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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.690
300.690a)
300.1210b)
300.1210d)6)
300.1220b)1)
300.1220b)2)
300.1220b)3)
300.1220b)6)
300.1220b)7)
300.3240a)
300.3240b)
300.3240d)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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S9999	Continued From page 1	S9999		

process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

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S9999	Continued From page 2 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other	S9999		

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S9999	Continued From page 3	S9999		

modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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.

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.

These requirements are not met as evidenced by:

A. Based on interview and record review the facility failed to prevent repetitious inappropriate sexual behaviors between residents by failing to

Illinois Department of Public Health

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S9999	Continued From page 4	S9999		

identify, evaluate and analyze the inappropriate sexual behaviors. The facility failed to monitor, evaluate and implement effective interventions to provide supervision of R1. The facility nursing administration knowingly failed to follow the policy on Abuse Prevention and failed to immediately report to the Administrator and investigate repetitive inappropriate sexual behaviors between residents as potential allegations of sexual abuse. The facility failed to ensure the protection of the residents from further inappropriate sexual behaviors of R1. R1's ongoing repetitive inappropriate sexual behaviors continued toward R2, R3, R6 and R7. These collective failures resulted in the neglect of five of seven residents (R1, R2, R3, R6, R7) reviewed for supervision, on the sample of seven.

Findings include:

1. The facility Abuse Prevention Policy dated 5/2012 states, " 1. This facility will not condone resident abuse by.....other residents.....Any employee who has knowledge or reason to believe that a resident has been a victim of abuse by anyone as noted in #1 above, is under a duty to immediately report such incident or suspicion to his/her immediate supervisor.....The Resident must be protected from harm during the investigation.....the supervisor shall then notify the Administrator and Director of Nursing...The Director of Nursing or their designee will initiate an investigation immediately and in cases involving....residents....."

On 1/5/15 at 12:45pm E18, Administrator stated his expectation is for staff to report abuse allegations to their supervisor and the Administrator. On 1/7/15 at 9:25am E18,

Illinois Department of Public Health

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S9999	Continued From page 5	S9999		

Administrator confirmed the Abuse Prevention policy is "very vague" as relating to how to handle allegations of resident to resident altercations/abuse.

On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December 2014 about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated there was "really no findings-nothing more than two residents with dementia being sexually inappropriate." E18 stated residents would need to be "monitored by staff through routine checks" and he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

On 1/6/15 at 1:45pm E1, Director of Nursing (DON) stated the facility does not have policies which address how to handle the care needs and supervision of residents with behaviors. E1 stated the facility does not have a policy which is specific on how to handle resident to resident altercations.

2. R1's Minimum Data Set (MDS) dated 11/24/14 documents R1 has moderate cognitive impairment.

R1's Physician Progress Note dated 11/19/14 by Z1, Physician states R1 was admitted to the facility on 11/17/14 with a diagnosis of Alzheimer's Dementia with behavior concerns. The note states, "[R1]... ....significant behavior issues....inappropriate sexual behavior, and tried on several medications....inappropriate sexual behavior that had prompted a trial of Estradiol[Estrogen}...has not been given for the last three days and so we're going to stay off of

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S9999	Continued From page 6	S9999		

that now and monitor symptoms closely...."

R1's Progress Note dated 7/13/14 by Z2, Former Physician states, "Six month followup for chronic problems.....history....of behavioral problems....Wife[Z3] reports that [R1's] inappropriate behavior is very much under control on Estradiol.....also is on Seroquel...for same problem of inappropriate behaviors....."

R1's Interdisciplinary Note dated 11/29/14 at 8:23pm by E8 RN (Registered Nurse) states, "[R1] came down hallway, grabbed a female resident (unidentified) and attempted to take her down the hallway.....redirected....[R1] found in a room inappropriately touching another resident (unidentified). Other resident was removed and [R1] was redirected. As [R1] passed another female resident (unidentified) he proceeded to grab her also...[R1] again redirected...Will cont[continue] to monitor."

On 1/5/15 at 11:20am when asked about the note dated 11/29/14, E8, RN stated she did not "remember who the resident was, who reported it to me.... It was charted as a behavior." E8 stated she did not report the incident (11/29) to E1, DON (Director of Nursing) or "anyone."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident on 11/29/14.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

3. On 1/1/15 at 4:00pm E7, CNA stated, "I was doing cares and saw someone go past fast....got to last door on the left side of the long

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S9999	Continued From page 7	S9999		

hall-opened the door and [R1] was sitting on [R14's] bed, [R6] was in the wheelchair and [R1] had [R6's] top off-her bra was off and when I walked in [R1] was taking his face off of [R6's] breast. I pulled [R6] back and asked [R1] 'What are you doing?' [R1] said 'putting her [R6] to bed.' I said what do you mean? [R1] said 'I'm going to f..... her." E7 stated she reported the incident to the nurse, but was unable remember the name of the nurse. On 1/7/15 at 3:20pm E7 stated, "I am 120% sure it was [R6]....it [occurred] before the 15 minute checks [for R1] were begun."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident involving R1 and R6.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

R6's Physician Progress Note dated 11/6/14 documents a diagnosis of Dementia. The MDS dated 11/30/14 documents cognitive impairment with long/short memory problems and no behaviors.

4. R1's Interdisciplinary Notes dated 12/1/14 at 3:01pm states, "...[R1] out to nurse's desk with only a t-shirt on.....taking [R1] back to room, found female resident[R3] on his bed with no pants on.....[R1] has shown increased behaviors of sexual advance toward female residents and staff over past few days....15 minute checks initiated this shift...."

On 1/6/15 at 12:20pm E9, CNA stated she walked R1 back to his room, and found R3 wearing only a undershirt, no pants/brief "lying on her back, legs spread, with eyes closed" on R1's bed.

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S9999	Continued From page 8	S9999		

On 1/1/15 at 9:45am E1, DON and E2, ADON (Assistant Director of Nursing) stated the incident was reported on 12/1/14 to E2 and then E2 notified E1. E1 stated she notified E18, Administrator of the incident.

R3's MDS dated 12/7/14 documents diagnoses of Anxiety disorder and Dementia. The MDS documents severe cognitive impairment and wandering/physical/verbal behaviors 4-6 days per week.

5. R1's Interdisciplinary Notes dated 12/3/14 at 4:50pm states, "...conducting 15 min[minute] checks to find [R1] in a room at end of hall with a female resident[R7]....[R7] was in a state of undress while...[R1] was fully clothed on the other side of the room sitting on the bed.....Staff is watching [R1] continuously..."

On 1/5/15 at 3:55pm E24, CNA stated "....were doing 15 minute checks and we couldn't find [R1]. I walked in on [R1] and [R7] -at very end of the long hall, [R14's] room..[R1] was standing on the opposite side of the room of [R7], he was fully dressed. When [R1] saw me,he sat down on the bed . [R7] was scooting on the floor on her behind-only had a sweater on-her onsie, hipster, brief, shoes and socks were off-[R7] was talking fast." E24 stated she reported the incident to E21, RN.

On 1/6/15 at 2:00pm E21, RN stated she notified E1, DON of the incident immediately. E21 stated R1 was on 1:1's for the rest of the shift.

On 1/6/15 at 1:45pm E1, DON stated, "There was something on 12/3/14, reported to me on 12/3-[R7]-told [E21] to make sure [R1] was 1:1's and

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S9999	Continued From page 9	S9999		

notify families."

On 1/7/15 at 9:20am E2, ADON confirmed there was no investigation done of the incident involving R1 and R7.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

R7's Physician Progress Note dated 11/6/14 documents a diagnosis of "Severe dementia, Alzheimer's type.....continues just to wander pretty constantly...."

6. R1's Interdisciplinary Note dated 12/4/14 at 6:54pm by E15, RN states "....Continues to go after female resident...difficult to redirect.....15 minute checks...continue to monitor." R1's note at 8:45pm states "[R1] continues to make sexual advances toward female staff and residents. Grabbing at females inappropriately, attempting to undress female residents....difficult to redirect....15 minute checks ongoing..."

On 1/1/15 at 4:00pm E7, CNA stated, "I walked into [R1's] room and [R1] was sitting in the recliner chair and [R2] was sitting on him-straddling his legs. [R1] had his hand around [R2's] bottom and his other hand was on [R2's] breast. [R1] had her[R2] onsie unzipped and fully off of her to the waist....I reported to a nurse but don't remember who it was.."

On 1/6/15 at 1:45pm E1, DON stated, "Reported to me on 12/4/14. I told [E15] to monitor him-and then told [E2,ADON] on 12/5/14. Anytime there was an incident [with R1] the nurse's would do 1:1's until he[R2] was settled down in room, once

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S9999	Continued From page 10	S9999		

the other residents were settled and not wandering in his room, he would sleep all night."

The undated investigation titled "[R1] and [R2]" states, "12/4/14 Staff found a female resident in a male resident's room. She was sitting on his lap and he was fondling her breast when staff entered room. Staff quickly separated the residents and redirected the female resident to the common area....."

On 1/6/15 at 9:35am E2, ADON stated she started the investigation of the incident (12/4/14) on 12/5/14. E2 stated the investigation consisted of interviewing E15. E2 confirmed no other staff were interviewed. E2 stated R1 was on 15 minute checks, the door sensor alarm and they were doing "visual checks when out of the room-not 1:1's-just eyeballing him."

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

7. On 1/7/15 at 3:20pm E7, CNA stated, "I found [R2] in [R1's] room again, [R1] had [R2] with her back to him-was getting ready to unzip [her onsie], but it[zipper] was missing the tongue, so he[R1] was having trouble [unzipping onsie]." E7 stated R1 was on 15 minute checks and the sensor door alarm was being used at the time of the witnessed incident, but she is unable to remember the specific date it occurred. E7 stated she reported the incident to E21, RN.

On 1/6/15 at 2:20pm E21, RN stated it was reported to me that "[R2] was found in his[R1] room-he was trying to pull [R2's] zipper down and staff intervened. I did not report this to anyone

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S9999	Continued From page 11	S9999		

because nothing happened."

On 1/6/15 at 1:45pm E1, DON confirmed she was not aware of the incident involving R2 and R1.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

8. On 1/1/15 at 5:00pm E16, CNA stated, " [R2] was wandering-he[R1] tried to grab her breast and I intervened first....it was after a 15 minute check was done-Did not take it to [E1, DON] or [E2 ADON]-I'm sure they are aware-have not talked to them personally."

On 1/5/15 at 11:20am E8, RN stated, "Spoke with CNA[E16]- [E16] had just left [R1's] room from doing 15 minute check- told me they were called into [R1's] room, [R1] was on knees, [R2] was dressed sitting on bed. [R2's] top was down or up-can't remember-[R2] sitting back on the bed-not sure if there was any touch or not...." E8 stated the whole incident from the time E16 did the 15 minute check on R1 to when "I checked [R1] was 6 minutes." E8 stated she called E1, DON to report what happened. E8 stated E1 told her she would check into the incident, "[E1] said to hold off on documenting, told me to wait [she] would check into what happened. [I] asked how to document, [E1] said to wait and [E1] will investigate-I was never called." E8 confirmed she never documented the incident which occurred between R1 and R2. E8 stated the incident occurred on a weekend, during suppertime, but she was not sure of the date.

On 1/6/15 at 1:45pm E1, DON stated she was called by E8 on 12/20/14 and told what happened

Illinois Department of Public Health

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S9999	Continued From page 12	S9999		

between R2 and R1. E1 stated she told E8 "we would look into it on Monday[12/21], to make sure [R1] was 1:1's." E1 denied telling E8 to hold off documenting the incident. E1 stated she told E8 to "just document what happened with [R2] and [E8] said if [I] needed anything else to call her on Monday."

The undated investigation titled "[R2] and [R1]" by E2, ADON states, "12/20/14 Staff notified by a visiting family member across the hall. They stated staff had just been down there. There was a female resident[R2] in his[R1] room...[R2] was sitting on the bed with her top down and [R1] was fondling her breast..Visual checks in place. Alarm on door of male resident[R1]. " The investigation does not document staff/family interviews.

On 1/6/15 at 1:25pm E2, ADON stated she became aware of the incident involving R1 and R2, which occurred on 12/20/14, when told about it by E1, DON on 12/22/14. E2 stated she started the investigation on 12/22/14. On 1/5/15 at 1:30pm E2 stated 15 minute checks, visual checks when out of the room and sensor door alarm continued, with the new intervention being to give the Xanax three times a day to R1.

