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 01/15/2009

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 12 inserted anything into his rectum. E2 was asked if she examined R1 upon his return to the residential facility on 12/11/08. E2 stated she informed E6 (nurse) about the information she received from R1's workshop. E2 stated E6 examined R1 and did not notice anything unusual. E2 was asked if she or E6 charted / documented any examination in R1's nurses notes. E2 reviewed R1's nursing notes and verified there was no documentation that an examination of R1 occurred. E2 also reviewed the nursing communication book - E2 verified she did not document any examination in the nursing communication book. E2 was asked if R1's physician was notified that R1 may have inserted a foreign body into his rectum. E2 stated she did not notify R1's physician.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.700a)1)2) 350.1210 b) 350.1220 j) 350.3240 a) 350.3240 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	W9999		

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W9999	Continued From page 13 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. 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 350.1220 Physician Services	W9999		

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W9999	Continued From page 14	W9999		

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j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

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)

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 1 client (R1) was found to have inserted a foreign body into his rectum on 12/25/08 and 12/27/08.

1) The facility failed to adequately supervise R1 to prevent him from inserting foreign bodies into his rectum, and failed to examine and provide follow up nursing services after being notified of a potential insertion.

2) The facility failed to thoroughly investigate 2 incidents of neglect (R1 - noted to have inserted a foreign body into his rectum on 12/25/08 and 12/27/08).

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3) The facility failed to ensure the Administrator was immediately notified of allegations of neglect (R1 inserted and removed, on 12/25/08, a plastic bag and a plastic spoon from his rectum). The facility also failed to notify IDPH (Illinois Department of Public Health), in accordance with State Law, of this incident of neglect (R1).

Findings include:

R1, per review of his December 2008 POS (Physician's Order Sheet), is a 61 year old male whose diagnoses include Moderate Mental Retardation, Type I Bipolar Disorder, Depression with Anxiety/Agitation and Ataxia. R1, observed and interviewed 1/9/09 at 10:15am, is verbal. R1 is non-ambulatory and utilizes a wheelchair for mobility. R1 is capable of self propelling his wheelchair.

R1's behavior program, dated 10/15/08, was reviewed. R1's behavior program identifies that R1 has a history of inserting objects into his rectum. Review of R1's behavior program progress notes identify R1 last inserted a foreign body into his rectum in October 2005. At that time R1 had to have the foreign body surgically removed. R1 also had a colostomy, which was ultimately reversed.

The facility's Abuse/Neglect Policy, dated 4/10/08, was reviewed. The policy defines neglect as:
"Neglect - a 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.

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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 allegation where:
- The alleged failure causing injury or deterioration is 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 more than 24 hours."

The policy also notes the following procedure regarding neglect:
"If a staff member suspects that an incident of abuse and / or neglect has occurred, the staff member is to report it immediately to the Charge Nurse.
- Any allegation of abuse or neglect is to be reported to the Administrator / Designee immediately. The Administrator will advise appropriate parties ... e.g. Residential Service Director (RSD) and Director of Nursing (DON) and initiate an investigation."
"With any alleged abuse / injury or neglect the nurse on duty is to do an immediate exam / assessment. 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."

A facility Incident Report, dated 12/27/08 9:30am, and written by E5 (nurse), was reviewed. The Incident Report notes the following:
A staff member (E7 - direct care) reported to E5 that while assisting R1 with his shower (12/27/08 at approximately 9:30am), R1's rectum felt "hard." E5 documented that 2 days ago (12/25/08) R1 pulled out a plastic bag and spoon

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W9999	Continued From page 17 from his rectum. E5 also documented the area (rectum) was inspected and it felt hard upon examination. No visible object was noted and there was no bleeding and no complaints of discomfort. E5 notified R1's attending physician. The physician ordered R1 to be sent to the emergency room for an examination. R1 was transferred to a local hospital, via rescue squad, at 10:45am. R1 returned to the facility 12/27/08 at 12:45pm with a diagnosis of foreign body (toilet paper) in rectum. Hospital records for R1, dated 12/27/08, noted the following: Diagnosis - "Foreign body, rectum" Assessment - "Toilet paper (tightly packed in rectum) was removed with forceps without complications" E1 (Administrator) was interviewed 1/8/09 at 12:25pm. E1 verified that on 12/27/08 at approximately 9:30am, E7 was assisting R1 with his shower when he felt R1's rectum to be hard. E7 notified E5 who examined R1. E5 notified R1's physician who ordered R1 be sent to the emergency room for an evaluation. R1 was subsequently diagnosed with a foreign body insertion in his rectum. E1 also stated that on 12/25/08 staff (E7) reported to the nurse (E5) that during shower time (approximately 11:45am) R1 pulled a plastic bag and a plastic spoon out of his rectum. E1 stated she was made aware of the 12/25/08 incident of foreign body insertion on the afternoon of 12/26/08. E1 stated at this time she told staff that R1 could not be alone in his bedroom. E1 also stated after the 2nd incident of foreign body insertion (12/27/08) R1's supervision level was changed to 1 to 1 supervision 24 hours a day. E1 stated this level	W9999		

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W9999	Continued From page 18	W9999		

of supervision was implemented when R1 returned from the hospital on 12/27/08 at approximately 12:45pm.

