PRINTED: 02/08/2010 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145350	B. WIN				C 9/2009
	ROVIDER OR SUPPLIER	IEADOWS		4	REET ADDRESS, CITY, STATE, ZIP CODE 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	F	000			
	Complaint Investig 0994228 - IL43803 0994442 - IL44031	- No deficiencies					
F 223			F 2	223			
	sexual, physical, a	ne right to be free from verbal, and mental abuse, corporal voluntary seclusion.					
		ot use verbal, mental, sexual, corporal punishment, or on.					
	by: Based on record refailed to ensure that (R1& R2) are free (R1&	eview and interviews the facility at 2 of 10 sampled residents of physical abuse by staff. In an Immediate Jeopardy, was notified of the Immediate /09 at 4:15p.m. The dy was determined to have at approximately 8p.m. the Jeopardy was abated on was suspended and nated the facility remains out severity Level II. The conference on 10/21/09 at the following interview E2 stated there					
ABORATOR	•	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145350	B. WIN	IG			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS		42	EET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD OLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	was an investigatio 09/09/09 involving Aide-CNA) was sus and subsequently to fabuse was subsited (CNA) was terminated abuse of R2 in add E2 also stated that witnessing E4 slap R2 is 64 years old a craniotomy due to a ventriculoperitonea history of agitation, Nurses note dated 12:30a.m. this write R2's left third finger Assessment to the finger is swollen and pain, but unable to hand and these fing this happened.' R2 and stated 'two girls vietnam jumped or applied and physici rule out fracture. Nurses note dated R2's third finger gresslight swelling. Xrastates two women strong but they were took it out on her. On 09/09/09 E2 initi incident involving Robtained a statemed This was done to make the substance of the results of the substance of the substanc	n of alleged abuse initiated on R2. E2 stated E4 (Nurse spended pending investigation erminated because allegation tantiated. E2 also stated E6 ted for not reporting alleged ition to previous issues. on 09/09/09 E5 reported	F:	223			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			ETED
		145350	B. WING	3	10/:	C 2 9/2009
	ROVIDER OR SUPPLIER	MEADOWS	5	STREET ADDRESS, CITY, STATE, ZIP COI 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	my finger. They sa strong but we are se CNA's were trying were trying to hara. On 09/09/09 at 2p. which reads; On SE4 around 3:30p.m E4 wrapped R2's r she asked me to hand. E4 was gettin hand and was poin "don't fight me." Estocause before sha a scratch on the form on 09/10/09 at 10: statement which rewithen she sees me We just talk to her Sunday (09/06/09) was still in bed whe she kicked us and about 4:30p.m. We she scratched me moved her hand and me with her good hand on the lift. In be quiet". She talk held her right hand wrapped her right hand wrapped her right hand wrapped her wrisdo. R2's current care phad alteration in acrelated to limited mimpairment. Needs	aid to me "you think you are stronger." When asked if the to help her she said "no they ss me." m. E2 obtained E6's statement sunday (09/06/09) she helped at to 4p.m. R2 was fighting. ight hand with a washcloth and old her R2's right hand. I did g upset. E4 held R2's right ting a finger at her saying 4 was getting hot tempered e wrapped R2's hand, she got	F 22	23		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	STRUCTION (X3) DATE SI COMPLE	
		145350	B. WII	NG _			C 9/2009
	ROVIDER OR SUPPLIER	IEADOWS	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	plan approaches to approach R2 in a g what you are going and/or differently if Results of final inve 09/11/09 by E1 (Ac 09/09/09 R2 report earlier her hand ha members while proreport R2 was unal the incident occurre identified was suspinvestigation it was (E4) had tied down upon witness state it was determined to founded and E4 was employment. 2. During interview (Director of Care Dhad investigated and investigated are of a resident. E3 sher and was not sureportable. E3 stated she observed a slap. E3 did state reporting this concept At approximately 90 the facility and intestated that on 09/00 investigation regard E5 (CNA) reported R1's hand on 09/00 firestand and on 09/00 firest	these identified problems are; tentle manner and explain to do. Re-approach later resistant. Sestigation report dated diministrator) states; On ed to staff that several days dispensed back by staff eviding care. At the time of the cole to determine the date that ed. Staff member who R2 mended (E6). Upon learned that another CNA R2 wrists during care. Based ments and E4's own statement that the allegation of abuse is as terminated from You on 10/21/09 at 8:50a.m. E3 elivery) was asked if facility by recent allegations of abuse tated that a CNA did approach are if something was led this CNA (name not given) another CNA holding R1's dishat she considered a bit of the there was a delay in the ern. a.m. on 10/21/09 E2 arrived in riviews continued with E2. E2 9/09 she began the ding R2 and on the same day that she observed E4 slap 5/09 at approximately 8p.m.	F	223			