R2's Physician Progress Note dated 11/19/14 documents a diagnosis of Advanced Dementia. The MDS dated 10/26/14 documents moderate cognitive impairment and behaviors of wandering 4-6 days per week.

On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 13	S9999		

made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

On 1/6/15 at 1:45pm E1, DON confirmed she notified E18, Administrator of the first allegation involving R1 and R3 on 12/1/14. E1 confirmed she did not notify E18 of any further incidents involving R1 being sexually inappropriate with other residents. When asked why she did not notify E18 of the further incidents involving R1 being sexually inappropriate with R7(12/3/14), R2 (12/4/14) and R2 (12/20/14) E1 stated "they were not abuse, were behaviors, no harm [occurred]."

B. Based on interview and record review the facility failed to identify, immediately report and investigate repetitive inappropriate sexual behaviors between residents to the Administrator. The facility failed to consider those behaviors as potential abuse and ensure the protection of the residents from further inappropriate sexual contact. The facility failed to implement effective interventions to protect residents from the repetitive inappropriate sexual behaviors of R1. R1's ongoing repetitive inappropriate sexual behaviors continued toward R2, R3, R6 and R7. The facility failed to report the allegations of inappropriate sexual behaviors between residents to the State Survey and Cerification Agency (Illinois Department of Public Health). These failures affect five of five resident (R1, R2, R3, R6, R7) reviewed for abuse, on the sample of seven.
Findings include:

R1's Minimum Data Set (MDS) dated 11/24/14 documents R1 has moderate cognitive impairment, behaviors of wandering/other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 14	S9999		

behaviors occurring 4 to 6 days of the week and requires supervision with ambulation.

R1's Physician Progress Note dated 11/19/14 by Z1, Physician states R1 was admitted to the facility on 11/17/14 with a diagnosis of Alzheimer's Dementia with behavior concerns. The note states, "[R1]... ....significant behavior issues of anxiety, inappropriate sexual behavior, and tried on several medications.....Behavior issues discussed with wife[Z3]....inappropriate sexual behavior that had prompted a trial of Estradiol[Estrogen}...has not been given for the last three days and so we're going to stay off of that now and monitor symptoms closely...."

R1's Progress Note dated 7/13/14 by Z2, Former Physician states, "Six month followup for chronic problems.....history....of behavioral problems....Wife[Z3] reports that [R1's] inappropriate behavior is very much under control on Estradiol.....also is on Seroquel...for same problem of inappropriate behaviors....."

1. R1's Interdisciplinary Note dated 11/29/14 at 8:23pm by E8 RN (Registered Nurse) states, "[R1] came down hallway, grabbed a female resident (unidentified) and attempted to take her down the hallway.....redirected....[R1] found in a room inappropriately touching another resident (unidentified). Other resident was removed and [R1] was redirected. As [R1] passed another female resident (unidentified) he proceeded to grab her also...[R1] again redirected...Will cont[continue] to monitor."

On 1/5/15 at 11:20am when asked about the note dated 11/29/14, E8, RN stated she did not "remember who the resident was, who reported it to me....what CNA [Certified Nurse Aide] told me..

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 15	S9999		

It was charted as a behavior." E8 stated she did not report the incident (11/29) to E1, DON (Director of Nursing) or "anyone."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident on 11/29/14.

2. On 1/1/15 at 4:00pm E7, CNA stated, "I was doing cares and saw someone go past fast.... got to the hall- got to last door on the left side of the long hall-opened the door and [R1] was sitting on [R14's] bed, [R6] was in the wheelchair and [R1] had [R6's] top off-her bra was off and when I walked in [R1] was taking his face off of [R6's] breast. I pulled [R6] back and asked [R1] 'What are you doing?' [R1] said 'putting her [R6] to bed.' I said what do you mean? [R1] said 'I'm going to f..... her." E7 stated she reported the incident to the nurse, but was unable remember the name of the nurse. E7 was unable to give a specific day/time which the incident occurred. On 1/7/15 at 3:20pm when asked if there was any way she could have been mistaken on the identify of the female resident (R6) E7 stated, "I am 120% sure it was [R6]....it [occurred] before the 15 minute checks [for R1] were begun."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident involving R1 and R6.

R6's Physician Progress Note dated 11/6/14 documents a diagnosis of Dementia. The MDS dated 11/30/14 documents cognitive impairment with long/short memory problems and no behaviors.

3. R1's Interdisciplinary Notes dated 12/1/14 at 3:01pm states, "...[R1] out to nurse's desk with only a t-shirt on.....taking [R1] back to room, found female resident[R3] on his bed with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 16	S9999		

pants on.....both residents dressed and taken to separate rooms.....[R1] has shown increased behaviors of sexual advance toward female residents and staff over past few days. Grabbing at them and trying to get them to go with him. Not easily redirected.....15 minute checks initiated this shift....[Z1, Physician] made aware....N.O. (new order) estradiol 0.25mg (milligrams) daily.

On 1/6/15 at 12:20pm E9, CNA stated she walked R1 back to his room, and found R3 wearing only a undershirt, no pants/brief "lying on her back, legs spread, with eyes closed" on R1's bed.

On 1/1/15 at 9:45am E1, DON and E2, ADON (Assistant Director of Nursing) stated the incident was reported on 12/1/14 to E2 and then E2 notified E1. E1 stated 15 minute checks were initiated for R1 on 12/1/14. E1 stated they also looked at staffing, the documentation in R1's record and talked to other staff as well as the ones involved during the investigation.

R3's MDS dated 12/7/14 documents diagnoses of Anxiety disorder and Dementia. The MDS documents severe cognitive impairment and wandering/physical/verbal behaviors 4-6 days per week.

4. R1's Interdisciplinary Notes dated 12/3/14 at 4:50pm states, "...conducting 15 min[minute] checks to find [R1] in a room at end of hall with a female resident[R7]....[R7] was in a state of undress while...[R1] was fully clothed on the other side of the room sitting on the bed.....Staff is watching [R1] continuously..."

On 1/5/15 at 3:55pm E24, CNA stated "Myself and [E22,CNA] were doing 15 minute checks and we couldn't find [R1]. I walked in on [R1] and [R7]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 17	S9999		

-at very end of the long hall, [R14's] room..[R1] was standing on the opposite side of the room of [R7], he was fully dressed. When [R1] saw me,he sat down on the bed . [R7] was scooting on the floor on her behind-only had a sweater on-her onsie, hipster, brief, shoes and socks were off-[R7] was talking fast." E24 stated she reported the incident to E21, RN.

On 1/6/15 at 2:00pm E21, RN stated she notified E1, DON of the incident immediately. E21 stated she escorted R1 out of the room and he was on 1:1's for the rest of the shift.

On 1/6/15 at 1:45pm E1, DON stated, "There was something on 12/3/14, reported to me on 12/3-[R7]-told [E21] to make sure [R1] was 1:1's and notify families."

On 1/7/15 at 9:20am E2, ADON confirmed there was no investigation done of the incident involving R1 and R7.

R7's Physician Progress Note dated 11/6/14 documents a diagnosis of "Severe dementia, Alzheimer's type.....continues just to wander pretty constantly...."

5. R1's Interdisciplinary Note dated 12/4/14 at 6:54pm by E15, RN states "....Continues to go after female resident and is difficult to redirect.....15 minute checks...continue to monitor." R1's note at 8:45pm states "[R1] continues to make sexual advances toward female staff and residents. Grabbing at females inappropriately, attempting to undress female residents. Staff intervening each time, very difficult to redirect. Continues to wear onsie's and 15 minute checks ongoing..."

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 18	S9999		

On 1/1/15 at 4:00pm E7, CNA stated, "I walked into [R1's] room and [R1] was sitting in the recliner chair and [R2] was sitting on him-straddling his legs. [R1] had his hand around [R2's] bottom and his other hand was on [R2's] breast. [R1] had her[R2] onsie unzipped and fully off of her to the waist....I reported to a nurse but don't remember who it was.."

On 1/6/15 at 1:45pm E1, DON stated, "Reported to me on 12/4/14. I told [E15] to monitor him-and then told [E2,ADON] on 12/5/14. Anytime there was an incident [with R1] the nurse's would do 1:1's until he[R2] was settled down in room, once the other residents were settled and not wandering in his room, he would sleep all night."

The undated investigation titled "[R1] and [R2]" states, "12/4/14 Staff found a female resident in a male resident's room. She was sitting on his lap and he was fondling her breast when staff entered room. Staff quickly separated the residents and redirected the female resident to the common area....."

On 1/6/15 at 9:35am E2, ADON confirmed R2 was the female resident found in R1's room on 12/4/14. E2 stated she started the investigation on 12/5/14, which consisted of interviewing E15, no other staff. E2 stated R1 was on 15 minute checks, the door sensor alarm and they were doing "visual checks when out of the room-not 1:1's-just eyeballing him."

6. On 1/7/15 at 3:20pm E7, CNA stated, "I found [R2] in [R1's] room again, [R1] had [R2] with her back to him-was getting ready to unzip [her onsie], but it[zipper] was missing the tongue, so he[R1] was having trouble [unzipping onsie]." E7 stated R1 was on 15 minute checks and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 19	S9999		

sensor door alarm was being used at the time of the witnessed incident, but she is unable to remember the specific date it occurred. E7 stated she reported the incident to E21, RN.

On 1/6/15 at 2:20pm E21, RN stated it was reported to me that "[R2] was found in his[R1] room-he was trying to pull [R2's] zipper down and staff intervened. I did not report this to anyone because nothing happened."

On 1/6/15 at 1:45pm E1, DON confirmed she was not aware of the incident involving R2 and R1.

7. On 1/1/15 at 5:00pm E16, CNA stated, " [R2] was wandering-he[R1] tried to grab her breast and I intervened first....it was after a 15 minute check was done-Did not take it to [E1, DON] or [E2 ADON]-I'm sure they are aware-have not talked to them personally."

On 1/5/15 at 11:20am E8, RN stated, "Spoke with CNA[E16]- [E16] had just left [R1's] room from doing 15 minute check- told me they were called into [R1's] room, [R1] was on knees, [R2] was dressed sitting on bed. [R2's] top was down or up-can't remember-[R2] sitting back on the bed-not sure if there was any touch or not...." E8 stated the whole incident from the time E16 did the 15 minute check on R1 to when "I checked [R1] was 6 minutes." E8 stated she called E1, DON to report what happened. E8 stated E1 told her she would check into the incident. E8 confirmed she never documented the incident which occurred between R1 and R2.

On 1/6/15 at 1:45pm E1, DON stated she was called by E8 on 12/20/14 and told what happened between R2 and R1. E1 stated she told E8 "we would look into it on Monday[12/21], to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 20	S9999		

make sure [R1] was on 1:1's."

The undated investigation titled "[R2] and [R1]" by E2, ADON states, "12/20/14 Staff notified by a visiting family member across the hall. They stated staff had just been down there. There was a female resident[R2] in his[R1] room...[R2] was sitting on the bed with her top down and [R1] was fondling her breast..Visual checks in place. Alarm on door of male resident[R1]. " The investigation does not document staff/family interviews.

On 1/6/15 at 1:25pm E2, ADON stated she became aware of the incident involving R1 and R2, which occurred on 12/20/14, when told about it by E1, DON on 12/22/14. E2 stated she started the investigation on 12/22/14. E2 stated she contacted Z1 on 12/22/14 and received a routine Xanax order. On 1/5/15 at 1:30pm E2 stated 15 minute checks, visual checks when out of the room and sensor door alarm continued, with the new intervention being to give the Xanax three times a day and prn to R1.

R2's Physician Progress Note dated 11/19/14 documents a diagnosis of Advanced Dementia. The MDS dated 10/26/14 documents moderate cognitive impairment and behaviors of wandering 4-6 days per week.

On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated there was "really no findings-nothing more than two residents with dementia being sexually inappropriate." E18 stated residents would need to be "monitored by staff through routine checks" and he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 21	S9999		

made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

On 1/6/15 at 1:45pm E1, DON confirmed she notified E18, Administrator of the first allegation involving R1 and R3 on 12/1/14. E1 confirmed she did not notify E18 of any further incidents involving R1 being sexually inappropriate with other residents. When asked why she did not notify E18 of the further incidents involving R1 being sexually inappropriate with R7(12/3/14), R2 (12/4/14) and R2 (12/20/14) E1 stated "they were not abuse, were behaviors, no harm [occurred]."

