Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: ___ B. WING ___	C 11/20/2014

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) COMPLETE DATE
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.3240a) 350.3240d) 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. 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)	Z9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
11/26/14

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d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure for 1 of 1 individual in the sample (R1) the proper supervision and monitoring when:

1. Facility failed to provide proper supervision to R1 resulting in R1 being outside of the building completely unclothed for 17 minutes in 50 degrees temperature on 11/04/14.
2. Facility failed to provide proper monitoring of R1 on 11/09/14 while seated unclothed on the toilet resulting in a 5 centimeter penis laceration requiring 4 sutures.

Findings include:

Per R1's record, R1 is an individual who returned to the facility from an extended medical rehabilitation facility on 10/07/14. R1 functions in the Profound Intellectual Disability range, is non-verbal, independently ambulates, wears an adult disposable pull-up underwear and is on general supervision inside the facility. R1's diagnoses include Seizure disorder and PICA per the October 2014 Physician's Orders sheet.

Undated Facility Policy/Procedure on Resident

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Abuse/Neglect includes:
Definition: 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.
Procedure Regarding Investigation of Incident of Alleged Abuse/Neglect:
1. Notify the local police department immediately.
2. If there is suspicion of sexual or physical abuse and/or injury the resident is to be sent to the hospital for evaluation and treatment. Seeking medical attention as quickly as possible is of the essence.
3. Notification to IDPH (Illinois Department of Public Health); within 24 hours of the incident.

1. Facility Accident/Incident Report dated 11/04/14 includes a summary including "at 12:00 PM R1's Family member was here visiting him, she had just left the building. R1 went out into the front foyer and removed his clothing and walked outside naked. R1 walked out approximately 10 feet in the front of the building...An ankle alarm was implemented immediately due to the severity of the incident."

R1 had a 30-day staffing at the facility on 11/04/14. Per interviews and facility investigation summary, the following occurred:
11:39 AM - R1 is in the front foyer, took of his pants (and was left unclothed from the waist down) and walked outside through door 1.
11:43 AM - R1 took off his shirt (now completely unclothed) outside on the front porch, attempted to get back into the facility but could not because the door was locked. (There are two marked door bells out on the front door, one to be used at night shift that rings at the nurse station and a second one that rings in the office adjacent to the front

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foyer. R1 does not know how to ring the door bell per interview with (Qualified Intellectual Disability Professional) E5 on 11/10/14 at 1:00 PM).
11:58 AM - R1 walked down the front walkway towards the parking lot. (Administrative Assistant) E8 saw R1 unclothed and walking down the walkway (through her office window adjacent to the front foyer). E8 paged for assistance and (Qualified Intellectual Disability Professional) E5 heard the page and arrived at the front foyer area. E5 went out door 7, witnessed a non-staff male standing in front of a vehicle and immediately approached R1.
12:00 PM - R1 back inside the facility with E5. E5 proceeded to assist R1 in putting on clothes including socks, shoes, pants and shirt. E5 remained with R1 for the rest of the afternoon until approximately 4:00 PM.

Approximately within one hour of R1 returning inside the building with E5, an ankle alarm was applied to R1's ankle. E5 and (Residential Services Director), E2 validated, on 11/10/14 approximately at 1:00 PM, that R1's ankle alarm was applied due to the severity of the event of R1 walking outside of the building unclothed. E2 added that telephone consent from the guardian and approval from the human rights committee were obtained on 11/04/14. E5 validated he approached R1 through door 1 and not door 7. E2 validated that IDPH was not notified because R1 did not walk off the property (the walkway and parking lot are still part of the facility).

The facility exit door 1 leads out to the walkway where R1 was found. This walkway leads to a parking area that is immediately adjacent to a busy two-lane, one-way each lane street.

Approximately on 11/12/14 at 12:43 PM,

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(Residential Services Director) E2 and surveyor measured the length of the walkway through the parking area and validated the following measurements:
73 feet - distance R1 was found on the walkway away from the front door to the building. This walkway is approximately a total of 75 feet long.
50 feet - approximate measurement of the parking area adjacent to the walkway before the busy street starts.