		m. E2 obtained E5's statement to go ask E4 for her help at					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	
		145350	B. WII	NG _			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	8p.m. I went to roc and curtain was dra trying to take off Rothink on her left hall hand like you would something wrong. probably the right halped R1's hand to notice." I don't rothed E4 you can't sl hand and said "loof the room. On 09/10/09 at 10a statement which rebed she pinched me, me chair in her room. her up, it was to eashe pinched me, mistake I hit her on E5 told me "you camistake. After she with a little force. R1's current care procan be verbally and caregivers by biting include approach or resident is calm an at a later time. Results of investigation (Administrator) statementer reported with the communicate and the unable to obtain a signer was suspense.	and 184. The door was open awn. I walked to E4. She was I's shirt. R1 pinched E4, I and, and then E4 slapped her d slap a kids hand if they do I don't know for sure, it as and. When asked if E4, E5 responded "enough for us emember how R1 reacted. I ap her. E4 showed me her k she pinched me." Then I left a.m. E2 obtained E4's ads; When I was putting R1 to be y left breast. She was on her Me and E5 were trying to sit and went up and by the arm (not on the hand). Innot do this." I said it was by pinched me I held her hand allan dated 09/01/09 states R1 diphysically aggressive to g and scratching. Interventions almly, maintain distance until different is resistive, return attion dated 09/11/09 by E1 tes; On 09/05/09 A staff witnessing another staff on the hand. R1 is unable to therefore the facility was statement from her The staff ended, family and physician II body assessment was also	F	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	145350	B. WIN	G			C 9/2009
NAME OF PROVIDER OR SUPPLIER MANORCARE OF ROLLING MEAN	pows		422	ET ADDRESS, CITY, STATE, ZIP CODE 5 KIRCHOFF ROAD LLING MEADOWS, IL 60008		
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
and subsequent intervito substantiate the aller This allegation was not stated above. As previous observation on 09/ During interview on 10/ alleged abuse of R1 wait was witnessed by a shad no prior concerns was found on R1 and rissues or concerns with Surveyor did state that begin until four days aftit was not reported for The Facility took the forthe Immediate Jeopard On 09/09/09, after an if was identified, R2 recentives supervisor and the physical findings. The in the resident's mood, physician and family with finger was discolored and completed findings. On 09/09/09 CNA (E5) allegation of staff to read an assessment was convere no physical finding allegation of abuse. The	ings. Upon investigation iews the facility was unable gation. It reported on 09/05/09 as iously stated E5 reported /09/09. Four days later. /21/09 E1 was asked why as unfounded even though staff person. E1 stated E4 with residents, no redness no other resident had any h E4. It the investigation did not fter alleged abuse because four days. Illowing steps to remove dy: Injury of unknown origin eived an assessment by the here were no other re were no changes noted behavior or affect. The rere notified. The left third and swollen. X-ray was d on 09/09/09 with no I reported a potential sident abuse related to R1. ompleted on R1. There ags that substantiated the here were no changes mood, behavior or affect.	F 2	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145350	B. WIN	IG _			C 9/2009
	PROVIDER OR SUPPLIER	EADOWS	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	on 09/09/09, the Arnursing re-inservice immediate reporting neglect and misappemployee received reporting. When allegation we E6) were suspende initiated. Employee terminated. Assessments were supervisor on non-irooms 203 through findings that substatabuse. Assessments were supervisor on non-irooms 179 through findings that substatabuse. In addition, interviee interviewable residerelated to staff treat the interviewable residerelated to the care in provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the care in the provided to other residence of the provided to other provided to other residence of the provided to other provi	dministrative Director of ed CNA (E5) regarding the g of allegation of abuse, propriation of property. The previous education on abuse ere reported, employees (E4 & ed and investigation was es were subsequently completed by nurse noterviewable resident in 221. There were no physical antiated any allegation of completed by nurse nterviewable residents in 186. There were no physical antiated any allegation of ws were conducted on ents to identify concerns they receive or the care esidents. and Administrative Director of nave completed re-inservice e-Neglect-Misappropriation of with the center staff on	F	223			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