On 1/14/15 at 10:10am E1, DON confirmed she notified the Illinois Department of Public Health of the incident on 12/1/14 involving R1 and R3, but did not notify the Department of allegations of further incidents involving R1 being sexually inappropriate with R7 (12/3/14) , R2 (12/4/14), and R2 (12/20/14).

The facility Abuse Policy dated 5/2012 states, " 1. This facility will not condone resident abuse by.....other residents.....Any employee who has knowledge or reason to believe that a resident has been a victim of abuse by anyone as noted in #1 above, is under a duty to immediately report such incident or suspicion to his/her immediate supervisor.....The Resident must be protected from harm during the investigation.....the supervisor shall then notify the Administrator and Director of Nursing...The Director of Nursing or their designee will initiate an investigation immediately and in cases involving....residents, the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the 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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 22	S9999		

C. Based on interview and record review the facility failed to ensure supervision for five of seven residents(R1,2,3,6,7) reviewed for supervision, on the sample of 7. The facility failed to prevent repetitious inappropriate sexual behaviors between residents by failing to identify, evaluate and analyze the inappropriate sexual behaviors. The facility failed to monitor, modify and implement effective interventions to provide supervision of R1. R1's ongoing repetitive inappropriate sexual behaviors continued toward R2, R3, R6 and R7.
Findings include:

R1's Minimum Data Set (MDS) dated 11/24/14 documents R1 has moderate cognitive impairment, behaviors of wandering/other behaviors occurring 4 to 6 days of the week and supervision with ambulation. The Care Plan dated 12/7/14 documents R1 ambulates on his own and has behaviors of being "socially inappropriate at times...undress and walk about the unit...void in inappropriate places" with interventions as follows: "If I have taken my clothes off...assist me to put my clothes back on. I have dementia and am unable to control my social behaviors. Don't tell me what I did was wrong, just help me get dressed again....Approach..slowly....give..short simple cues...I try to touch females inappropriately....tried to lead them back to my room...intervene....redirect away from that person...involve in activity...wearing a onsie to prevent me from undressing in public places...assist to bathroom...15 minute visual checks on...whereabouts for my safety and others...." The Care Plan does not address use of a sensor alarm on the door frame.

R1's Physician Progress Note dated 11/19/14 by Z1, Physician states R1 was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 23	S9999		

facility on 11/17/14 with a diagnosis of Alzheimer's Dementia with behavior concerns. The note states, "[R1] formerly cared for by [Z2, Physician].....significant behavior issues of anxiety, inappropriate sexual behavior, and tried on several medications.....Behavior issues discussed with wife[Z3]....[R1] had both times of anxiety as well as inappropriate sexual behavior that had prompted a trial of Estradiol[Estrogen}...has not been given for the last three days and so we're going to stay off of that now and monitor symptoms closely....will be getting records.....from [Z2]...." The note documents it was dictated on 11/19/14, transcribed on 11/24/14 and faxed to the facility on 11/25/14.

R1's Progress Note dated 7/13/14 by Z2, Former Physician states, "Six month followup for chronic problems.....history....of behavioral problems....Wife[Z3] reports that [R1's] inappropriate behavior is very much under control on Estradiol.....also is on Seroquel...for same problem of inappropriate behaviors....."

R1's electronic Interdisciplinary Notes dated 11/17-11/26/14 document R1 coming out in the hall with a "brief and a t-shirt...various state of undress...out of room [times] 7 with no pants on....redirected...."

1. R1's Interdisciplinary Note dated 11/29/14 at 8:23pm by E8 RN (Registered Nurse) states, "[R1] came down hallway, grabbed a female resident (unidentified) and attempted to take her down the hallway.....redirected....[R1] found in a room inappropriately touching another resident (unidentified). Other resident was removed and [R1] was redirected. As [R1] passed another female resident (unidentified) he proceeded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 24	S9999		

grab her also...[R1] again redirected...Will cont[continue] to monitor." On 1/5/15 at 11:20am when asked about the note dated 11/29/14, E8, RN(Registered Nurse) stated she did not "remember who the resident was, who reported it to me....what CNA [Certified Nurse Aide] told me.. It was charted as a behavior." E8 stated she did not report the incident (11/29) to E1, DON (Director of Nursing) or "anyone."

2. On 1/1/15 at 4:00pm E7, CNA(Certified Nurse Aide) stated, "I was doing cares and saw someone go past fast. I finished the care I was giving, got to the hall and all the doors were shut-was opening doors and got to last door on the left side of the long hall-opened the door and [R1] was sitting on [R14's] bed, [R6] was in the wheelchair and [R1] had [R6's] top off-her bra was off and when I walked in [R1] was taking his face off of [R6's] breast. I pulled [R6] back and asked [R1] 'What are you doing?' [R1] said 'putting her [R6] to bed.' I said what do you mean? [R1] said 'I'm going to f..... her." E7 stated she reported the incident to the nurse, maybe E15 or E21, RN's, but was not sure. E7 was unable to give a specific day/time which the incident occurred. On 1/7/15 at 3:20pm when asked if there was any way she could have been mistaken on the identify of the female resident (R6) E7 stated, "I am 120% sure it was [R6]. I saw someone go really fast through crack of door-I finished with care-took me 3-5 minutes tops-stepped out doorway-looked down hall, mostly doors were shut-opened each door-stepped into [R14's] room-[R1] was sitting on [R14's] bed-[R6's] wheelchair was right in front of [R1]-his [R1's] legs were together, [R6's] legs were spread open and his legs were in the middle of hers. [R6's] shirt was off, bra was off-[R1] was coming up from her chest. [R6] was kinda

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 25	S9999		

disorientated-mumbling-there was no screaming-I would have heard her screaming...it [occurred] before the 15 minute checks [for R1] were begun."

R6's Physician Progress Note dated 11/6/14 documents a diagnosis of Dementia. The MDS dated 11/30/14 documents cognitive impairment with long/short memory problems, no behaviors and extensive assist with dressing, transfers and ambulation.

3. R1's Interdisciplinary Notes dated 12/1/14 at 4:34am states, "[R1] accosting female cna's and [E17]nurse....grabbed [E17], tried to kiss her and push her into the bed....15 minutes after that, [R1] came out of room and accosted [E25, CNA] from behind by reaching around and grabbing her breast, then grabbed her other breast and she was unable to get away without assist from another cna....." On 1/5/15 at 12:15pm E17, RN stated she did not notify anyone of R1's inappropriate behaviors with herself and E25.

4. R1's Interdisciplinary Notes dated 12/1/14 at 3:01pm states, "...[R1] out to nurse's desk with only a t-shirt on.....taking [R1] back to room, found female resident[R3] on his bed with no pants on.....both residents dressed and taken to separate rooms.....[R1] has shown increased behaviors of sexual advance toward female residents and staff over past few days. Grabbing at them and trying to get them to go with him. Not easily redirected.....15 minute checks initiated this shift....Continues to walk hallways with no pants on....wearing onsie's at this time...[Z1, Physician] made aware....N.O. (new order) estradiol 0.25mg (milligrams) daily. Wife[Z3] is here...spoke with her regarding increase in this behavior and order for estradiol. [Z3] stated, 'I had hoped this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 26	S9999		

behavior wouldn't come back'.....[Z3] is aware of [R1's] past sexual behaviors....."

On 1/6/15 at 12:20pm E9, CNA stated she walked R1 back to his room, and found R3 wearing only a undershirt, no pants/brief "lying on her back, legs spread, with eyes closed" on R1's bed. E9 stated R3 said she was ok when asked, and R3 was not crying or acting upset. E9 stated the incident with R1 and R3 happened while 1/2 the CNA's were on break. E9 stated R3 had been toileted right before staff went on break.

On 1/1/15 at 9:45am at E1, DON(Director of Nursing) and E2, ADON (Assistant Director of Nursing) stated R3 was found asleep on R1's bed on 12/1/14, which is "not unusual for [R3] to be asleep on someone's bed-whenever [R3] is incontinent she will remove her brief and lay down." E1 stated R3's undergarment was lying by the "foot of the bed" and R1's was "by the bathroom." E1 stated the incident was reported on 12/1/14 to E2 and then E2 notified E1. E1 stated 15 minute checks were initiated for R1 on 12/1/14. E1 stated they also looked at staffing, the documentation in R1's record and talked to other staff as well as the ones involved during the investigation.

The 15 Minute Visual Checks form dated 12/1/14-1/1/15 documents 15 minute checks being done for R1.

R3's MDS dated 12/7/14 documents diagnoses of Anxiety disorder and Dementia. The MDS documents severe cognitive impairment, wandering/physical/verbal behaviors 4-6 days per week and incontinence of bladder.

R1's Physician Progress Note by Z1 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 27	S9999		

12/3/14 documents "issues ...of sexual aggression towards female staff as well as female residents....[R1] has apparently had this problem for some time and in the past estrogen had been started. We did restart Estrogen yesterday. He is on SSRI[Selective Serotonin Reuptake Inhibitor-Lexapro] and...am going to start [R1] on spironolactone as an anti-testosterone medication....."

5. R1's Interdisciplinary Notes dated 12/3/14 at 4:50pm states, "...conducting 15 min[minute] checks to find [R1] in a room at end of hall with a female resident[R7]....[R7] was in a state of undress while...[R1] was fully clothed on the other side of the room sitting on the bed.....Staff is watching [R1] continuously..."

On 1/5/15 at 3:55pm E24, CNA stated "Myself and [E22,CNA] were doing 15 minute checks and we couldn't find [R1]. I walked in on [R1] and [R7] -at very end of the long hall, [R14's] room..[R1] was standing on the opposite side of the room of [R7], he was fully dressed. When [R1] saw me,he sat down on the bed . [R7] was scooting on the floor on her behind-only had a sweater on-her onsie, hipster, brief, shoes and socks were off-[R7] was talking fast." E24 stated she reported the incident to E21, RN.

On 1/1/15 at 5:00pm E22, CNA stated E24 and herself were looking for R1 because he was 15 minute checks. E22 stated R7 was on the floor of R14's room with only a shirt on, her brief was on the bed and R1 was sitting on R14's bed by the window.

On 1/6/15 at 2:00pm E21, RN stated she was on supper break when the incident with R1 and R7 was reported to her. E21 stated R7 was sitting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 28	S9999		

the floor with a sweater on, onsie off and R1 was fully clothed sitting on the opposite side of the room. E21 stated she escorted R1 out of the room and he was on 1:1's for the rest of the shift. E21 stated she notified E1, DON of the incident immediately.

On 1/6/15 at 1:45pm E1, DON stated, "There was something on 12/3/14, reported to me on 12/3-[R7]-told [E21] to make sure [R1] was 1:1's and notify families."

On 1/7/15 at 9:20am E2, ADON confirmed there was no investigation done of the incident involving R1 and R7.

R7's Physician Progress Note dated 11/6/14 documents a diagnosis of "Severe dementia, Alzheimer's type.....continues just to wander pretty constantly...." The MDS dated 11/2/14 states R7 has moderate cognitive impairment, long/short term memory problems, wanders and requires supervision with ambulation.

6. R1's Interdisciplinary Note dated 12/4/14 at 6:54pm by E15, RN states "....Continues to go after female resident and is difficult to redirect.....15 minute checks...continue to monitor." R1's note at 8:45pm states "[R1] continues to make sexual advances toward female staff and residents. Grabbing at females inappropriately, attempting to undress female residents. Staff intervening each time, very difficult to redirect. Continues to wear onsie's and 15 minute checks ongoing..."

On 1/1/15 at 4:00pm E7, CNA stated, "I walked into [R1's] room and [R1] was sitting in the recliner chair and [R2] was sitting on him-straddling his legs. [R1] had his hand around

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 29	S9999		

[R2's] bottom and his other hand was on [R2's] breast. [R1] had her[R2] onsie unzipped and fully off of her to the waist. I yelled for help and [E11, CNA] came to help me. [E11] helped get [R2]....I reported to a nurse but don't remember who it was.."

On 1/5/15 at 3:50pm E11, CNA stated "I don't remember the exact date, but his alarm was going off and [E7] went down there and I went down there. [R2] was on [R1's] lap--onsie was down to waist-she had a bra on and [R1] was fondling her. I think this was during the 15 minute checks. We reported to [E15,RN] and she said the 15 minute checks were not enough."

