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 _____	05/07/2010

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 441	Continued From page 30 The varied drills for the facility were reviewed. The varied drills conducted from 4/27/09 through 4/23/10 are as follows: * 4/27/09 - Severe weather drill * 5/13/09 - Severe weather drill * 6/19/09 - Severe weather drill * 3/30/10 - Severe weather drill * 4/1/10 - Severe weather drill * 4/23/10- Severe weather drill During an interview with E2 (Residential Services Director) on 4/27/10 at 10:45am, E2 was asked if there were any other varied drills other than severe weather. E2 stated that they used to perform bomb threat drills. E2 stated that they have not been running the bomb threat drills lately, so they have revised their schedule to add them back to the rotation. E2 confirmed that they do not run any other varied drills other than severe weather.	W 441		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.3240a) 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	W9999		

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W9999	Continued From page 31 least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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: Based on interview and record review, the facility failed to implement their policy to prevent neglect when they failed to implement 2 hour night time checks and monitor 1 of 1 clients (R11) who expired on 2/3/10. Findings include: R11, per review of his 7/21/09 IPP (Individual Program Plan), was a 37 year old male whose diagnoses included Moderate Mental Retardation, Seizure Disorder, Anxiety, Bipolar Disorder, NIDDM (Non Insulin Dependent Diabetes Mellitus), Hyperlipidemia and Hypertensive Hydrocephalus. Review of R11's 7/21/09 IPP noted that R11 was admitted to the facility on 6/30/08. Review of R11's nurses notes identified that R11 expired on 2/3/10 at 6:57am. The facility's "Resident Abuse / Neglect" policy, dated 2/5/10, was reviewed and noted the following:	W9999		

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W9999	Continued From page 32 "POLICY - Resident abuse or punishment (physical, verbal, sexual, or psychological) and/or neglect by facility staff, another Resident, family, or a visitor will not be tolerated at Meadows. Prevention will be the focus in an effort to avoid any such incident. ... * Neglect - failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a Resident or in the deterioration of a Resident's physical or mental condition. Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results in physical injury to a Resident or in the deterioration of a Resident's physical or mental condition. This shall include any allegations where: * The alleged failure causing injury or deteriorations ongoing or repetitious, or * A Resident required medical treatment as a result of the alleged failure, or * The failure is alleged to have caused a noticeable negative impact on a Resident's health, behavior or activities for 24 hours. ... " Review of the facility's Incident Reports identified that R11 expired on 2/3/10 at 6:57am. The facility's summary of their investigation of R11's death included, in summary, the following: On 2/3/10 at 6:15am E5 (direct care/CNA - Certified Nurses Aid) entered R11's bedroom to assist R11 with getting dressed. E5 noted that R11 was unresponsive and immediately notified E6 (LPN). E6 noted R11 to be pale and unresponsive to stimuli. R11 had no breath sounds and no vitals could be obtained. Carotid pulse was not palpable. E6 told E8 (direct care) to get E4 (nurse). E4 gathered a CPR facemask and cardiac board and went into R11's bedroom.	W9999		

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W9999	Continued From page 33	W9999		

E4 assessed R11 and he was not responsive to any stimuli. Carotid pulse was not palpable, no chest movements were observed and there were no signs of breathing. R11 was transferred onto the cardiac board by E4, E6 and E8 and CPR was initiated. E11 (secretary) called 911, and the paramedics arrived within a few minutes. The paramedics assessed R11 then called a local hospital. R11 was pronounced dead at 6:57am.

E5 was interviewed on 4/28/10 at 1:35pm. E5 stated that on 2/3/10 at approximately 6:10am he entered R11's bedroom. E5 stated he saw R11 in bed and he was "very white." E5 stated he was scared so he ran out of R11's bedroom and yelled for the nurse. E5 stated E6 (nurse) entered R11's room and he then left the areas to assist other clients. E5 stated he was in shock, that is why he yelled for the nurse.

R11's nurses notes were reviewed. E3 (DON - Director of Nursing) documented on 2/4/10 at 1200 hours, that "Seizure" was listed as R11's cause of death by the medical examiner.

A "Level of Supervision" assessment was completed for R11 on 12/30/09. The assessment identifies R11's level of supervision as "Same Room Observation." The assessment also identifies, "Nights are general supervision with 1 -hour building rounds and 2 - hour individual resident room checks. (The exception being 1:1)."