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	ROVIDER OR SUPPLIER	IEADOWS		4	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008	10,2	3/2003
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	The Administrator a Nursing/Designee I in-service educatio residents who are a demonstrated compresidents and/or state and	and Administrative Director of have completed with staff, in on delivery of care for sensitive to care and/or have bative behaviors to other aff 10/22/09 through 10/25/09. The in-serviced on appropriation of Resident entation prior to patient contact ces (HR) or designee on appropriation of Resident ted by center staff. Validation is completed the appropriation of Resident is done by HR who submits a committee for follow-up to on is completed. Intify interventions for patients be placed in the CNA data diuse. The direct care delivery is an of care to residents identified, shall be completed through tings. The will be completed by completed by completed through tings. The will be completed by completed through tings and days to monitor direct ded to patients that are did to validate that care plan is suddits will be submitted to the	F:	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145350	B. WING		C 10/29/2009	
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 6000	CODE	207200
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 223	Continued From p	page 8	F 223	3		
F 225 SS=J	recommendations 483.13(c)(1)(ii)-(iii	to sustain compliance.), (c)(2) - (4) STAFF	F 22			
	been found guilty mistreating reside had a finding enteregistry concerning of residents or mister and report any known of law again indicate unfitness other facility staff or licensing author. The facility must entered involving mistreating including injuries of misappropriation of reported immediate facility and to othe State law through	not employ individuals who have of abusing, neglecting, or nts by a court of law; or have ared into the State nurse aide g abuse, neglect, mistreatment sappropriation of their property; owledge it has of actions by a st an employee, which would for service as a nurse aide or to the State nurse aide registry rities. Ensure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are tely to the administrator of the er officials in accordance with established procedures state survey and certification				
	violations are thor	nave evidence that all alleged oughly investigated, and must tential abuse while the progress.				
	to the administrate representative and accordance with S survey and certific days of the incide	nvestigations must be reported or or his designated d to other officials in State law (including to the State cation agency) within 5 working nt, and if the alleged violation is the corrective action must be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145350	B. WIN	IG			C 9 /2009
	PROVIDER OR SUPPLIER	EADOWS	•	4:	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD COLLING MEADOWS, IL 60008		
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F 225	Continued From pa	ge 9	F2	225			
	by: Based on record refailed to ensure that (E5 & E6) report obthe time of observaresidents (R1& R2). The failure of E5 to 09/05/09 regarding working and mistre. These failures result Jeopardy. E1 (Administrator). Jeopardy on 10/21/1 Immediate Jeopard begun on 09/05/09. E5 witnessed an all report observations to report witnessing 09/06/09. While the Immediate 09/09/09 when E4 subsequently terminof compliance at a Findings Include:	report observations on R1, allowed E4 to continue at R2 on 09/06/09. Ited in an Immediate was notified of the Immediate 09 at 4:15p.m. The ly was determined to have at approximately 8p.m. when leged abuse of R1 and did not a until 09/09/09. E6 also failed an alleged abuse of R2 on the Jeopardy was abated on was suspended and nated, the facility remains out					
	9:10a.m. E2 (Direct asked if facility had alleged abuse. Duwas an investigatio 09/09/09 involving Aide-CNA) was susand subsequently t	tor of Nurses-DON) was any recent investigations of ring interview E2 stated there in of alleged abuse initiated on R2. E2 stated E4 (Nurse spended pending investigation erminated because allegation tantiated. E2 also stated E6					