On 1/1/15 at 8:35am E15, RN stated, "I am not aware of any...sexual abuse...[R1] is in a onsie because he urinates inappropriately...." At 4:00pm when asked about the note dated 12/4/14, E15 stated R1 tried to get ahold of them[female residents when they] were walking with him-he grabbed ahold and [tried to get] zipper down of the onsie's on the back.....Had to be either [R2] or [R15]." When asked E15 was not aware that R1 had a history of inappropriate sexual behavior.

On 1/6/15 at 1:45pm E1, DON stated, "Reported to me on 12/4/14. I told [E15] to monitor him-and then told [E2,ADON] on 12/5/14. Anytime there was an incident [with R1] the nurse's would do 1:1's until he[R2] was settled down in room, once the other residents were settled and not wandering in his room, he would sleep all night."

The undated investigation titled "[R1] and [R2]" states, "12/4/14 Staff found a female resident in a male resident's room. She was sitting on his lap and he was fondling her breast when staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 30	S9999		

entered room. Neither resident was upset or anxious. Staff quickly separated the residents and redirected the female resident to the common area. 12/5/14...Husband contacted and informed of situation....he was wondering what safeguards we had in place to prevent this. I informed him of the visual checks and door alarm on his door.....informed him the doctor[Z1] is aware...Discussed this at IDT[Interdisciplinary Meeting]...discussed with the [Z1] about medications...."

On 1/6/15 at 9:35am E2, ADON confirmed R2 was the female resident found in R1's room on 12/4/14. E2 stated she thought E15 reported the incident to her on 12/4/14. E2 stated she started the investigation on 12/5/14, which consisted of interviewing E15, no other staff. E2 stated R1 was on 15 minute checks, the door sensor alarm and they were doing "visual checks when out of the room-not 1:1's-just eyeballing him."

R1's Interdisciplinary Notes dated 12/5/14 at 11:19am state, "New order...for Seroquel 25mg bid[twice daily].....[Z3, wife] informed of behavior last evening[12/4] of fondling a female resident[R2]."

7. On 1/7/15 at 3:20pm E7, CNA stated, "I found [R2] in [R1's] room again, [R1] had [R2] with her back to him-was getting ready to unzip [her onsie], but it[zipper] was missing the tongue, so he[R1] was having trouble [unzipping onsie]." E7 stated R1 was on 15 minute checks and the sensor door alarm was being used at the time of the witnessed incident, but she is unable to remember the specific date it occurred. E7 stated she checked R1's 15 minute check records at the time and stated, " I checked it was 3 minutes since the last check[15 minute] was done." E7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 31	S9999		

stated she reported the incident to E21, RN.

On 1/6/15 at 2:20pm E21, RN stated it was reported to me that "[R2] was found in his[R1] room-he was trying to pull [R2's] zipper down and staff intervened. I did not report this to anyone because nothing happened."

8. On 1/1/15 at 5:00pm E16, CNA stated, " I saw down short hall, so went down, [R2] was wandering-he[R1] tried to grab her breast and I intervened first. It [happened] maybe a month ago- I remember telling somebody-it was with [R2], was after a 15 minute check was done-Did not take it to [E1, DON] or [E2 ADON]-I'm sure they are aware-have not talked to them personally."

On 1/5/15 at 11:20am E8, RN stated, "I was in the dining room passing medications and was called to floor. Spoke with CNA[E16]- [E16] had just left [R1's] room from doing 15 minute check- told me they were called into [R1's] room, [R1] was on knees, [R2] was dressed sitting on bed. [R2's] top was down or up-can't remember-[R2] sitting back on the bed-not sure if there was any touch or not. I checked [R2] and [R1] .." E8 stated the whole incident from the time E16 did the 15 minute check on R1 to when "I checked [R1] was 6 minutes." E8 stated she talked with E16 to find out what happened and immediately called E1, DON to report what happened. E8 stated E1 told her she would check into the incident, "[E1] said to hold off on documenting, told me to wait [she] would check into what happened. [I] asked how to document, [E1] said to wait and [E1] will investigate-I was never called." E8 confirmed she never documented the incident which occurred between R1 and R2. E8 stated the incident occurred on a weekend, during suppertime, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 32	S9999		

she was not sure of the date.

On 1/6/15 at 1:45pm E1, DON stated she was called by E8 on 12/20/14 and told what happened between R2 and R1. E1 stated she told E8 "we would look into it on Monday[12/21], to make sure [R1] was 1:1's." E1 denied telling E8 to hold off documenting the incident. E1 stated she told E8 to "just document what happened with [R2] and [E8] said if [I] needed anything else to call her on Monday."

The undated investigation titled "[R2] and [R1]" states, "12/20/14 Staff notified by a visiting family member across the hall. They stated staff had just been down there. There was a female resident[R2] in his[R1] room...[R2] was sitting on the bed with her top down and [R1] was fondling her breast..[E8] assisted staff to redirect the two residents away from each other without problems. Neither resident was angry, upset or anxious. Visual checks in place. Alarm on door of male resident[R1]. " The investigation does not document and staff/family interviews.

R1's Fax Notification Order Sheet dated 12/22/14 documents "[R1] increase in behavior. Please increase Xanax 0.5mg to tid[three times daily] and continue Xanax 0.5mg prn [every 8 hours]."

R1's Interdisciplinary Note dated 12/23/14 at 4:09pm states, "Spoke with...[Z1, Physician]...had been receiving Xanax PRN[as needed]....behaviors had subsided considerably. When didn't receive the Xanax PRN [R1] started to fondle staff and residents. Received an order to give Xanax tid[three times daily] and PRN...continue with 15 minute checks and 1:1's to redirect from the behavior."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 33 On 1/6/15 at 1:25pm E2, ADON stated she became aware of the incident involving R1 and R2, which occurred on 12/20/14, when told about it by E1, DON on 12/22/14. E2 stated she started the investigation on 12/22/14. E2 stated she contacted Z1 on 12/22/14 and received a routine Xanax order. On 1/5/15 at 1:30pm E2 stated the note dated 12/23/14 relates to the incident which occurred on 12/20/14 involving R1 and R2. E2 confirmed there is no documentation of the incident in R1's record. E2 stated 15 minute checks, visual checks when out of the room and sensor door alarm continued, with the new intervention being to give the Xanax three times a day and prn to R1. R2's Physician Progress Note dated 11/19/14 documents a diagnosis of Advanced Dementia. The MDS dated 10/26/14 documents moderate cognitive impairment, long/short term memory impairment, behaviors of wandering 4-6 days per week and ambulation with supervision. (A) 300.1210a) 300.1210d)6) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 34	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis.

6) All necessary precautions shall be taken to assure that the residents' environment remains free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-tem care facility, is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

These requirements were not met as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 35	S9999		

by:

Based on record review and interview, the facility failed to reassess and implement behavioral interventions, provide effective supervision and update the Plan of Care for (R4). This failure resulted in R4 having continued access to other residents after physically assaulting and causing a head laceration to another resident (R5). R4 and R5 are two of seven residents reviewed for supervision in the sample of seven. These failures have the potential to affect all 21 residents (R4, R5, R8 through R13 and R16 through R28) living on the Alzheimer's Special Care Unit.

Findings include:

The Physician Order Sheet dated April 2014 documents the following diagnoses for R4: Alzheimer's, Dementia with Behavioral Disturbances, Reactive Confusion, Insomnia and Anxiety. The same Physician Order Sheet documents R4 with orders for Zyprexa, an anti-psychotic medication and Ativan for anxiety.

The Care Plan dated April 2014 for R4 documents R4 becoming resistive with care toward staff. This same Care Plan does not address R4's physical or verbal behaviors directed towards staff and other residents.

Nursing Notes dated 3/19/14 document R4 being admitted from a psychiatric care facility. On 3/27/14 Nursing Notes document that R4 came to the Nurses Station and told E6, Licensed Practical Nurse "I'm coming in there and beating the F%#* out of you." The same Nursing Note documents that R4 then entered another resident's room, identified as R9, and told R9 he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 36	S9999		

was going to" beat the S&*#" out of her.

The Nursing Notes dated 3/29/14 document R4 becoming combative, going in and out of residents room, trying to get residents up out of bed.

On 3/30/14 Nursing Notes document R4 as "remained very aggressive with staff and other residents" and R4 grabbed E3, Licensed Practical Nurse around the neck and told E3 he was "going to kill" her. R4 then went to R10's room and grabbed R10 by the arm and pulled R10 out of his chair. The Nursing Note goes on to document that R4 continued to wander and was kicking chairs and threatening to kill anyone he talked to, going in and out of other resident's rooms.

On 3/31/14 at 1:56 pm the Nursing Notes Document that R4 was pulling another resident (R8) down the hallway and dragging R8's walker.

Nursing Notes on 4/3/14 document "(R4) wandering unit as usual".

On 4/6/14 Nursing Notes document "(R4) up wandering the unit. Very restless and agitated.....continues to threaten staff and went into other resident's room and made threatening remarks to them."

On 4/7/14 documentation in the Nursing Notes state "in and out of resident's rooms."

A Nursing Note dated 4/8/14 documented by E3, Licensed Practical Nurse, states at 4:00 pm R4 was wandering in the hallway at which time R4 encountered another male resident (R5). Earlier in the shift a Certified Nursing Assistant (E4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

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MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Continued From page 37	S9999		

heard R5 yell at R4 and told R4 to stay away from him and that he didn't like R4. E3 documented "As I came out of the (medication) room I saw (R4) push the other resident (R5) into the door frame and heard him say 'stay the hell away from me.' (R4) then walked away from the area."
A facility Incident Report dated 4/7/14 documents that R4 pushed another resident, R5 in the hallway causing R5 to lose his balance and hit his head on the door frame. The Incident Report states R5 sustained a laceration to the back of his head that required seven staples at the hospital and was returned to the facility.

Nursing Notes dated 4/9/14 and 4/10/14 document that R4 was wandering the unit and going in and out of rooms.

On 4/11/14 Nursing Notes document that R4 went into R8's room and attempted to crawl into R8's bed with R8 in the bed. On 4/11/14 Nursing Notes document that R4 was trying to move the back on a reclining chair while another resident, identified as R11 was sitting in it.

On 4/12/14 R4's Nursing Notes at 3:40 pm document that R4 slapped another resident in the face, identified as R13, while going down the hall with a staff member. The Nursing Note goes on to document that at 3:55 pm a phone call was placed to the on-call psychiatrist for transfer to the hospital for evaluation. At 4:15 pm per the Nursing Note on this same date, R4 was found in his room between his foot board and heater with a large hematoma to his forehead. R4 was sent out to the Emergency Room for evaluation and discharged from the facility.

A facility Incident Report dated 4/12/14 documents that R4 had an unwitnessed fall in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 38	S9999		

room and was found between the headboard and the heater of his room with a large hematoma to the forehead. There was no further documentation concerning this incident available for review.

On 1/7/15 at 1:00 pm E4, Certified Nursing Assistant stated that on 4/7/14 there were two different incidents between R4 and R5. E4 stated she saw R4 push R5 but R5 did not fall at this time. R4 walked away and R5 was taken to his room by E3. E4 states she left to go to another unit to retrieve music and charting material and when E4 returned R5 was found on the floor up against the doorframe with his head cut. R5 was sent to the hospital. E4 stated that one on one supervision was done on R5 on an intermittent basis, lasting for 10-15 minutes at a time.

On 1/7/15 at 1:30 pm E3 stated she witnessed the incident between R4 and R5 that took place on 4/7/14. E3 stated that R4 actually picked R5 up off the floor about 6-8 inches and slammed R5 into the door frame striking R5's head and causing a laceration about two inches long and gaping open. E3 stated she told E1, Director of Nursing this and E1 told E3 she could not document that in R4's chart and proceeded to tell E3 how to document the incident. E3 stated "I was told by (E1) to just put in the chart that (R4) pushed (R5) and (R5) lost his balance and fell, so I did." E3 went on to state there was never continuous one on one supervision by staff done on R4. E3 stated "One of the staff would just sit (R4) down and be with him for awhile and when he calmed he would get up and wander the unit."

The facility Abuse Policy dated May 2012 does not give guidance to employees on how to respond to resident to resident altercations.

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 39	S9999		

R4 resided on a closed, secure Alzheimers Special Care unit, housing 20 other residents, R5, R8 through R13 and R16 through R28, all with cognitive impairment.

On 1/7/15 at 3:20 pm E2, Assistant Director of Nursing stated "I suppose we should have done 24 hour one on one supervision on (R4)".

On 1/8/15 at 1:00 pm E5, Licensed Practical Nurse stated staff were aware that R4 was a highly agitated resident. E5 stated "we absolutely knew he would hurt someone, staff or residents."