E2 (RSD - Residential Service Director) was interviewed on 4/28/10 at 11:50am. E2 explained that R11 was on same room observation during the day, unless he was in his bedroom or the bathroom. E2 stated that R11 was to be

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W9999	Continued From page 34 monitored every 2 hours during the night time (from 10pm until 6am). E2 (RSD) was interviewed on 4/29/10 at 11:30am. E2 stated that prior to 2/3/10 third shift staff were to monitor all clients every 2 hours between 10:00pm and 6:00am. The staff were expected to check the clients physical condition and report any abnormalities to the nurse on duty. E2 stated that prior to 2/3/10 staff were not documenting that these 2 hour rounds were being completed. E2 stated that after R11 expired, on 2/3/10, the facility developed and implemented an "Hourly Rounds" check sheet. E2 stated the "Hourly Rounds" check sheet was initiated 2/4/10. E1 (Administrator) was interviewed on 4/28/10 at 2:30pm. E1 stated that E7 (former direct care) was the third shift staff responsible for monitoring R11 every 2 hours from 2/2/10 thru 2/3/10. E1 stated that E7 was terminated due to not being able to confirm that he did a complete set of rounds on his shift. E1 stated E7 could not confirm he observed R11 and/or entered his room on 2/2/10 thru 2/3/10. E1 stated when E7 was interviewed he made a statement that he only assisted the clients that have a B & B (Bowel and Bladder) schedule. E7 stated, to E1, that he did not monitor R11 (2/2/10 thru 2/3/10 1pm to 6am) because he was not on a B & B schedule. E7's personnel file was reviewed. E1 wrote the following to E7 on 2/4/10: "This is to inform you that your employment at Meadows is terminated on February 4, 2010 due to failure to follow your schedule. ... " (A)	W9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 35	W9999		

350.620a)
350.1210
350.1210b)
350.1235a)
350.3240a)

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 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Section 350.1235 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment.

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W9999	Continued From page 36 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: Based on interview and record review, the facility failed to immediately initiate CPR (Cardio Pulmonary Resuscitation) for 1 of 1 clients (R11) found unresponsive. Findings include: R11, per review of his 7/21/09 IPP (Individual Program Plan), was a 37 year old male whose diagnoses included Moderate Mental Retardation, Seizure Disorder, Anxiety, Bipolar Disorder, NIDDM (Non Insulin Dependent Diabetes Mellitus), Hyperlipidemia and Hypertensive Hydrocephalus. Review of R11's 7/21/09 IPP noted that R11 was admitted to the facility on 6/30/08. Review of the facility's Incident Reports identified that R11 expired on 2/3/10 at 6:57am. The facility's summary of their investigation of R11's death included the following: On 2/3/10 at 6:15am E5 (direct care / CNA - Certified Nurses Aid) entered R11's bedroom to assist R11 with getting dressed. E5 noted that R11 was unresponsive and immediately notified E6 (LPN). E6 noted R11 to be pale and unresponsive to stimuli. R11 had no breath sounds and no vitals could be obtained. Carotid	W9999		

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W9999	Continued From page 37	W9999		

pulse was not palpable. E6 told E8 (direct care) to get E4 (nurse). E4 gathered a CPR facemask and cardiac board and went into R11's bedroom. E4 assessed R11 and he was not responsive to any stimuli. Carotid pulse was not palpable, no chest movements were observed and there were no signs of breathing. R11 was transferred onto the cardiac board by E4, E6 and E8 and CPR was initiated. E11 (secretary) called 911, and the paramedics arrived within a few minutes. The paramedics assessed R11 then called a local hospital. R11 was pronounced dead at 6:57am.

R11's nurses notes were reviewed. E3 (DON - Director of Nursing) documented on 2/4/10 at 1200 hours, that "Seizure" was listed as R11's cause of death by the medical examiner.

The facility provided documentation of interviews of staff that were working with R11 the evening of 2/2/10 thru 2/3/10. E5's interview summary notes that he entered R11's bedroom on 2/3/10 at approximately 6:15am to get R11 up and ready for breakfast. At this time E5 found R11 to be unresponsive to he went to get the nurse (E6).

E5 was interviewed on 4/28/10 at 1:35pm. E5 stated that on 2/3/10 at approximately 6:10am he entered R11's bedroom. E5 stated he saw R11 in bed and he was "very white." E5 stated he was scared so he ran out of R11's bedroom and yelled for the nurse. E5 stated E6 (nurse) entered the room and he left the area to assist other clients. E5 stated he was in shock, that is why he yelled for the nurse.

E6's written statement (not dated) was reviewed. E6 documented that on the start of the shift (no date), the report was that R11 was "okay." At

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W9999	Continued From page 38 6:15am E6 was called, by direct care staff, to check on R11 because he was unresponsive. E6 entered R11's bedroom and observed R11 to be pale. "Resident appeared to be sleeping. Resident was unresponsive to stimuli, no breath sounds, and no vitals could be obtained. Carotid pulse not palpable, absent. Writer (E6) called for assistance from AM nurse, so CPR could be initiated. CPR performed, no response to CPR, no signs of breathing. CPR continued until EMS (Emergency Medical Services) paramedics on the scene. ... " Paramedics contacted a physician at a local hospital and R11 was pronounced dead at 6:57am. E6 was interviewed on 5/5/10 at 7:20am via telephone call. E6 verified she was the only nurse on duty on third shift on the evening of 2/2/10 thru 2/3/10. (First shift nurse arrived to the facility at 5:00am) E6 stated that she was notified, by a CNA (Certified Nurses Aid), that R11 was unresponsive. E6 was asked if she knew the approximate time the CNA notified her of R11 being unresponsive. E6 stated she could not remember the time, but maybe it was around 5:00am or 6:00am. E6 stated she went into R11's bedroom and saw he was unresponsive so she started CPR. E6 was asked if she immediately initiated CPR as her written statement notes she called for assistance from the AM nurse so CPR could be initiated. At this time E6 stated she could not remember. E6 stated she could not remember all of the details. E6 stated she does remember that no problems were reported to her from the previous shift. E6 also stated there were no problems reported to her prior to staff finding R11 unresponsive.	W9999		