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		145350	B. WING	€			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS		4225	r Address, City, State, Zip Code Kirchoff Road LING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	(CNA) was terminal abuse of R2 in add E2 also stated that witnessing E4 slap R2 is 64 years old a craniotomy due to a ventriculoperitonea history of agitation, Nurses note dated 12:30a.m. this write R2's left third finger Assessment to the finger is swollen and pain, but unable to hand and these fing this happened.' R2 and stated 'two girls' Vietnam jumped or applied and physiciarule out fracture. Nurses note dated R2's third finger greslight swelling. Xrastates two women strong but they wer took it out on her. On 09/09/09 E2 initincident involving Robtained a statemer This was done to mof them was E6. Timy finger. They sastrong but we are strong but	ted for not reporting alleged ition to previous issues. on 09/09/09 E5 reported R1 on 09/05/09. and diagnoses includes right right lateral meningioma, I shunt due to hydrocephalus, irritability and combativeness. 09/09/09 at 6:45a.m. states at er was informed by CNA that r looks purplish in color finger done and found the id purplish in color. R2 denies bend and said 'this is my bad gers were like this even before a was asked what happened is right out the boat from in me.' Cold compresses were ian ordered X-ray of finger to 09/09/09 at 3:30p.m. stated eenish/yellow in color with my negative for fracture. R2 CNA's told her she looked be stronger, jumped her and that an investigation of the stronger, jumped her and the stronger when asked if the to help her she said "no they to help her she said "no they	F 2.	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	ISTRUCTION (X3) DATE SI COMPLE	
		145350	B. WI	NG _			C 9/2009
	ROVIDER OR SUPPLIER	EADOWS		4:	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
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	had alteration in ac related to limited m impairment. Needs and at times is resis Care plan approach problems are; appr and explain what yo Re-approach later a	and/or differently if resistant.					
	Results of final inve	estigation report dated					

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	PROVIDER OR SUPPLIER	IEADOWS	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	and curtain was dra trying to take off R1 think on her left har hand like you would something wrong. probably the right h slapped R1's hand, to notice." I don't re told E4 you can't shand and said "look the room. On 09/10/09 at 10a statement which re bed she pinched m chair in her room. her up, it was to ea she pinched me my I hit her on the arm "you cannot do this After she pinched m force. R1's current care p can be verbally and caregivers by biting include approach cresident is calm and at a later time. Results of final inve 09/11/09 by E1 (Ad 09/05/09 A staff member was sphysician were notifications).	awn. I walked to E4. She was also shirt. R1 pinched E4, I and, and then E4 slapped her also shand. When asked if E4 as and. When asked if E4 as and. When asked if E4 as and	F 2	225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		145350	B. WI	NG _		C 10/29/2009	
	ROVIDER OR SUPPLIER	IEADOWS	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	investigation and si facility was unable This allegation was stated above. As puthis observation on During interview or alleged abuse of R it was witnessed by had no prior concervas found on R1 a issues or concerns Surveyor did stated begin until four day During interview or asked if E5 had mashe waited four day stated E5 said she but this statement vinvestigation. The Facility took the Immediate Jeon On 09/09/09, after was identified, R2 murse supervisor and physical findings. The resident's mood physician and familifinger was discolor ordered and complifindings. On 09/09/09 CNA (allegation of staff to	ubsequent interviews the to substantiate the allegation. In not reported on 09/05/09 as previously stated E5 reported 09/09/09, four days later. In 10/21/09 E1 was asked why 1 was unfounded even though of a staff person. E1 stated E4 rms with residents, no redness and no other resident had any with E4. Ithat the investigation did not a safter alleged abuse. In 10/21/09 E1 and E2 were ade any statement as to why yes to report the allegation. E1 did not know who to report to, was not written as part	F	225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	TED