Per www.weatherunderground.com/history for the facility's city and zip code, the temperature recorded on 11/04/14 at the following times were:
11:10 AM - 52.0 degrees Fahrenheit
11:41 AM - 51.1 degrees Fahrenheit
11:52 AM - 50.0 degrees Fahrenheit
12:20 PM - 50.0 degrees Fahrenheit.

AM Direct care assessment report dated 10/23/14 by (Direct care staff) E10 include the following:
(R1) at times will strip down and remove all his clothes...At times will leave the building (doesn't go far)...(R1) is very fast and curious about his surroundings.

Interview with E10, on 11/17/14 approximately at 12:30 PM, regarding R1 leaving the building include "R1 likes to push the (exit) doors open and peak out, usually exit door 1, 4 and 5."

PM Direct care assessment report dated 10/30/14 by (Direct care staff), E12 include the following:
(R1) undresses himself.

Behavior Observation Progress Note include the following entries:
10/31/14 at 1:20 PM by (Qualified Intellectual

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Disability Professional) E5, R1 was in main hallway outside of his room with no clothes on.
11/03/14 at 6:13 PM by E5, same as 10/31/14 at 1:20 PM entry above.

Untitled piece of paper in the Behavior Observation Progress Note section include:
11/02/14 at 11:15 (AM) by (Nurse) E7, R1 undressed completely and was walking in hallway.
11/02/14 at 11:45 (AM) by (Nurse) E7, R1 undressed completely and walked in hallway.

R1's 11/04/14 30-day Resident Habilitation Plan include the following reports:
1. Sometimes R1 will pull down his pants and diaper in public places.
2. Specified behavior: Chewing on clothing and/or blankets/burp cloths.
3. Behavior program - yes (for) putting non-edible items in his mouth.
4. Summary of maladaptive behavior: Hurtful to others, Destructive property, Socially offensive behavior. These three behaviors at this time do not warrant a behavior program. Targeted maladaptive behavior addressed by current Individual behavior programs: chewing on clothing and/or blanket/burp clothes.

E2 validated, approximately on 11/12/14 at 11:15 PM, that R1's behavior programs identified on 11/04/14 at the 30-day staffing was related to R1's diagnosis of Pica. E2 validated that wandering and socially offensive behavior program was added after R1 walked outside the facility unclothed on 11/04/14.

R1 was outside the facility completely without clothes on 11/04/14 from 11:43 AM through 12:00 PM, a total of 17 minutes. The average

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temperature at the time R1 was outside was 50 degrees Fahrenheit. R1 was approximately 52 feet away from a busy two-way street.

2. Facility Accident/Incident Report dated 11/09/14 at 10:15 PM includes "R1 is non-verbal. R1 was using the toilet and (Direct care staff) E9 stepped out to tell the nurse (E4) about R1's condition. R1 was having loose bowel movement and had a fever. So when E9 came back to check on R1, only to find out that R1 was bleeding. R1 had scratched the skin off the upper shaft of his genital."

Nurse's Notes for the 11/09/14 10:15 incident includes a midnight note written by nurse E6 with the following information "R1 was noted with a self-inflicted laceration to the genital area while being toileted. The nurse on duty was unable to control bleeding even after pressure was applied. R1 was also reported to have loose bm (bowel movement) as well times two. Local paramedic provider was contacted to transfer R1 to local hospital for further evaluation. Vitals = BP 97/68, P 86, R 20, Temp 98.9, SPO2 98% RA."

Facility Summary of Incident/Accident Report include the following information regarding the 11/09/14 incident of unknown origin:
10:11 PM - (Direct care staff) E9 walks into bedroom with snack for R1. E9 found R1 needed to be changed due to bowel movement. All of R1's clothes were removed and R1 was placed on the toilet.
10:16 PM - E9 left R1's bedroom and informed nurse E4 of R1's loose bowel movement. E4 told E9 of R1's medication contributing to the bowel movement.
10:17 PM - E9 back in R1's bedroom (finds blood).