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W9999	Continued From page 39 E4's (nurse) written statement (not dated) was reviewed. E4 documented that on 2/2/10 on the PM shift R11 was alert and without obvious distress. E4 documented that on Wednesday February 3, 2010 at 0620 writer (E4) was approached by a direct care staff who stated (E6) the nurse needed her assistance with R11 - who was unresponsive. E4 gathered a CPR face mask and the cardiac board and went into R11's bedroom. "Upon assessment resident (R11) was stiff, cold, pale, was not responsive to any stimuli. Carotid pulse was not palpable, no chest movements observed, no signs of breathing noted. CPR initiated, 911 activated. Paramedics arrived at 0640. They assessed the resident and called a physician, (from local hospital), who pronounced (R11) dead at 0657. (E12) paged and notified regarding the incident at 0650." E4 was interviewed on 4/28/10 at 12:55pm. E4 stated that she started work on 2/3/10 at 5:00am. E4 stated that at approximately 6:15am she was called to R11's bedroom by E9 (direct care). E9 told E4 that E6 (nurse) needed her assistance with R11. E4 stated at this time she pushed the med cart down the hall and locked it in the med room. E4 stated she then grabbed the CPR mask and board and proceeded to R11's bedroom. E4 stated she assessed R11, he was not breathing, was not responsive and he was cold - "really cold and stiff." E4 stated the CPR board was put under R11 - who was in his bed, and CPR was initiated. E4 stated that another staff called 911. E4 stated that when the paramedics arrived they did not continue CPR, as they stated R11 was in rigor mortis. Surveyor downloaded, on May 4, 2010,	W9999		

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W9999	Continued From page 40 documentation from the American Heart Association regarding Adult Basic Life Support (dated 11/28/05). The American Heart Association identifies the following steps be taken when an adult is found unresponsive: 1. No movement or response 2. Phone 911 or emergency Number, Get AED (Automated External Defibrillator) (or send second rescuer to do this) 3. Open Airway, check Breathing 4. If not breathing, give 2 Breaths that make chest rise 5. If no response, check pulse - If no pulse 6. Give cycles of 30 compression and 2 breaths until AED / defibrillator arrives, ALS (Advanced Life Support) providers take over, or victim starts to move 7. AED / defibrillator arrives 8. Check Rhythm - Shockable Rhythm 9. If shockable - Give 1 shock Resume CPR immediately for 5 cycles 10. If not shockable - Resume CPR immediately for 5 cycles - Check rhythm every 5 cycles; continue until ALS providers take over or victim starts to move The American Heart Association also identifies: If a lone rescuer finds an unresponsive adult, the rescuer should activate the EMS (Emergency Medical Services) system (phone 911), get and AED (if available), and return to the victim to provide CPR and defibrillation if needed. When 2 or more rescuers are present, one rescuer should begin the steps of CPR while a second rescuer activates the EMS system and gets the AED. E2 was interviewed on 4/29/10 at 2:50pm. E2 stated the facility does have an AED available	W9999		

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W9999	Continued From page 41	W9999		

and it is kept at the nurses station. E2 stated nursing staff did not use the AED on R11 on 2/3/10 when he was found unresponsive.

E3 (DON) was interviewed on 4/28/10 at 1:52pm. E3 was asked to explain the facility's protocol/expectation regarding finding a client who is unresponsive. E3 stated the client should be checked for any signs of life (breathing, pulse ...). If unresponsive rescue breaths and chest compressions should begin. Staff should notify someone to call 911. CPR should continue until paramedics arrive. Surveyor identified that E6 documented, in her written statement, that she called for assistance from E4 so CPR could be initiated. Surveyor asked E3, if E6 should have initiated CPR, prior to waiting for assistance from E4. E3 stated E6 should have initiated CPR. E3 stated, "They were freaked out" as to why nursing staff did not immediately initiate CPR.

On 4/29/10 at 9:52am Z1 (Deputy Chief - of a local fire department) was interviewed. Z1 verified that paramedics responded to a 911 call on 2/3/10. Z1 provided surveyor a copy of the paramedics Log Call Sheet. The local paramedics 911 Log Call sheet identifies that when they arrived to the facility (2/3/10 at 06:39) R11 was "found supine in bed, pale, showing signs of lividity and rigor mortis."

The facility's investigation does not identify that R11 had signs of lividity and rigor mortis.
E6 (nurse) documented, in nursing progress notes, that R11 was "... unresponsive to stimuli, no breath sounds and no vitals could be obtained, carotid pulse not palpable ... " E4 (nurse) documented, in nursing progress notes, that R11 "... was pale, stiff, unresponsive to any