On 1/8/15 at 2:55 pm E1 stated "Yes (R4) probably should have been supervised more closely."

(A)

300.610a)
300. 690b)
300.690c)
300.1220b)6)
300.3240b)
300.3240d)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

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MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Continued From page 40	S9999		

Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 41	S9999		

nursing services of the facility, including:
6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

Section 300.3240 Abuse and Neglect

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.

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.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to develop a comprehensive Abuse Prevention policy by not identifying how to handle resident to resident altercations/behaviors, which potentially could lead to potential abusive situations. The policy doesn't specify to immediately report allegations of abuse to the Administrator. The facility failed to operationalize the Abuse Prevention policy by multiple staff failures to report to the Administrator and investigate repetitive inappropriate sexual behaviors between residents as potential allegations of sexual abuse. The facility failed to operationalize the policy to ensure the protection of the residents from further inappropriate sexual behaviors of R1. R1's ongoing repetitive inappropriate sexual behaviors continued toward R2, R3, R6 and R7. These failures have the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 42	S9999		

potential to affect all 106 residents residing in the facility.

Findings include:

1. The facility Abuse Prevention Policy dated 5/2012 states, " 1. This facility will not condone resident abuse by.....other residents.....Any employee who has knowledge or reason to believe that a resident has been a victim of abuse by anyone as noted in #1 above, is under a duty to immediately report such incident or suspicion to his/her immediate supervisor.....The Resident must be protected from harm during the investigation.....the supervisor shall then notify the Administrator and Director of Nursing...The Director of Nursing or their designee will initiate an investigation immediately and in cases involving....residents, the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the Illinois Department of Public Health.....Any reasonable suspicion of a crime committed against a resident....will also be reported [to] the local law enforcement...."

On 1/5/15 at 12:45pm E18, Administrator confirmed the Abuse Prevention policy dated 5/2012 as written, is that staff will report allegations of abuse to the supervisor and then the supervisor will notify the Director of Nursing (DON) and Administrator. E18 stated his expectation is for staff to report abuse allegations to their supervisor and the Administrator. On 1/7/15 at 9:25am E18, Administrator confirmed the Abuse Prevention policy is "very vague" as relating to how to handle allegations of resident to resident altercations/abuse.

On 1/5/15 at 12:45pm E18, Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Continued From page 43	S9999		

he was notified by E1, DON around the first of December 2014 about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated there was "really no findings-nothing more than two residents with dementia being sexually inappropriate." E18 stated residents would need to be "monitored by staff through routine checks" and he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

2. R1's Minimum Data Set (MDS) dated 11/24/14 documents R1 has moderate cognitive impairment.

R1's Physician Progress Note dated 11/19/14 by Z1, Physician states R1 was admitted to the facility on 11/17/14 with a diagnosis of Alzheimer's Dementia with behavior concerns. The note states, "[R1]... ....significant behavior issues of anxiety, inappropriate sexual behavior, and tried on several medications....inappropriate sexual behavior that had prompted a trial of Estradiol[Estrogen}...has not been given for the last three days and so we're going to stay off of that now and monitor symptoms closely...."

R1's Progress Note dated 7/13/14 by Z2, Former Physician states, "Six month followup for chronic problems.....history....of behavioral problems....Wife[Z3] reports that [R1's] inappropriate behavior is very much under control on Estradiol.....also is on Seroquel...for same problem of inappropriate behaviors....."

R1's Interdisciplinary Note dated 11/29/14 at 8:23pm by E8 RN (Registered Nurse) states, "[R1] came down hallway, grabbed a female

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 44	S9999		

resident (unidentified) and attempted to take her down the hallway.....redirected....[R1] found in a room inappropriately touching another resident (unidentified). Other resident was removed and [R1] was redirected. As [R1] passed another female resident (unidentified) he proceeded to grab her also...[R1] again redirected...Will cont[continue] to monitor."

On 1/5/15 at 11:20am when asked about the note dated 11/29/14, E8, RN stated she did not "remember who the resident was, who reported it to me.... It was charted as a behavior." E8 stated she did not report the incident (11/29) to E1, DON (Director of Nursing) or "anyone."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident on 11/29/14.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

3. On 1/1/15 at 4:00pm E7, CNA stated, "I was doing cares and saw someone go past fast.... got to the hall- got to last door on the left side of the long hall-opened the door and [R1] was sitting on [R14's] bed, [R6] was in the wheelchair and [R1] had [R6's] top off-her bra was off and when I walked in [R1] was taking his face off of [R6's] breast. I pulled [R6] back and asked [R1] 'What are you doing?' [R1] said 'putting her [R6] to bed.' I said what do you mean? [R1] said 'I'm going to f..... her." E7 stated she reported the incident to the nurse, but was unable remember the name of the nurse. On 1/7/15 at 3:20pm E7 stated, "I am 120% sure it was [R6]....it [occurred] before the 15 minute checks [for R1] were begun."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 45	S9999		

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident involving R1 and R6.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

R6's Physician Progress Note dated 11/6/14 documents a diagnosis of Dementia. The MDS dated 11/30/14 documents cognitive impairment with long/short memory problems and no behaviors.

4. R1's Interdisciplinary Notes dated 12/1/14 at 3:01pm states, "...[R1] out to nurse's desk with only a t-shirt on.....taking [R1] back to room, found female resident[R3] on his bed with no pants on.....[R1] has shown increased behaviors of sexual advance toward female residents and staff over past few days....15 minute checks initiated this shift...."

On 1/6/15 at 12:20pm E9, CNA stated she walked R1 back to his room, and found R3 wearing only a undershirt, no pants/brief "lying on her back, legs spread, with eyes closed" on R1's bed.

On 1/1/15 at 9:45am E1, DON and E2, ADON (Assistant Director of Nursing) stated the incident was reported on 12/1/14 to E2 and then E2 notified E1.

R3's MDS dated 12/7/14 documents diagnoses of Anxiety disorder and Dementia. The MDS documents severe cognitive impairment and wandering/physical/verbal behaviors 4-6 days per week.

On 1/5/14 at 12:45pm E18, Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 46	S9999		

the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

5. R1's Interdisciplinary Notes dated 12/3/14 at 4:50pm states, "...conducting 15 min[minute] checks to find [R1] in a room at end of hall with a female resident[R7]....[R7] was in a state of undress while...[R1] was fully clothed on the other side of the room sitting on the bed.....Staff is watching [R1] continuously..."

On 1/5/15 at 3:55pm E24, CNA stated ".....were doing 15 minute checks and we couldn't find [R1]. I walked in on [R1] and [R7] -at very end of the long hall, [R14's] room..[R1] was standing on the opposite side of the room of [R7], he was fully dressed. When [R1] saw me,he sat down on the bed . [R7] was scooting on the floor on her behind-only had a sweater on-her onsie, hipster, brief, shoes and socks were off-[R7] was talking fast." E24 stated she reported the incident to E21, RN.

On 1/6/15 at 2:00pm E21, RN stated she notified E1, DON of the incident immediately. E21 stated R1 was on 1:1's for the rest of the shift.

On 1/6/15 at 1:45pm E1, DON stated, "There was something on 12/3/14, reported to me on 12/3-[R7]-told [E21] to make sure [R1] was 1:1's and notify families."

On 1/7/15 at 9:20am E2, ADON confirmed there was no investigation done of the incident involving R1 and R7.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 47	S9999		

residents, except the incident on 12/1/14.

R7's Physician Progress Note dated 11/6/14 documents a diagnosis of "Severe dementia, Alzheimer's type.....continues just to wander pretty constantly...."

6. R1's Interdisciplinary Note dated 12/4/14 at 6:54pm by E15, RN states "....Continues to go after female resident...difficult to redirect.....15 minute checks...continue to monitor." R1's note at 8:45pm states "[R1] continues to make sexual advances toward female staff and residents. Grabbing at females inappropriately, attempting to undress female residents....difficult to redirect....15 minute checks ongoing..."

On 1/1/15 at 4:00pm E7, CNA stated, "I walked into [R1's] room and [R1] was sitting in the recliner chair and [R2] was sitting on him-straddling his legs. [R1] had his hand around [R2's] bottom and his other hand was on [R2's] breast. [R1] had her[R2] onsie unzipped and fully off of her to the waist....I reported to a nurse but don't remember who it was.."

On 1/6/15 at 1:45pm E1, DON stated, "Reported to me on 12/4/14. I told [E15] to monitor him-and then told [E2,ADON] on 12/5/14. Anytime there was an incident [with R1] the nurse's would do 1:1's until he[R2] was settled down in room, once the other residents were settled and not wandering in his room, he would sleep all night."

The undated investigation titled "[R1] and [R2]" states, "12/4/14 Staff found a female resident in a male resident's room. She was sitting on his lap and he was fondling her breast when staff entered room. Staff quickly separated the residents and redirected the female resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 48 the common area....." On 1/6/15 at 9:35am E2, ADON stated she started the investigation of the incident 12/4/14) on 12/5/14. E2 stated the investigation consisted of interviewing E15. E2 confirmed no other staff were interviewed. E2 stated R1 was on 15 minute checks, the door sensor alarm and they were doing "visual checks when out of the room-not 1:1's-just eyeballing him." On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14. 7. On 1/7/15 at 3:20pm E7, CNA stated, "I found [R2] in [R1's] room again, [R1] had [R2] with her back to him-was getting ready to unzip [her onsie], but it[zipper] was missing the tongue, so he[R1] was having trouble [unzipping onsie]." E7 stated R1 was on 15 minute checks and the sensor door alarm was being used at the time of the witnessed incident, but she is unable to remember the specific date it occurred. E7 stated she reported the incident to E21, RN. On 1/6/15 at 2:20pm E21, RN stated it was reported to me that "[R2] was found in his[R1] room-he was trying to pull [R2's] zipper down and staff intervened. I did not report this to anyone because nothing happened." On 1/6/15 at 1:45pm E1, DON confirmed she was not aware of the incident involving R2 and R1. On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Continued From page 49	S9999		

8. On 1/1/15 at 5:00pm E16, CNA stated, " [R2] was wandering-he[R1] tried to grab her breast and I intervened first....it was after a 15 minute check was done-Did not take it to [E1, DON] or [E2 ADON]-I'm sure they are aware-have not talked to them personally."

On 1/5/15 at 11:20am E8, RN stated, "Spoke with CNA[E16]- [E16] had just left [R1's] room from doing 15 minute check- told me they were called into [R1's] room, [R1] was on knees, [R2] was dressed sitting on bed. [R2's] top was down or up-can't remember-[R2] sitting back on the bed-not sure if there was any touch or not...." E8 stated the whole incident from the time E16 did the 15 minute check on R1 to when "I checked [R1] was 6 minutes." E8 stated she called E1, DON to report what happened. E8 stated E1 told her she would check into the incident, "[E1] said to hold off on documenting, told me to wait [she] would check into what happened. [I] asked how to document, [E1] said to wait and [E1] will investigate-I was never called." E8 confirmed she never documented the incident which occurred between R1 and R2. E8 stated the incident occurred on a weekend, during suppertime, but she was not sure of the date.

On 1/6/15 at 1:45pm E1, DON stated she was called by E8 on 12/20/14 and told what happened between R2 and R1. E1 stated she told E8 "we would look into it on Monday[12/21], to make sure [R1] was 1:1's." E1 denied telling E8 to hold off documenting the incident. E1 stated she told E8 to "just document what happened with [R2] and [E8] said if [I] needed anything else to call her on Monday."

The undated investigation titled "[R2] and [R1]" by

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

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S9999	Continued From page 50	S9999		

E2, ADON states, "12/20/14 Staff notified by a visiting family member across the hall. They stated staff had just been down there. There was a female resident[R2] in his[R1] room...[R2] was sitting on the bed with her top down and [R1] was fondling her breast..Visual checks in place. Alarm on door of male resident[R1]. " The investigation does not document staff/family interviews.

On 1/6/15 at 1:25pm E2, ADON stated she became aware of the incident involving R1 and R2, which occurred on 12/20/14, when told about it by E1, DON on 12/22/14. E2 stated she started the investigation on 12/22/14. On 1/5/15 at 1:30pm E2 stated 15 minute checks, visual checks when out of the room and sensor door alarm continued, with the new intervention being to give the Xanax three times a day to R1.

R2's Physician Progress Note dated 11/19/14 documents a diagnosis of Advanced Dementia. The MDS dated 10/26/14 documents moderate cognitive impairment and behaviors of wandering 4-6 days per week.