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10:18 PM - E9 walks out of R1's bedroom toward nurse station to inform E4 of blood coming from R1's genital area. E9 told E4 that R1 scratched himself on his penis. E4 tells E9 to take R1 into shower room to clean the feces and blood. E9 gets a hospital gown from the clean utility room. E9 returns to R1's bedroom.
10:20 PM - R1 and E9 are out of R1's bedroom walking towards shower when nurse E4 notices blood on R1's gown located around the genital area. R1, E9 and E4 enters the shower room. E4 assessed a laceration and noted a skin tear with a piece of skin flapped over with medium amount of blood.
10:21 PM - E4 stepped out of the shower room and calls local paramedic service provider.
10:24 PM - E4 was in and out of the shower room getting supplies for the bleeding laceration.
10:26 PM - E4 gets additional supplies. In and out of shower room. Dressing to penis secured.
10:32 PM - E4 out of shower room into nurse station. E4 starts making copies from a chart.
10:41 PM - E4 in shower room, observes R1 vomiting and with continuing bowel movement. E4 notices dressing to penis had feces and needed to be changed. E4 went out of shower room to get more dressing supplies.
10:43 PM - local paramedic provider arrives at the nurse station.
10:44 PM - Nurse E6 arrives.
10:45 PM - E6 obtains dressing supplies.
10:47 PM - E6 gets gloves, goes into shower room, observes chunky and loose stool, removes dressing from penis due to feces on the dressing and re-applies a clean dressing which R1 rips off. E6 calls E4 for more dressing supplies.
10:52 PM - E4 in and out of shower room with more dressing supplies.
10:54 PM - E4 in shower room to check on R1 and if E6 was done with the dressing to R1's

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penis laceration. (third dressing to penis laceration now secured).
10:55 PM - E4, E6, E9 and R1 walks out of the shower room. R1 is wearing a hospital gown and was assisted to the gurney of the paramedics.
10:57 PM - R1 was out of the facility with paramedics and E9 on the way to the local emergency room.

Facility Investigation included report that per E9's illustration, R1's laceration is a U-shaped skin folded downward towards the head of the penis. Facility concluded that R1's fingernail caused the laceration since the skin tear/laceration is in the same shape as a fingernail/tip.

(Residential Services Director) E2 validated, on 11/12/14 at 11:13 PM, that the local paramedic provider called on 11/09/14 is a non-emergency paramedic provider.

(Nurse) E3 was asked regarding nursing staff response and documentation regarding R1's penis laceration on 11/09/14. E3 validated on 11/12/14 at 4:04 PM the following:
1. The local paramedic provider called on 11/09/14 is an ambulance transport provider the facility utilizes for individual situations that do not need immediate response as an emergency situation. This provider is cheaper for the facility.
2. There should be nursing documentation of the size, depth, location and amount of bleeding from R1's penis laceration.
3. E4, E6 and E9 were helping clean, shower and bandage R1 on the night of 11/09/14.

(Nurse) E4 was interviewed, on 11/12/14 at 4:30 PM, regarding penis laceration of R1 on 11/09/14. E4 validated the following:
1. R1 had active moderate amount of bleeding,

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no clot.
2. Cut to penis was on top of R1's penis, closer to his body.
3. R1 was still having loose bowel movement when local paramedic provider arrived.
4. We call 911 for life threatening events. Local paramedic provider gave us 45 minutes as estimated time of arrival but they were there in 10 to 15 minutes. It was an emergency but 911 was not called.
5. R1 had liquid stool and chunks of stool, it was all over R1's legs so R1 needed to be showered.
6. E6 saw the penis laceration flap, E4 did not write the nurse's note because of shift change (E6 wrote the nurse's note).
7. E4 illustrated the approximate size of the laceration and the illustration was measured at approximately three-fourths of an inch wide by half an inch long.