		145350	B. WI	NG _			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS	•	4:	REET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	were no physical finallegation of abuse noted in the resider Physician and famiorders were given. police of the allegation of the allegati	Indings that substantiated the antimer were no changes on the mood, behavior or affect. Ity were notified. No new The administrator notified the tion of abuse on 09/09/09. Indinistrative Director of the CNA (E5) regarding the gof allegation of abuse, propriation of property. The previous education on abuse of a previous education on abuse of and investigation was not easily the got and investigation of abuse. The got and investigation of abuse and in	F:	225			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		145350	B. WING _		10/:	C 29/2009
	PROVIDER OR SUPPLIER	MEADOWS	4	REET ADDRESS, CITY, STATE, ZIP COD 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	education on Abus Resident Property 10/21/09 through 1 The Administrator Nursing/Designee in-service educatio residents who are demonstrated com residents and/or st New Employees a Abuse-Neglect-Mis Property during ori by Human Resour Annual in-services Abuse-Neglect-Mis Property is comple that center staff ha Abuse-Neglect-Mis Property in-service report to the QAA ensure the educati Care Plans that ide that resist care will book for review an Monitoring to ensu consistent with pla as resistive to care morning QAA mee Weekly QAA audit Administrative Dire direct care delivery care delivery provi	se-Neglect-Misappropriation of with the center staff on 10/23/09. and Administrative Director of have completed with staff, on on delivery of care for sensitive to care and/or have obative behaviors to other aff 10/22/09 through 10/25/09. The in-serviced on sappropriation of Resident entation prior to patient contact ces (HR) or designee. On sappropriation of Resident entation prior to patient contact ces (HR) or designee. The sappropriation of Resident ested by center staff. Validation as completed the sappropriation of Resident est done by HR who submits a Committee for follow-up to ons is completed. The placed in the CNA data do use. The direct care delivery is not care to patients identified est shall be completed through	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		C
		145350	B. WING _			9/2009
	ROVIDER OR SUPPLIER	IEADOWS	4:	EET ADDRESS, CITY, STATE, ZIP CODE 225 KIRCHOFF ROAD OLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 17	F 225			
	being followed.					
F9999	QAA Committee for	o sustain compliance.	F9999			
	LICENSURE VIOL	ATIONS				
	300.3240a) 300.3240b) 300.3240e)					
	Section 300.3240 A	Abuse and Neglect				
		ee, administrator, employee shall not abuse or neglect a				
	aware of abuse or immediately report	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act)				
	investigation of a re- resident indicates, that an employee of the perpetrator of the immediately be bar with residents of the of any further investigation.	rpetrator of abuse. When an eport of suspected abuse of a based upon credible evidence, if a long-term care facility is ne abuse, that employee shall red from any further contact e facility, pending the outcome tigation, prosecution or against the employee.				
	These Regulations by:	were not met as evidenced				
	Based on record re	view and interviews the facility				

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	TED
		145350	B. WIN	1G _			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS		4	REET ADDRESS, CITY, STATE, ZIP CODE 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	Findings Include: 1. During entrance 9:10a.m. E2 (Direct asked if facility had alleged abuse. During Aide-CNA) was sustand subsequently to fabuse was substituted (CNA) was terminated abuse of R2 in addiso stated that on witnessing E4 slap. R2 is 64 years old a craniotomy due to reventriculoperitone a history of agitation, Nurses note dated 12:30a.m. this write R2's left third finger Assessment to the finger is swollen and pain, but unable to hand and these fing this happened.' R2 and stated 'two girls Vietnam jumped or applied and physici rule out fracture. Nurses note dated	at 2 of 10 sampled residents of physical abuse by staff. The conference on 10/21/09 at tor of Nurses-DON) was any recent investigations of ring interview E2 stated there in of alleged abuse initiated on R2. E2 stated E4 (Nurse spended pending investigation erminated because allegation tantiated. E2 also stated E6 ted for not reporting alleged ition to previous issues. E2 09/09/09 E5 reported	F99	999			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		145350	B. WIN	1G _			C 9/2009
	ROVIDER OR SUPPLIER	EADOWS		4	REET ADDRESS, CITY, STATE, ZIP CODE 1225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	states two women of strong but they were took it out on her. On 09/09/09 E2 initi incident involving RE2 obtained a state reads: This was do CNA's, one of them and wiggling my fin think you are strong asked if the CNA's said "no they were On 09/09/09 at 2:00 statement which reshe helped E4 arou was fighting. E4 will washcloth and she right hand. I did no held R2's right hand her saying "don't fig tempered because hand, she got a scrong on 09/10/09 at 10:0 statement which rewith the sees me We just talk to her sounday (09/06/09). Was still in bed whe she kicked us and sabout 4:30p.m. We	consider the second of the sec	F99	999	*		