On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

On 1/6/15 at 1:45pm E1, DON confirmed she notified E18, Administrator of the first allegation involving R1 and R3 on 12/1/14. E1 confirmed she did not notify E18 of any further incidents involving R1 being sexually inappropriate with

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 51	S9999		

other residents. When asked why she did not notify E18 of the further incidents involving R1 being sexually inappropriate with R7(12/3/14), R2 (12/4/14) and R2 (12/20/14) E1 stated "they were not abuse, were behaviors, no harm [occurred]."

9. On 1/14/15 at 10:10am E1, DON confirmed she notified the Illinois Department of Public Health of the incident on 12/1/14 involving R1 and R3, but did not notify the Department of allegations of further incidents involving R1 being sexually inappropriate with R7 (12/3/14) , R2 (12/4/14), and R2 (12/20/14).

(B)

300.610a)
300.695a)3)
300.695b)3)
300.695c)1)
300.695c)5)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.695 Contacting Local Law Enforcement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 52 a) For the purpose of this Section, the following definitions shall apply: 3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 5) Facility investigation of the situation. These requirements are not met as evidenced by: Based on interview and record review the facility failed to operationalize their abuse policy by failing to form a suspicion of a crime in relation to these behaviors and notify local law enforcement. These failures have the potential to affect all 106 residents residing in the facility.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 53	S9999		

Findings include:

1. The facility Abuse Prevention Policy dated 5/2012 states, " 1. This facility will not condone resident abuse by.....other residents.....Any employee who has knowledge or reason to believe that a resident has been a victim of abuse by anyone as noted in #1 above, is under a duty to immediately report such incident or suspicion to his/her immediate supervisor.....The Resident must be protected from harm during the investigation.....the supervisor shall then notify the Administrator and Director of Nursing...The Director of Nursing or their designee will initiate an investigation immediately and in cases involving....residents, the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the Illinois Department of Public Health.....Any reasonable suspicion of a crime committed against a resident....will also be reported [to] the local law enforcement...."

On 1/5/15 at 12:45pm E18, Administrator confirmed the Abuse Prevention policy dated 5/2012 as written, is that staff will report allegations of abuse to the supervisor and then the supervisor will notify the Director of Nursing (DON) and Administrator. E18 stated his expectation is for staff to report abuse allegations to their supervisor and the Administrator. On 1/7/15 at 9:25am E18, Administrator confirmed the Abuse Prevention policy is "very vague" as relating to how to handle allegations of resident to resident altercations/abuse.

On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December 2014 about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated there was "really no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 54	S9999		

findings-nothing more than two residents with dementia being sexually inappropriate." E18 stated residents would need to be "monitored by staff through routine checks" and he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15.

On 1/15/15 at 2:45pm when asked if he considered the incident on 12/1/14 for reasonable suspicion of a crime, R18, Administrator stated "At that time I did not believe there was a reasonable suspicion of a crime.....I did not notify the police...." E18 stated he considers "all allegations as a potential for a crime."

2. R1's Minimum Data Set (MDS) dated 11/24/14 documents R1 has moderate cognitive impairment.

R1's Physician Progress Note dated 11/19/14 by Z1, Physician states R1 was admitted to the facility on 11/17/14 with a diagnosis of Alzheimer's Dementia with behavior concerns. The note states, "[R1]... ....significant behavior issues of anxiety, inappropriate sexual behavior, and tried on several medications....inappropriate sexual behavior that had prompted a trial of Estradiol[Estrogen}...has not been given for the last three days and so we're going to stay off of that now and monitor symptoms closely...."

R1's Progress Note dated 7/13/14 by Z2, Former Physician states, "Six month followup for chronic problems.....history....of behavioral problems....Wife[Z3] reports that [R1's] inappropriate behavior is very much under control on Estradiol.....also is on Seroquel...for same problem of inappropriate behaviors....."

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	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 55	S9999		

R1's Interdisciplinary Note dated 11/29/14 at 8:23pm by E8 RN (Registered Nurse) states, "[R1] came down hallway, grabbed a female resident (unidentified) and attempted to take her down the hallway.....redirected....[R1] found in a room inappropriately touching another resident (unidentified). Other resident was removed and [R1] was redirected. As [R1] passed another female resident (unidentified) he proceeded to grab her also...[R1] again redirected...Will cont[continue] to monitor."

On 1/5/15 at 11:20am when asked about the note dated 11/29/14, E8, RN stated she did not "remember who the resident was, who reported it to me.... It was charted as a behavior." E8 stated she did not report the incident (11/29) to E1, DON (Director of Nursing) or "anyone."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident on 11/29/14.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

3. On 1/1/15 at 4:00pm E7, CNA stated, "I was doing cares and saw someone go past fast.... got to the hall- got to last door on the left side of the long hall-opened the door and [R1] was sitting on [R14's] bed, [R6] was in the wheelchair and [R1] had [R6's] top off-her bra was off and when I walked in [R1] was taking his face off of [R6's] breast. I pulled [R6] back and asked [R1] 'What are you doing?' [R1] said 'putting her [R6] to bed.' I said what do you mean? [R1] said 'I'm going to f..... her." E7 stated she reported the incident to the nurse, but was unable remember the name of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

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(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
S9999	Continued From page 56	S9999		

the nurse. On 1/7/15 at 3:20pm E7 stated, "I am 120% sure it was [R6]....it [occurred] before the 15 minute checks [for R1] were begun."

On 1/6/15 at 1:45pm E1, DON confirmed she was not notified of the incident involving R1 and R6.

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

R6's Physician Progress Note dated 11/6/14 documents a diagnosis of Dementia. The MDS dated 11/30/14 documents cognitive impairment with long/short memory problems and no behaviors.

4. R1's Interdisciplinary Notes dated 12/1/14 at 3:01pm states, "...[R1] out to nurse's desk with only a t-shirt on.....taking [R1] back to room, found female resident[R3] on his bed with no pants on.....[R1] has shown increased behaviors of sexual advance toward female residents and staff over past few days....15 minute checks initiated this shift...."

On 1/6/15 at 12:20pm E9, CNA stated she walked R1 back to his room, and found R3 wearing only a undershirt, no pants/brief "lying on her back, legs spread, with eyes closed" on R1's bed.

On 1/1/15 at 9:45am E1, DON and E2, ADON (Assistant Director of Nursing) stated the incident was reported on 12/1/14 to E2 and then E2 notified E1.

R3's MDS dated 12/7/14 documents diagnoses of Anxiety disorder and Dementia. The MDS documents severe cognitive impairment and

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 57 wandering/physical/verbal behaviors 4-6 days per week. On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14. 5. R1's Interdisciplinary Notes dated 12/3/14 at 4:50pm states, "...conducting 15 min[minute] checks to find [R1] in a room at end of hall with a female resident[R7]....[R7] was in a state of undress while...[R1] was fully clothed on the other side of the room sitting on the bed.....Staff is watching [R1] continuously..." On 1/5/15 at 3:55pm E24, CNA stated "....were doing 15 minute checks and we couldn't find [R1]. I walked in on [R1] and [R7] -at very end of the long hall, [R14's] room..[R1] was standing on the opposite side of the room of [R7], he was fully dressed. When [R1] saw me,he sat down on the bed . [R7] was scooting on the floor on her behind-only had a sweater on-her onsie, hipster, brief, shoes and socks were off-[R7] was talking fast." E24 stated she reported the incident to E21, RN. On 1/6/15 at 2:00pm E21, RN stated she notified E1, DON of the incident immediately. E21 stated R1 was on 1:1's for the rest of the shift. On 1/6/15 at 1:45pm E1, DON stated, "There was something on 12/3/14, reported to me on 12/3-[R7]-told [E21] to make sure [R1] was 1:1's and notify families." On 1/7/15 at 9:20am E2, ADON confirmed there was no investigation done of the incident involving R1 and R7.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 58	S9999		

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

R7's Physician Progress Note dated 11/6/14 documents a diagnosis of "Severe dementia, Alzheimer's type.....continues just to wander pretty constantly...."

6. R1's Interdisciplinary Note dated 12/4/14 at 6:54pm by E15, RN states "....Continues to go after female resident...difficult to redirect.....15 minute checks...continue to monitor." R1's note at 8:45pm states "[R1] continues to make sexual advances toward female staff and residents. Grabbing at females inappropriately, attempting to undress female residents....difficult to redirect....15 minute checks ongoing..."

On 1/1/15 at 4:00pm E7, CNA stated, "I walked into [R1's] room and [R1] was sitting in the recliner chair and [R2] was sitting on him-straddling his legs. [R1] had his hand around [R2's] bottom and his other hand was on [R2's] breast. [R1] had her[R2] onsie unzipped and fully off of her to the waist....I reported to a nurse but don't remember who it was.."

On 1/6/15 at 1:45pm E1, DON stated, "Reported to me on 12/4/14. I told [E15] to monitor him-and then told [E2,ADON] on 12/5/14. Anytime there was an incident [with R1] the nurse's would do 1:1's until he[R2] was settled down in room, once the other residents were settled and not wandering in his room, he would sleep all night."

The undated investigation titled "[R1] and [R2]" states, "12/4/14 Staff found a female resident in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 59	S9999		

male resident's room. She was sitting on his lap and he was fondling her breast when staff entered room. Staff quickly separated the residents and redirected the female resident to the common area....."

On 1/6/15 at 9:35am E2, ADON stated she started the investigation of the incident 12/4/14) on 12/5/14. E2 stated the investigation consisted of interviewing E15. E2 confirmed no other staff were interviewed. E2 stated R1 was on 15 minute checks, the door sensor alarm and they were doing "visual checks when out of the room-not 1:1's-just eyeballing him."

On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14.

7. On 1/7/15 at 3:20pm E7, CNA stated, "I found [R2] in [R1's] room again, [R1] had [R2] with her back to him-was getting ready to unzip [her onsie], but it[zipper] was missing the tongue, so he[R1] was having trouble [unzipping onsie]." E7 stated R1 was on 15 minute checks and the sensor door alarm was being used at the time of the witnessed incident, but she is unable to remember the specific date it occurred. E7 stated she reported the incident to E21, RN.

On 1/6/15 at 2:20pm E21, RN stated it was reported to me that "[R2] was found in his[R1] room-he was trying to pull [R2's] zipper down and staff intervened. I did not report this to anyone because nothing happened."

On 1/6/15 at 1:45pm E1, DON confirmed she was not aware of the incident involving R2 and R1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 60 On 1/5/14 at 12:45pm E18, Administrator stated the he was not aware of any incidents involving R1 being sexually inappropriate with female residents, except the incident on 12/1/14. 8. On 1/1/15 at 5:00pm E16, CNA stated, " [R2] was wandering-he[R1] tried to grab her breast and I intervened first....it was after a 15 minute check was done-Did not take it to [E1, DON] or [E2 ADON]-I'm sure they are aware-have not talked to them personally." On 1/5/15 at 11:20am E8, RN stated, "Spoke with CNA[E16]- [E16] had just left [R1's] room from doing 15 minute check- told me they were called into [R1's] room, [R1] was on knees, [R2] was dressed sitting on bed. [R2's] top was down or up-can't remember-[R2] sitting back on the bed-not sure if there was any touch or not...." E8 stated the whole incident from the time E16 did the 15 minute check on R1 to when "I checked [R1] was 6 minutes." E8 stated she called E1, DON to report what happened. E8 stated E1 told her she would check into the incident, "[E1] said to hold off on documenting, told me to wait [she] would check into what happened. [I] asked how to document, [E1] said to wait and [E1] will investigate-I was never called." E8 confirmed she never documented the incident which occurred between R1 and R2. E8 stated the incident occurred on a weekend, during suppertime, but she was not sure of the date. On 1/6/15 at 1:45pm E1, DON stated she was called by E8 on 12/20/14 and told what happened between R2 and R1. E1 stated she told E8 "we would look into it on Monday[12/21], to make sure [R1] was 1:1's." E1 denied telling E8 to hold off documenting the incident. E1 stated she told E8 to "just document what happened with [R2] and	S9999		