(Direct care staff), E9 was interviewed, on 11/12/14 at 4:53 PM, regarding the penis laceration of R1 on 11/09/14. E9 validated the following:
1. R1 had two puddings while seated in bed.
2. R1 had loose bowel movement, so R1 was placed on the toilet.
3. E9 saw blood on R1's hands. R1 was seated on the toilet with his hands holding on his penis while the penis is located inside the rim of the toilet.
4. E9 did not use the pull cord in the bathroom of R1.
5. E9 illustrated the approximate size of the laceration and the illustration was measured at approximately three fourths of an inch in length and width.

Review of the emergency room records validate "Questionable self-inflicted laceration.

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Circumcised male. The penile shaft has a 5 centimeter laceration. There is an uncomplicated laceration which is 5 centimeter in length. This would will require surgical closure to stabilize wound edges and ensure optimal healing. No active bleeding. No other deep tissue involvement. The wound is a flap type of laceration. Wound runs horizontally. U shaped defect in skin. Skin closed with 4 sutures."

One inch is equivalent to 2.54 centimeters.

(Residential Services Director) E2 validated, on 11/17/14 at 12:14 PM, that the facility investigation is complete. E2 checked the video footage and validated that the local paramedic provider arrived on 11/09/14 at 10:43 PM and not at 10:41 PM.

R1 was placed on the toilet without clothes for ongoing loose bowel movement on 11/09/14 at approximately 10:16 PM. At 10:17 PM, R1 was found to have blood in his genital area. At 10:18 PM, staff stayed with R1. R1 entered the shower room at 10:20 PM to get cleaned up and was found to have a flap laceration to the penis approximately three fourths of an inch long and wide. R1 stayed in the shower room for 35 minutes until 10:55 PM. Paramedic provider service arrived at 10:43 PM, 22 minutes after the call was placed. R1 did not get on the paramedic gurney until 10:55 PM which is 38 minutes since the blood in his genitals was discovered. R1 did not leave the building until 10:57 PM which is 40 minutes since the discovery of the blood in his genitals and 14 minutes since the paramedics arrived in the facility. R1 received four sutures to the penis to close the U-shaped flap laceration wound that was measured at 5 centimeter in length on the penis shaft.

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Imposed Plan of Correction
for: 350.620a 350.3240a
350.1210 350.3240d

Tag: W149…483.420(d)(1)
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.

1. **Actions to abate, eliminate, or correct the deficiency**
   - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
   - Meadows' level of supervision policy and procedure will be reviewed and if necessary revised
     - To be completed by December 15, 2014
   - All staff will be in-serviced on the level of supervision policy and procedure
     - To be completed by December 20, 2014
   - All individuals residing at Meadows will have their level of supervision re-assessed to ensure appropriate supervision levels
     - To be completed by December 15, 2014
   - All staff will be in-serviced on changes to an individual's level of supervision
     - To be completed by December 20, 2014

3. **How facility assures that the POC will be followed or completed; i.e. who will monitor compliance**
   - At each individual's annual staffing the level of supervision will be reviewed and documented on the IDT Discussion Page.
     - To be completed at the next annual staffing
   - Monthly, the Residential Director will review with the ID Team all individual's level of supervision to ensure there is no need to make any changes to increase or decrease an individual's level.
     - To be completed by December 20, 2014

4. **Completion dates…as ~~above~~**

20 days from Receipt of Notice

Attachement B

Imposed plan of Correction

Tag W 153…483.420(d)(2)

The facility must ensure that all allegation of mistreatment, neglect, or abuse, as well as injuries of unknown source are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

1. **Actions to abate, eliminate, or correct the deficiency**
    - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
    - Meadows' will review the Accident and Incident Report Policy, to ensure that the policy states that all allegation of mistreatment, neglect, or abuse, as well as injuries of unknown source are reported to the required parties.
        - To be initiated by De~~cember 20,~~ 2014
    - The Nursing Department will be in-serviced on the revised Accident and Incident Report Policy
        - To be completed by Dec~~ember 20, 201~~4

