with) no findings - other than input from a couple (hab aides) who commented that resident has been known to crawl out over the bed on his own." ... "@ this time it is concluded that the injury (fractured humerus) occurred @ the time of the fall (with) the eyebrow injury." Surveyor reviewed the list of people who were interviewed by the facility for the investigation. There is a summary of statements, but, no reproducible document of staff statements. Surveyor reviewed staffing schedule for the period between the last documented fall and the injury discovery. All habilitation staff were not interviewed. One nurse was interviewed. There is no evidence that overnight nurse was interviewed. The facility did not resolve	W9999		

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MEADOWS	**3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008**

(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
W9999	Continued From page 78 statements made by staff regarding R4 crawling out of bed. R4 had 5 unwitnessed falls from 2/15 through 2/16. There is no evidence in the investigation that the facility investigated to determine if R4 had another fall or injured himself in another way. Staff statements indicated R4 did not offer complaints and did not guard the arm until the bruising was noted on 2/19/08. 4. According to the 12/13/07 Individual Program Plan (IPP), R6 is a 59 year old male whose diagnoses include, Severe Mental Retardation, Down Syndrome, Mitral Valve Prolapse, Bilateral Varicose Veins, Degenerative Scoliosis, and Osteoarthritis both legs. R6's IQ is 27 and his adaptive behavior score is 7 years 0 months. The 12/13/07 IPP states "Adaptive devices: (Wheelchair, Glasses, Hearing Aid, Shower Chair, Clothing Protector, Eating Utensils, Walker, Helmet, Special Socks/Hose, Orthopedic Shoes, Other): Wheel chair (Daily Use)." On 2/27/08 at 6:50 a.m. surveyor noticed a call light signal. No one attended to the call light. Surveyor asked Z4 who was preparing medications, what was making the noise. Surveyor noticed a light above a bedroom door and entered R6's room with Z4. R6 said "I need a wheelchair." Z4 said, "you should be walking with a walker, per P.T. (Physical Therapy)." R6 was crying and said he had a pain in his knee. R6 said, "I fell last night." Z4 told surveyor R6 has osteoporosis and had history of a fracture. Z4 told R6 he would get Tylenol for R6. Surveyor discussed this situation with E2, Residential Services Director at 8:55 a.m. E2	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G026	A. BUILDING _____ B. WING _____	C 03/11/2008

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MEADOWS	**3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008**

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W9999	Continued From page 79 said R6 probably knew you were in the building he does things for attention. Review of nurse's notes states "02/27/08 8:25 a.m. was found on the floor on his buttocks. The walker, was facing opposite of him. States as he was coming out of the bathroom, he sat on the edge of roommate's bed (and) then fell to his "butt". "Then stated he just sat on the floor. Assisted up. Was moving bil.(bilateral) extremities (without) diff. (difficulty). (No) evidence of injury (after) assessment. Ambulating per usual altho (although) bent forward. Instructed to walk straight. Did so for a few secs (seconds) (and) then sat on his rocker." "2/27/08 12:15 PM to (hospital) for x-rays of both hips, (both) knees (and) both feet as (prescribed) by Z1" Nurse's notes for 2/27/08 3:20 p.m. state "Radiologist called (and) stated res. (resident) has a (fracture) (right) hip that's a couple of weeks old - 1 (week) old." Review of the facility Incident/Accident log states, "2/20/08 (R6) stated he fell out of w/c (wheelchair) sitting on buttocks - no injury noted." On 3/6/2008 at 1:05 p.m., surveyor interviewed E2. E2 said the facility did not investigate because they knew what happened. E2 said she was there when R6 fell on 2/20/2008. There is no evidence that the facility did any follow-up investigation when the x-ray of 2/27/2008 showed the fracture was a week old. (A)	W9999		