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
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 61 [E8] said if [I] needed anything else to call her on Monday." The undated investigation titled "[R2] and [R1]" by E2, ADON states, "12/20/14 Staff notified by a visiting family member across the hall. They stated staff had just been down there. There was a female resident[R2] in his[R1] room...[R2] was sitting on the bed with her top down and [R1] was fondling her breast..Visual checks in place. Alarm on door of male resident[R1]. " The investigation does not document staff/family interviews. On 1/6/15 at 1:25pm E2, ADON stated she became aware of the incident involving R1 and R2, which occurred on 12/20/14, when told about it by E1, DON on 12/22/14. E2 stated she started the investigation on 12/22/14. On 1/5/15 at 1:30pm E2 stated 15 minute checks, visual checks when out of the room and sensor door alarm continued, with the new intervention being to give the Xanax three times a day to R1. R2's Physician Progress Note dated 11/19/14 documents a diagnosis of Advanced Dementia. The MDS dated 10/26/14 documents moderate cognitive impairment and behaviors of wandering 4-6 days per week. On 1/5/15 at 12:45pm E18, Administrator stated he was notified by E1, DON around the first of December about R1 being sexually inappropriate with R3 and an investigation was done. E18 stated he instructed E1 if any "further incidents occurred to let him know." E18 stated he was not made aware of any further incidents involving R1 being sexually inappropriate with female residents until 1/1/15. On 1/6/15 at 1:45pm E1, DON confirmed she	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006001	A. BUILDING: _____ B. WING _____	C 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Continued From page 62 notified E18, Administrator of the first allegation involving R1 and R3 on 12/1/14. E1 confirmed she did not notify E18 of any further incidents involving R1 being sexually inappropriate with other residents. When asked why she did not notify E18 of the further incidents involving R1 being sexually inappropriate with R7(12/3/14), R2 (12/4/14) and R2 (12/20/14) E1 stated "they were not abuse, were behaviors, no harm [occurred]." 9. On 1/14/15 at 10:10am E1, DON confirmed she notified the Illinois Department of Public Health of the incident on 12/1/14 involving R1 and R3, but did not notify the Department of allegations of further incidents involving R1 being sexually inappropriate with R7 (12/3/14) , R2 (12/4/14), and R2 (12/20/14). On 1/20/14 at 10:15am E1, DON stated she did not form a suspicion of a crime (Elder Justice Act) and notify law enforcement as stated in the policy for the incidents on 12/1/14, 12/3/14, 12/4/14 or 12/20/14 involving R1 being sexually inappropriate with other residents. (B)	S9999		

Imposed POC
for 300.610a)
300.1210b)
300.1210d)6)
300.1220b)1)2)
300.1220b)6)7)
300.3240a)
300.3240b

MEADOWS MENNONITE HOME
24588 Church Street
Chenoa, Illinois 61726

Investigation of Complaint No. 1465890

Date of Survey: January 21, 2015

ID Prefix Tag No.	Combined Plan of Correction and Allegations of Compliance
	This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is not an admission to the alleged deficiencies, and is submitted at the request of the Illinois Department of Public Health ("IDPH"). Preparation and execution of this combined plan of correction and allegations of compliance does not constitute an admission or agreement by Meadows Mennonite Home ("Meadows" or "facility") as to the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The combined plan of correction and allegations of compliance is prepared and/or executed solely because it is required by the provisions of federal and State laws. Meadows submits that it was in substantial compliance with the certification requirements at the time of the survey.
F224 483.13(c)	Meadows must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **Regarding R1, R2, R3, R6, and R7:** R1 was transferred from the facility on January 1, 2015. The facility determined that it could no longer meet his needs.

Completion date: January 1, 2015

R2, R3, R6, and R7 have been closely monitored and assessed on an ongoing basis for any adverse results of the alleged events, including changes in mood, affect, and demeanor since November 17, 2014. No changes in mood, affect, and demeanor have been noted as of February 3, 2015. Care plans have been reviewed and revised relative to outcome of safety reassessments, redirection of wandering residents to common areas, and activity reassessments.

The Life Enrichment (activities) Program has been reassessed for effectiveness for these residents.

Completion date: February 16, 2015

Training of all staff regarding effective supervision of residents initiated on January 1, 2015 (see attached).

Completion date: February 16, 2015

On January 6, 2015, every 24-Hour Report Sheet for the previous six weeks was reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour Report Sheets.

Completion date: January 7, 2015

As imposed by IDPH's January 30, 2015 notice, a directed in-service was also presented (see attached), and the following areas were covered:

Supervision:

- How to determine an appropriate level of supervision to prevent resident-on-resident

Attachment B
Imposed Plan of Correction

abuse;

- How to implement an appropriate level of supervision when the potential for resident-on-resident abuse has been identified; and
- How to implement an appropriate level of supervision when resident-on-resident abuse has been identified.

Completion date: February 10, 2015

A directed in-service was also presented (see attached), and the following areas were covered:

Abuse:

- What is abuse and how to recognize abuse;
- How to evaluate who is vulnerable to abuse;
- Effective interventions to prevent abuse;
- How to respond to abuse and allegations of abuse; and
- How to report allegations of alleged abuse.

Completion date: February 10, 2014

Regarding Other Residents Potentially Affected by the Alleged Practice:

Every 24-Hour Report Sheet for the previous six weeks was reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour Report Sheets.

Completion date: January 7, 2015

Residents were assessed to determine their risk for potential abuse. Results were documented in their medical records and incorporated into their care plans.

A directed in-service was also presented, and the following areas were covered:

Supervision:

- How to determine an appropriate level of supervision to prevent resident-on-resident abuse;
- How to implement an appropriate level of supervision when the potential for resident-on-resident abuse has been identified; and
- How to implement an appropriate level of supervision when resident-on-resident abuse has been identified.

Completion date: February 10, 2015

A directed in-service was also presented, and the following areas were covered:

Abuse:

- What is abuse and how to recognize abuse;
- How to evaluate who is vulnerable to abuse;
- Effective interventions to prevent abuse;
- How to respond to abuse and allegations of abuse; and
- How to report allegations of suspected abuse.

Completion date: February 10, 2015

Systems Modifications:

Meadows has reviewed and revised its policies and procedures (see attached) including, but not limited to:

The Supervision of Residents with Behaviors Policy was written as of February 3, 2015. In-servicing of all staff is completed.

Completion date: February 16, 2015

The Abuse Prevention Policy was reviewed and revised. Training of all staff was conducted on the Abuse Prevention Policy including recognizing, reporting, and documenting suspected abuse.

Completion date: January 7, 2015

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident movement on hallways with documentation every 30 minutes. The Neighborhood monitors were educated on supervising residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. The results of this monitoring will be reviewed and quantified for follow-through compliance. The results will be reported to the Quality Assurance ("QA") Committee.

The Resident-to-Resident Altercation Policy was developed and implemented (see attached), and all staff in-servicing completed.

Completion date: February 16, 2015

The Admission to the Health Center Policy was revised (see attached) to include all new residents placed on 15- minute checks for the first two days of residency. If no behaviors are noted, then monitoring returns to routine. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. In-servicing of all staff has been completed.

Completion date: February 16, 2015

The Admissions Policy also includes pre-screening potential residents for medical and behavioral history to be included in the initial care planning process.

Completion date: February 5, 2015

Residents were assessed to determine their risk for abuse. Results were documented in their medical record. The assessment was incorporated into the routine admission/readmission process and will be reviewed/updated at a minimum of quarterly and or upon a relevant significant change in resident's condition.

Completion date: January 7, 2015

Training was initiated on January 1, 2015 on recognizing, reporting, and documenting unusual occurrences. The Incident Reporting Policy was written and all in-servicing completed.

Completion date: February 16, 2015

Documentation in-service for all nursing staff was provided.

Completion date: February 16, 2015

A Wandering Policy was developed and implemented with all staff in-servicing completed.

Completion date: February 16, 2015

A new Wandering and Elopement assessment form (see attached) was developed and uploaded to our electronic medical record.

Completion date: February 5, 2015

The effectiveness of the Life Enrichment Program will be re-evaluated, and any changes deemed necessary or appropriate will be implemented.

Completion date: February 16, 2015

The Administrator, Director of Nursing ("DON"), department heads, supervisory personnel, unit nurses, etc. will reasonably ensure compliance with facility policies/procedures through routine daily rounds, observation of resident-specific care plan intervention implementation, supervision of staff performance, and routine inspection of related documents.

Attachment B
Imposed Plan of Correction

Quality Assurance Monitoring Activities:

Random interviews of staff on all shifts and from all departments will be conducted regarding recognition of abuse, how to report, and who to report to weekly for eight weeks, and then monthly for four months. The results of the random checks will be quantified and a performance improvement study initiated with results reported to the QA Committee.

Observational audits of Neighborhood monitor process and record audits of related documentation will be conducted weekly for four weeks, and then biweekly for eight weeks. Audit results will be reviewed by the QA Committee for evaluation of trends/patterns and corrective actions implemented as indicated.

Audits of any alleged abuse investigation will be conducted weekly for eight weeks, and then monthly for four months regarding compliance with abuse investigation protocol. Any results outside compliance with the abuse investigation protocol will be remediated immediately and the appropriate steps taken. The results of the QA study will be reported to the QA Committee.

In addition, any alleged abuse investigation will be evaluated regarding the accuracy of the abuse determination (see above audit frequency). Any results determined to be inaccurate during the QA study will be remediated immediately, and the appropriate steps taken. The results will be reported to the QA Committee.

A chart auditing procedure was implemented with

results quantified and a performance improvement study initiated with results reported to the QA Committee monthly. Any deficient results will be followed up on and action taken as appropriate.

All incidents are and will continue to be tracked and trended monthly for resident, day of the week, shift, time of shift, injury, reportable injury to IDPH, and repeat occurrences. Identified trends will be reported as soon as identified to the DON and Neighborhood Supervisor for immediate remediation. The monthly trending report will be reported to the QA Committee and quarterly to the Board of Directors.

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident movement on hallways with documentation every 30 minutes. The Neighborhood monitors were provided with education on supervision of residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. The results of this monitoring will be reviewed and quantified for follow through compliance. The results will be reported to the QA Committee.

Total Completion Date: February 16, 2015

F 224 accepted

Attachment B
Imposed Plan of Correction

ID Prefix Tag No.	Combined Plan of Correction and Allegations of Compliance
F225 483.13(c)(1)-(4) Imposed POC for 300.610a) 300.690 300.1220b)6) 300.3240b) 300.3240d)	Meadows must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. Meadows must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to IDPH). Meadows must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the Administrator or his designated representative and to other officials in accordance with State law (including to IDPH) within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. **Regarding R1, R2, R3, R6, and R7:** R1 was transferred from the facility on January 1, 2015. The facility determined that it could no longer meet his needs.

Attachment B
Imposed Plan of Correction

Completion date: January 1, 2015

R2, R3, R6, and R7 have been closely monitored and assessed on an ongoing basis for any adverse results of alleged events, including changes in mood, affect, and demeanor since November 17, 2014. No changes in mood, affect, and demeanor have been noted as of February 3, 2015. Care plans have been reviewed and revised relative to outcome of safety reassessments, redirection of wandering residents to common areas, and activity reassessments.

The Life Enrichment (activities) Program has been reassessed for effectiveness for these residents.

Completion date: February 16, 2015

Training of all staff regarding effective supervision of residents initiated on January 1, 2015 (see attached).

Completion date: February 16, 2015

On January 6, 2015, every 24-Hour Report Sheet for the previous six weeks has been reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour Report Sheets.

Completion date: January 7, 2015

As imposed by IDPH's January 30, 2015 notice, a directed in-service was also presented (see attached), and the following areas were covered:

Supervision:

- How to determine an appropriate level of supervision to prevent resident-on-resident

abuse;

- How to implement an appropriate level of supervision when the potential for resident-on-resident abuse has been identified; and
- How to implement an appropriate level of supervision when resident-on-resident abuse has been identified.

Completion date: February 10, 2015

A directed in-service was also presented (see attached), and the following areas were covered:

Abuse:

- What is abuse and how to recognize abuse;
- How to evaluate who is vulnerable to abuse;
- Effective interventions to prevent abuse;
- How to respond to abuse and allegations of abuse; and
- How to report allegations of suspected abuse.

Completion date: February 10, 2014

Regarding Other Residents Potentially Affected by the Alleged Practice:

Every 24-Hour Report Sheet for the previous six weeks was reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour Report Sheets.

Completion date: January 7, 2015

Residents were assessed to determine their risk for potential abuse. Results were documented in their medical records and incorporated into their care plans.

Completion date: February 10, 2015

Systems Modifications:

Meadows has reviewed and revised its policies and procedures (see attached) including, but not limited to:

The Supervision of Residents with Behaviors Policy was written as of February 3, 2015. In-servicing of all staff is completed.