3. **How the facility will ensure that the POC will be followed or completed; i.e. who will monitor compliance**
    - The Residential Service Director will review weekly all accident/incident reports to ensure compliance with notifying Illinois Department of Public Health
        - To be initiated by Dec~~ember 20,~~ 2014

4. **Completion dates…as above**

20 days from Receipt of Notice

Imposed Plan of Correction

Tag W154…493.420(d)(3)
The facility must have evidence that all alleged violations are thoroughly investigated

1. **Actions to abate, eliminate, or correct the deficiency**
   - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
   - A new tool has been implemented to ensure thorough investigations for all alleged violations
     - To be implemented with the next investigation
   - An investigation policy will be written. This policy will include a two person investigation for all alleged violations
     - To be implemented by December 15, 2014

3. **How the facility will ensure that the POC will be followed or completed; i.e. who will monitor compliance**
   - The entire Management Team will meet after an investigation is completed to ensure a thorough investigation has been completed.
     - To be implemented with the next investigation.

4. **Completion dates…~~as above~~** 20 days from Receipt of Notice

imposed Plan of Correction

Tag W262…483.440(f)(3)(i)
Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights

1. **Actions to abate, eliminate, or correct the deficiency**
   - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
   - Meadows will review the elopement procedure and if necessary revisions will be made.
     - To be completed by December 20, 2014
   - If revisions are made to the elopement procedures the Nursing Staff and CNA's will be in-serviced
     - To be completed by December 20, 2014
   - A new tool will be implemented for the Human Rights Committee to assure to the committee that Meadows is using the least restrictive measure for each individual.
     - To be completed at the next Human Rights Meeting

3. **How the facility will ensure that the POC will be followed or completed; i.e. who will monitor compliance**
   - Monthly during the social service meeting, Meadows will address any individual who has a restrictive device to ensure that need is still present.
     - To be initiated by December 20, 2014

4. **Completion dates…~~as above~~** 20 days from Receipt of Notice

Imposed Plan of Correction

Tag W 278…483.450 (b)(1)(iii)
Insure prior to the use of more restrictive techniques, that the clients record documents that program incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective

1. **Actions to abate, eliminate, or correct the deficiency**
   - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
   - Meadows will review the elopement procedure and if necessary revisions will be made.
     - To be completed by December 20, 2014
   - If revisions are made to the elopement procedures the Nursing Staff and CNA's will be in-serviced
     - To be completed by December 20, 2014
   - A new tool will be implemented for the Human Rights Committee to assure to the committee that Meadows is using the least restrictive measure for each individual.
     - To be completed at the next Human Rights Meeting

3. **How the facility will ensure that the POC will be followed or completed; i.e. who will monitor compliance**
   - Monthly during the social service meeting, Meadows will address any individual who has a restrictive device to ensure that need is still present.
     - To be initiated by December 20, 2014

4. **Completion dates…as above**

20 days from Receipt of Notice

Imposed PLAN of Correction

Tag W331…483.460(c)
The facility must provide clients with nursing services in accordance with their needs

1. **Actions to abate, eliminate, or correct the deficiency**
   - Refer to steps to be taken to avoid future occurrences of the same and similar deficiency

2. **Steps to be taken to avoid future occurrences of the same and similar deficiency**
   - The nursing personnel will be in-serviced on the proper documentation for all medical incidents. The in-service will focus on a full description of what was present at the time of injury.
     - This will be completed by December 20, 2014

3. **How the facility will ensure that the POC will be followed or completed; i.e. who will monitor compliance**
   - The Administrator/designee will thoroughly review all nursing documentation when an accident/incident report is completed to ensure proper documentation in the individual's medical chart.
     - This be implemented by December 20, 2014

4. **Completion dates…as above**

20 days from Receipt of Notice