STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

MEADOWS — Facility Name
0594930 — I.D. Number

3250 SOUTH PLUM GROVE ROAD, ROLLING MEADOWS, ILLINOIS 60008 — Address

Reviewed By

December 13, 2005 — Date of Survey

COMPLAINT 0594930 — Type of Survey

Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.700a)1)2)
350.700b)
350.3240a)b)c)

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 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.
b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved.

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350.700b)
350.3240a)b)c)
(Cont'd.)

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)
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. (Section 3-610 of the Act)
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)
These regulations were not met as evidenced by the following:

Based on interview and record verification the facility failed to:

A. Implement their policy and procedures on Abuse for 1 of 1 clients (R1) by:
- not completing an Incident Report for alleged sexual abuse
- not notifying IDPH (Illinois Department of Public Health) of allegation of sexual abuse
- not conducting an investigation of alleged sexual abuse
- not notifying R1's physician of alleged sexual abuse

B. Ensure 1 of 1 clients (R2) health and safety needs were met post surgery (colostomy) after foreign object was removed from rectum by:
- not ensuring all small ("swallowable") objects were kept out of bedroom (including tongue tongue depressor)
- not defining then providing hourly checks and room checks as recommended

1) R1 is a 23 year old female whose diagnoses include Moderate MR (Mental Retardation), Seizure Disorder, Bipolar Disorder NOS (Not Otherwise Specified), Organic Brain Syndrome, Microcephaly, Psychosis unspecified and Oppositional Defiant Disorder.
R1, observed and interviewed 12/2/05, is verbal and ambulatory.

On 11/18/05 surveyor requested, from E3 (LPN), all allegations of abuse, neglect and mistreatment as well as all Incident Reports for the past 3 months. E3 gave surveyor a phone number and the name of a police officer from a local police department. E3 stated the local police interviewed R1 because R1's family members (grandmother and aunt) allegedly pulled R1's pants down and touched her genital area. The alleged incident occurred the end of September 2005 in R1's bedroom. E3 was unable to find an Incident Report regarding the alleged sexual abuse involving R1.

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E1 (Administrator) was interviewed 11/18/05 at 12:50pm. E1 was asked if the facility had any allegations of abuse, neglect or mistreatment in the past 3 months. E1 stated they have not. E1 was then asked why the local police were at the facility to interview R1. E1 stated the local police spoke to R1 because they (police) received a report of possible sexual abuse. The police report alleged a family member sexually assaulted R1. However the police found no credible evidence of sexual assault against R1. E1 verified, per interview, the facility did not report the alleged sexual abuse to IDPH. The facility did not investigate the alleged abuse.

The facility's policy on Resident Abuse, dated 3/28/05, includes the following:
- If a staff member feels that an incident of abuse or neglect has occurred, they should tell the shift supervisor. The shift supervisor shall immediately inform the charge nurse.
- The shift supervisor, nurse and other staff will begin a preliminary investigation. For all incidents of abuse an Incident Report will be completed and faxed to Public Health (IDPH).
- The Administrator will be contacted for incidents of potential abuse.
- The Resident involved will be questioned as well as any possible witnesses (i.e.. reliable residents, staff, family members ...)
- If the resident has injuries or it is a potential sexual abuse situation, the nurse on duty shall immediately examine the injured party. The resident will be sent to the local hospital for evaluation and treatment if warranted.

E2 (DON - Director of Nursing) documented on 9/30/05, per nursing notes, the following:
"Resident states that (Z4) et (and) (Z3) had resident pull her pants down to look at her 'cullo - itchy spots' - cullo is believed to be buttocks in Italian.
Witness - (E7, former QMRP)
Witness - (E3, LPN)
Addendum: Incident apparently took place on Sunday Sept. 25, 2005."

E2 documented on 10/9/05, per nursing notes, the following:
"5:15pm (local) police officer here to question writer et (and) resident (R1) regarding alleged incident which occurred on 09/25/05, involving (Z3) et (and) (Z4). Police here per residents mother (legal guardian) request."

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R1 was asked who she would tell if anyone hurt her. R1 said she would tell Z3. R1 said she would also tell E2 (DON). R1 stated, "I told (E2)."

E2 was interviewed 11/22/05 at 10:12am. E2 stated that on 9/30/05 R1 told her (E2), and E3 (LPN) and E7 (former QMRP) that Z3 and Z4 pulled her pants down to look at her buttocks. E2 explained that Z3 had called R1's guardian because Z3 thought R1 had a possible yeast infection or urinary tract infection as R1 was complaining of "itchy spots." E2 stated she checked R1 10/9/05 and she had no signs of a yeast or urinary tract infection.

E2 was asked if R1's physician was notified, due to allegation of possible sexual assault, of R1. E2 stated R1's physician was not notified of a possible sexual assault, or possible yeast or urinary tract infection. E2 stated R1's physician was notified of R1's drowsiness and unsteady gait on 10/27/05.

E2 was asked if there was an Incident Report (as per facility policy) regarding the 9/30/05 allegation that Z3 and Z4 pulled R1's pants down and touched her buttocks. E2 stated no Incident Report was written, the Incident was not reported to IDPH and there was no investigation of the alleged sexual abuse.

E2 was asked if an Incident Report was written after the local police interviewed R1, 10/9/05, regarding an allegation of sexual assault. E2 again stated no Incident Report was written, the Incident was not reported to IDPH and there was no investigation.

The facility failed to implement their policy on Abuse when R1 alleged sexual abuse 9/30/05. The facility failed to:

- complete an Incident Report documenting R1's allegation of sexual abuse
- notify IDPH of allegation of sexual abuse
- conduct an investigation of sexual abuse against R1
- notify R1's physician of possible sexual abuse and ensure R1 was examined

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