Completion date: February 16, 2015

The Abuse Prevention Policy was reviewed and revised. Training of all staff was conducted on the Abuse Prevention Policy including recognizing, reporting, and documenting suspected abuse.

Completion date: January 7, 2015

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident movement on hallways with documentation every 30 minutes. The Neighborhood monitors were educated on supervising residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. The

results of this monitoring will be reviewed and quantified for follow-through compliance. The results will be reported to the QA Committee.

The Resident-to-Resident Altercation Policy was developed and implemented (see attached), and all staff in-servicing completed.

Completion date: February 16, 2015

The Admission to the Health Center Policy was revised (see attached) to include all new residents placed on 15- minute checks for the first two days of residency. If no behaviors are noted, then monitoring returns to routine. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. In-servicing of all staff has been completed.

Completion date: February 16, 2015

The Admissions Policy also includes pre-screening potential residents for medical and behavioral history to be included in the initial care planning process.

Completion date: February 5, 2015

Residents were assessed to determine their risk for abuse. Results were documented in their medical record. The assessment was incorporated into the routine admission/readmission process and will be reviewed/updated at a minimum of quarterly and or

upon a relevant significant change in resident's condition.

Completion date: January 7, 2015

Training was initiated on January 1, 2015 on recognizing, reporting, and documenting unusual occurrences. The Incident Reporting Policy was written and all in-servicing completed.

Completion date: February 16, 2015

Documentation in-service for all nursing staff was provided.

Completion date: February 16, 2015

A Wandering Policy was developed and implemented with all staff in-servicing completed.

Completion date: February 16, 2015

A new Wandering and Elopement assessment (see attached) form was developed and uploaded to our electronic medical record.

Completion date: February 5, 2015

The effectiveness of the Life Enrichment Program will be re-evaluated, and any changes deemed necessary or appropriate will be implemented.

Completion date: February 16, 2015

The Administrator, DON, department heads, supervisory personnel, unit nurses, etc. will reasonably ensure compliance with facility policies/procedures through routine daily rounds, observation of resident-specific care plan intervention implementation, supervision of staff

performance, and routine inspection of related documents.

Quality Assurance Monitoring Activities:

Random interviews of staff on all shifts and from all departments will be conducted regarding recognition of abuse, how to report, and who to report to weekly for eight weeks, and then monthly for four months. The results of the random checks will be quantified and a performance improvement study initiated with results reported to the QA Committee.

Observational audits of Neighborhood monitor process and record audits of related documentation will be conducted weekly for four weeks, and then biweekly for eight weeks. Audit results will be reviewed by the QA Committee for evaluation of trends/patterns and corrective actions implemented as indicated.

Audits of any alleged abuse investigation will be conducted weekly for eight weeks, and then monthly for four months regarding compliance with abuse investigation protocol. Any results outside compliance with the abuse investigation protocol will be remediated immediately and the appropriate steps taken. The results of the QA study will be reported to the QA Committee.

In addition, any alleged abuse investigation will be evaluated regarding the accuracy of the abuse determination (see above audit frequency). Any results determined to be inaccurate during the QA study will be remediated immediately, and the appropriate steps taken. The results will be reported to the QA Committee.

A chart auditing procedure was implemented with results quantified and a performance improvement study initiated with results reported to the QA Committee monthly. Any deficient results will be followed up on and action taken as appropriate.

All incidents are and will continue to be tracked and trended monthly for resident, day of the week, shift, time of shift, injury, reportable injury to IDPH, and repeat occurrences. Identified trends will be reported as soon as identified to the DON and Neighborhood Supervisor for immediate remediation. The monthly trending report will be reported to the QA Committee and quarterly to the Board of Directors.

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident movement on hallways with documentation every 30 minutes. The Neighborhood monitors were provided with education on supervision of residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. The results of this monitoring will be reviewed and quantified for follow through compliance. The results will be reported to the QA Committee.

Total Completion Date: February 16, 2015

F 225

Accepted

ID Prefix Tag No.	Combined Plan of Correction and Allegations of Compliance
F323 483.25(h) Imposed POC for 300.690a) 300.1210b) 300.1210d)6) 300.1220b)1)2)3) 300.1220b)7) 300.3240a)	Meadows must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Regarding R1, R2, R3, R6, and R7:** R1 was transferred from the facility on January 1, 2015. The facility determined that it could no longer meet his needs. Completion date: January 1, 2015 R2, R3, R6, and R7 have been closely monitored and assessed on an ongoing basis for any adverse results of alleged events, including changes in mood, affect, and demeanor since November 17, 2014. No changes in mood, affect, and demeanor have been noted as of February 3, 2015. Care plans have been reviewed and revised relative to outcome of safety reassessments, redirection of wandering residents to common areas, and activity reassessments. The Life Enrichment (activities) Program has been reassessed for effectiveness for these residents. Completion date: February 16, 2015 Training of all staff regarding effective supervision of residents initiated on January 1, 2015 (see attached). Completion date: February 16, 2015 On January 6, 2015, every 24-Hour Report Sheet for the previous six weeks has been reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour

Attachment B
Imposed Plan of Correction

Report Sheets.

Completion date: January 7, 2015

As imposed by IDPH's January 30, 2015 notice, a directed in-service was also presented (see attached), and the following areas were covered:

Supervision:

- How to determine an appropriate level of supervision to prevent resident-on-resident abuse;
- How to implement an appropriate level of supervision when the potential for resident-on-resident abuse has been identified; and
- How to implement an appropriate level of supervision when resident-on-resident abuse has been identified.

Completion date: February 10, 2015

A directed in-service was also presented (see attached), and the following areas were covered:

Abuse:

- What is abuse and how to recognize abuse;
- How to evaluate who is vulnerable to abuse;
- Effective interventions to prevent abuse;
- How to respond to abuse and allegations of abuse; and
- How to report allegations of suspected abuse.

Completion date: February 10, 2014

Regarding Other Residents Potentially Affected by the Alleged Practice:

Every 24-Hour Report Sheet for the previous six weeks was reviewed for any resident-to-resident incidents or altercations. No new incidents have been noted on the 24-Hour Report Sheets.

Completion date: January 7, 2015

Residents were assessed to determine their risk for potential abuse. Results were documented in their medical records and incorporated into their care plans.

Completion date: February 10, 2015

Systems Modifications:

Meadows has reviewed and revised its policies and procedures (see attached) including, but not limited to:

The Supervision of Residents with Behaviors Policy was written as of February 3, 2015. In-servicing of all staff is completed.

Completion date: February 16, 2015

The Abuse Prevention Policy was reviewed and revised. Training of all staff was conducted on the Abuse Prevention Policy including recognizing, reporting, and documenting suspected abuse.

Completion date: January 7, 2015

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident

movement on hallways with documentation every 30 minutes. The Neighborhood monitors were educated on supervising residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. The results of this monitoring will be reviewed and quantified for follow-through compliance. The results will be reported to the QA Committee.

The Resident-to-Resident Altercation Policy was developed and implemented (see attached), and all staff in-servicing completed.

Completion date: February 16, 2015

The Admission to the Health Center Policy was revised (see attached) to include all new residents placed on 15- minute checks for the first two days of residency. If no behaviors are noted, then monitoring returns to routine. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors, and the care plan will be updated. The resident may, at the discretion of the attending physician, be referred for psychiatric consult. In-servicing of all staff has been completed.

Attachment B
Imposed Plan of Correction

Completion date: February 16, 2015

The Admissions Policy also includes pre-screening potential residents for medical and behavioral history to be included in the initial care planning process.

Completion date: February 5, 2015

Residents were assessed to determine their risk for abuse. Results were documented in their medical record. The assessment was incorporated into the routine admission/readmission process and will be reviewed/updated at a minimum of quarterly and or upon a relevant significant change in resident's condition.

Completion date: January 7, 2015

Training was initiated on January 1, 2015 on recognizing, reporting, and documenting unusual occurrences. The Incident Reporting Policy was written and all in-servicing completed.

Completion date: February 16, 2015

Documentation in-service for all nursing staff was provided.

Completion date: February 16, 2015

A Wandering Policy was developed and implemented with all staff in-servicing completed.

Completion date: February 16, 2015

A new Wandering and Elopement assessment (see attached) form was developed and uploaded to our electronic medical record.

Completion date: February 5, 2015

The effectiveness of the Life Enrichment Program

will be re-evaluated, and any changes deemed necessary or appropriate will be implemented.

Completion date: February 16, 2015

The Administrator, DON, department heads, supervisory personnel, unit nurses, etc. will reasonably ensure compliance with facility policies/procedures through routine daily rounds, observation of resident-specific care plan intervention implementation, supervision of staff performance, and routine inspection of related documents.

Quality Assurance Monitoring Activities:

Random interviews of staff on all shifts and from all departments will be conducted regarding recognition of abuse, how to report, and who to report to weekly for eight weeks, and then monthly for four months. The results of the random checks will be quantified and a performance improvement study initiated with results reported to the QA Committee.

Observational audits of Neighborhood monitor process and record audits of related documentation will be conducted weekly for four weeks, and then biweekly for eight weeks. Audit results will be reviewed by the QA Committee for evaluation of trends/patterns and corrective actions implemented as indicated.

Audits of any alleged abuse investigation will be conducted weekly for eight weeks, and then monthly for four months regarding compliance with abuse investigation protocol. Any results outside compliance with the abuse investigation protocol will be remediated immediately and the appropriate

steps taken. The results of the QA study will be reported to the QA Committee.

In addition, any alleged abuse investigation will be evaluated regarding the accuracy of the abuse determination (see above audit frequency). Any results determined to be inaccurate during the QA study will be remediated immediately, and the appropriate steps taken. The results will be reported to the QA Committee.

A chart auditing procedure was implemented with results quantified and a performance improvement study initiated with results reported to the QA Committee monthly. Any deficient results will be followed up on and action taken as appropriate.

All incidents are and will continue to be tracked and trended monthly for resident, day of the week, shift, time of shift, injury, reportable injury to IDPH, and repeat occurrences. Identified trends will be reported as soon as identified to the DON and Neighborhood Supervisor for immediate remediation. The monthly trending report will be reported to the QA Committee and quarterly to the Board of Directors.

As of 7:00 p.m. on January 6, 2015, Neighborhood monitors were implemented to monitor resident movement on hallways with documentation every 30 minutes. The Neighborhood monitors were provided with education on supervision of residents. If behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors and the care plan will be updated. The resident may, at the discretion of the

attending physician, be referred for psychiatric consult. The results of this monitoring will be reviewed and quantified for follow through compliance. The results will be reported to the QA Committee.

Total Completion Date: February 16, 2015

F323

accepted

Attachment B
Imposed Plan of Correction

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Meadows Mennonite Home

DATE AND TYPE OF SURVEY: Complaint 1465890/IL74031 conducted January 21, 2015

300.1210a)
300.1210d)6)
300.3240f)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis.

6) All necessary precautions shall be taken to assure that the residents' environment remains free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-tem care facility, is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

This will be accomplished by:

I. All residents will be assessed to determine risk for potential abuse and results will be incorporated into individual care plans. All residents will be assessed for abusive behaviors. If abusive behaviors are noted, interventions will be implemented until the resident no longer exhibits the behavior and/or the appropriateness of the admission can be reviewed for safety to the resident and the safety of others. The physician and family will be notified of the behaviors and the care plan will be updated. All incidents involving resident to resident abuse will be investigated and appropriate actions taken. These actions will include, but are not limited to, the notification of all required entities; a thorough assessment of each involved resident's condition, therapy, placement, and safety measures; and the safety of other residents of the facility.

II. All policies and procedures related to resident to resident abuse will be evaluated and revised as needed to ensure compliance with Illinois Skilled Nursing and Intermediate Care Facilities Code.

III. All staff will be in-serviced on policies and procedures pertaining to resident to resident abuse. The in-services will include all staff and will cover, at a minimum, how to recognize resident to resident abuse, how to assess who is at risk for resident to resident abuse, effective interventions to prevent abuse, how to determinate and implement appropriate level of supervision when the potential for resident to resident abuse has been identified, and what to do when resident to resident abuse occurs, including reporting requirements.

IV. Documentation of in-service training, assessments, investigations, policy and procedure review, and related follow up actions will be maintained by the facility.

V. The Administrator and QA committee will monitor items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 20 days of this notice.

MeadowsMennonite POC/lo/3/5/2015

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Imposed Plan of Correction