R1's nursing progress notes were reviewed and the following was documented by E2 (nurse): "12/11/08 1:50pm W/S (workshop) called stating res. (resident - R1) appears withdrawn. Apparently a staff member that res. (resident) was attached to has left. Also, (staff) stated that in his lunch bag, it was noted that only napkin & straw were in the pkt. (packet). A spoon was given so he could eat. She did not think he put anything "up there" (rectum). (E4 - QMRP) informed. Was in a good mood this AM prior to going to W/S."
The next entry in R1's nursing progress notes is dated 12/17/08.

E2 was interviewed 1/8/09 at 2:05pm. E2 verified that she received a phone call from R1's workshop staff on 12/11/08. E2 stated workshop staff told her R1 did not have a spoon in his sack lunch but the staff at workshop did not think he inserted anything into his rectum. E2 was asked if she examined R1 upon his return to the residential facility on 12/11/08. E2 stated she informed E6 (nurse) about the information she received from R1's workshop. E2 stated E6 examined R1 and did not notice anything unusual. E2 was asked if she or E6 charted/documented any examination in R1's nurses notes. E2 reviewed R1's nursing notes and verified there was no documentation that an examination of R1 occurred. E2 also reviewed the nursing communication book - E2 verified she did not document any examination in the nursing communication book. E2 was asked if R1's physician was notified that R1 may have inserted

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W9999	Continued From page 19 a foreign body into his rectum. E2 stated she did not notify R1's physician. The facility failed to implement their Abuse/Neglect Policy when they failed to provide R1 with adequate medical care and supervision after being made aware of a potential foreign body insertion on 12/11/08. The facility also failed to provide adequate medical care and supervision after R1 inserted and removed a foreign body from his rectum on 12/25/08, and again failed to adequately supervise R1 when a foreign body was foud in his rectum on 12/27/08. 2) A facility incident report was written 12/29/08 regarding the 12/25/08 incident in which R1 inserted/removed a plastic bag and a plastic spoon from his rectum. The incident report notes R1 was being showered 12/25/08 at 11:45am. At this time a plastic bag and a plastic spoon were pulled from R1's rectum. No further investigation of the incident of neglect is documented. There are no documented interviews of R1 and any staff that were involved in the incident. E1 was interviewed 1/8/09 at 1:35pm. E1 was asked if the facility was able to determine from where R1 obtained the plastic bag and plastic spoon that he was noted to have removed from his rectum on 12/25/08. E1 stated the facility has not determined where R1 may have obtained the plastic bag and plastic spoon. E1 verified no staff have been interviewed regarding the 12/25/08 foreign body insertion. E1 stated she was not aware if R1 has been interviewed. E1 stated the investigation is in progress. A 2nd facility incident report was written 12/27/08	W9999		

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W9999	Continued From page 20 regarding R1 being sent to the hospital and subsequently being diagnosed with foreign body (tightly packed toilet paper) in rectum. The facility's incident report includes a statement from E7 (direct care). E7 is identified as the staff who was assisting R1 with his shower on 12/27/08 at 9:45am. E7 noted R1's rectum was hard. E7 then notified E5 (nurse). The facility's investigation is not thorough. The facility did not interview R1 (who is verbal) or any other staff or clients. The facility did not address how R1 was able to insert a foreign body into his rectum (12/27/08) when he was not to be left alone in his bedroom/bathroom, as instructed by the Administrator on 12/26/08. 3) E1 (Administrator) was interviewed 1/8/09 at 12:25pm regarding an incident in which R1 inserted a foreign body into his rectum. E1 stated that on Thursday 12/25/08 at approximately 11:45am staff (E7 - direct care) reported to nursing staff that R1 had removed a plastic bag and a plastic spoon from his rectum. E1 verified this incident of alleged neglect was not immediately reported to the Administrator. E1 stated she was notified of the 12/25/08 incident of R1's foreign body insertion on 12/26/08 in the afternoon. E1 stated that IDPH was not notified of the incident in accordance with State Law (within 24 hours). E1 explained that nursing staff (E5 and E6) did not write an Incident Report regarding R1's 12/25/08 insertion and removal of a plastic bag and a plastic spoon. E1 explained that E3 (DON - Director of Nursing) reviewed the Nursing Communication Book on 12/29/08. At this time E3 noted the 12/25/08 and identified that no Incident Report was written and	W9999		