	moved her hand an me with her good h hand on the lift. I he	on the forehead. I told E6. R2 ad hit the lift. She tried to beat and. I told E6 that she hit her eld her hand I told her "please using words FB I					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145350	B. WIN	G			ට 9/2009
	ROVIDER OR SUPPLIER	IEADOWS	•	42	EET ADDRESS, CITY, STATE, ZIP CODE 25 KIRCHOFF ROAD DLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	wrapped her right harm above her wrisdo. R2's current care phad alteration in acrelated to limited mimpairment. Needs and at times is resiplan approaches to approach R2 in a gwhat you are going and/or differently if Results of final inveous to approach R2 in a gwhat you are going and/or differently if Results of final inveous to approach R2 in a gwhat you are going and/or differently if Results of final inveous to approach R2 was unalted the incident occurred identified was suspinvestigation it was (E4) had tied down upon witness state it was determined to founded and E4 was employment. 2. During interview (Director of Care Dhad investigated are of a resident. E3 sher and was not sureportable. E3 stated she observed hand and observed the state of the state	I did not do anything else. I hand with the bed sheet up the st. It was not the right thing to all and dated 06/15/09 states R2 divities of daily living (ADL's) hobility and cognitive stotal assist for most ADL's stive to care from staff. Care these identified problems are: tentle manner and explain to do. Re-approach later resistant. Destigation report dated diministrator) states: On the dot of the staff that several days do been pushed back by staff eviding care. At the time of the cole to determine the date that the destigation dates and E4's own statement that the allegation of abuse is	F99	99			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145350	B. WIN	G			ට 9/2009
	PROVIDER OR SUPPLIER	IEADOWS	•	42	EET ADDRESS, CITY, STATE, ZIP CODE 25 KIRCHOFF ROAD DLLING MEADOWS, IL 60008	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	arrived in the facilit with E2. E2 stated the investigation reday E6 (CNA) reposlap R1's hand on 8:00p.m. On 09/09/09 at 5:0 statement which reher help at 8:00p.m door was open and to E4. She was trypinched E4, I think slapped her hand lift they do somethin sure, it as probably if E4 slapped R1's for us to notice." I reacted. I told E4 yme her hand and s Then I left the room. On 09/10/09 at 10: statement which rebed she pinched me, mistake I hit her on E5 told me "you camistake. After she with a little force. R1's current care p can be verbally and caregivers by biting	ern. :00a.m. on 10/21/09 E2 y and interviews continued that on 09/09/09 she began garding R2 and on the same orted that she observed E4 09/05/09 at approximately Op.m. E2 obtained E5's ads: I went to go ask E4 for n. I went to room 184. The I curtain was drawn. I walked ing to take off R1's shirt. R1 on her left hand, and then E4 ike you would slap a kids hand g wrong. I don't know for the right hand. When asked hand, E4 responded "enough don't remember how R1 you can't slap her. E4 showed aid "look she pinched me."	F99	99			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		145350	B. WIN	G			C 9/2009
	PROVIDER OR SUPPLIER	IEADOWS	•	422	ET ADDRESS, CITY, STATE, ZIP CODE 25 KIRCHOFF ROAD DLLING MEADOWS, IL 60008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	resident is calm an at a later time. Results of investiga (Administrator) state member reported with member slap R1 or communicate and to unable to obtain a significant member was suspensive member was fullegation was stated above. As put this observation on allegation members was members with a substantial members was fullegation was stated above. As put this observation on allegation members was members was members was fullegation was stated above. As put this observation on allegation members was substantial members was substa	ation dated 09/11/09 by E1 tes: On 09/05/09 A staff witnessing another staff in the hand. R1 is unable to therefore the facility was statement from her The staff ended, family and physician Ill body assessment was also findings. Upon investigation terviews the facility was unable allegation. In not reported on 09/05/09 as previously stated E5 reported 09/09/09. Four days later. In 10/21/09 E1 was asked why I was unfounded even though I was a staff person. E1 stated E4 I with residents, no redness I not other resident had any with E4. Ithat the investigation did not its after alleged abuse because	F99	99			