STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS Complaint 1697411/ IL90798	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by:	Z9999	Attachment A Statement of Licensure Violations	

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Based on interview and record review, the facility failed to implement their policy to prevent neglect and the facility failed to ensure the QIDP effectively coordinated services,and supports to safeguard are in place for 1 client (R1) with a history of falls. The facility documented R1 sustained 22 falls in the past year, R1's injuries include; a Fractured Wrist, Hematoma, Head Injury, Bruised Rib and a Laceration.

Findings include:

The facility's undated policy titled, "Resident Abuse / Neglect" was reviewed and includes the following:
"Policy Statement: Resident abuse or punishment (physical, verbal, sexual, or psychological) and / or neglect by facility staff, another resident, family, or a visitor will not be tolerated at Meadows. Prevention will be the focus in an effort to avoid any such incident.
Definition of Abuse / Neglect: ...
Neglect - failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a Resident's physical or mental condition. Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results in physical injury to a Resident or in the deterioration of a Resident's physical or mental condition. This shall include any allegations where:
- The alleged failure causing injury or deterioration is ongoing or repetitious or
- A Resident required medical treatment as a result of the alleged failure or
- The failure is alleged to have caused a noticeable negative impact on a Residents health,

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behavior or activities for 24 hours. ... "

R1, per review of her January 2017 POS (Physician's Order Sheet) is a 70 year old female whose diagnoses include Profound ID (Intellectual Disability) and Down Syndrome.

Facility Incident Reports for R1 for the past year (January 2016 thru December 2016) were reviewed and include the following:

1. 1/14/16 5:40pm - R1 was trying to enter another resident's bedroom and the other resident closed the door and R1 fell. R1 was assessed by nursing and no injuries were noted.
2. 1/24/16 7:50am - R1 was found sitting on the floor outside another resident's bedroom. The facility identified that R1 was leaning against another resident's bedroom door when the other resident opened the door. R1 fell backwards, landed on her buttocks and rolled onto her back. R1 was assessed by nursing and no injuries were noted.
3. 2/28/16 4:50pm - Staff went to assist R1 to the dining room and tried to hold R1's left hand. R1 pulled her hand away and was crying. Nursing assessed R1 and noted swelling to forearm, area warm to touch and R1 acted very uncomfortable when area was palpated. The physician was notified and an X-Ray was ordered. X-Ray results revealed soft tissue swelling with an Incomplete Fracture of Radial Styloid Left Wrist. On 3/1/16 R1 received a long arm cast to her left arm.
The facility concluded (based on review of video footage) that on 2/28/16 at 1318 it appeared that R1 entered another resident's bedroom and was pushed out of the bedroom.
4. 3/14/16 0530 - R1 was found sitting on her buttocks in the dining room. The facility identified (based on review of video footage) that R1 was

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walking from the dining room to the living room when she fell. R1 was assessed by nursing and no injuries were noted.

5. 3/21/16 11:55am - R1 was found laying on the floor on her right side. The facility identified (based on review of video footage) that R1 entered another resident's bedroom and was pushed out of the bedroom. R1 fell to the floor. R1 was assessed by nursing and no injuries were noted.

6. 3/21/16 5:40am - R1 was found sitting on her buttocks in the hallway. The facility identified (based on review of video footage) that R1 was fell in the hallway. R1 was assessed by nursing and no injuries were noted.

7. 4/3/16 9:30am - R1 was found sitting on her buttocks. The facility identified (based on review of video footage) that R1 was standing by an Activity table when she lost her balance and fell. Another resident notified staff that R1 fell. R1 was assessed by nursing and no injuries were noted.

8 and 9. 5/2/16 7:30am and 8:30am (2 falls) - At 0730 R1 was found in a seated position on the floor. No injuries were noted. At 8:30am R1 was found in a seated position on the floor, a bump (with discoloration) to the middle of forehead was noted. The facility identified (based on review of video footage) that at 7:15am R1 was ambulating in the Activity Room. R1 stumbled backwards and fell. Approximately 1/2 hour later R1 was sleeping in the Activity Room in a chair without arms. R1 fell to the right landing on her right side hitting her head /face on the floor.

10. 5/2/16 3:45pm - Nursing staff were notified, by another resident, that R1 had fallen. The facility identified (based on video footage) that R1 was in the Activity Room when she fell. The facility noted that R1 was standing holding onto a chair, R1 bent forward and it appeared as if she

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was sleeping. R1 fell backwards to her buttocks and then to her right side. R1 was assessed by nursing and no new injuries were noted.
R1's nursing notes were reviewed and on 5/2/16 R1 was sent to the Emergency Room due to multiple falls in less than 12 hours.
11. 5/27/16 4:50am - Staff heard a "thump" sound and observed R1 on the floor. The facility identified (based on video footage) that R 1 was ambulating in the hallway and she fell forward. Nursing assessed R1 and noted a scrape to R1's left knee.
12. 6/11/16 8:10pm - Nursing was paged to the dining room to assess R1 who was found sitting on the floor. The facility identified (based on review of video footage) that R1 fell after being pushed by another resident. R1 was assessed by nursing and no injury was noted.
13. 7/12/16 5:15pm - Staff documented that after dinner she heard a "loud thud" and witnessed R1 hit the floor on her back side. R1 fell on her backside and her legs flew up. R1 was assessed by nursing and no injuries were noted.
14. 8/3/16 6:25pm - R1 was found sitting on the floor in the hallway. The facility identified (based on review of video footage) that R1 was ambulating in the hallway when she fell to her knees and then sat on her buttocks. R1 was assessed by nursing and no injuries were noted.
15. 8/8/16 5:00pm - Staff observed R1 standing in the dining room when she fell backwards landing on her buttocks. R1 was assessed by nursing and no injuries were noted.
16. 8/10/16 3:25pm - R1 was found sitting on the floor ain another resident's bedroom. The facility identified (based on review of video footage) that R1 lost her balance and fell to her buttocks. R1 was assessed by nursing and no injuries were noted.
17. 9/15/16 3:30pm - R1 was entering another

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resident's bedroom when she missed a step and fell on her buttocks. R1 was assessed by nursing and no injuries were noted.

18. 9/23/16 4:50pm - R1 was walking with staff to the dining room when R1 let go of staff's hand and fell. R1 was assessed by nursing and no injuries were noted.

19. 11/8/16 8:15pm - R1 was found in a seated position on the floor at the foot of her bed. The facility concluded that R1 lost her balance and fell while ambulating in her bedroom. R1 was assessed by nursing and no injuries were noted.

20. 11/29/16 8:50pm - R1 was found on the floor in a supine position. The facility identified that nursing staff went into R1's bedroom and found R1 on the floor leaning up against her dresser. The facility noted that it appears as if R1 lost her balance and fell backwards against her dresser. R1 was assessed by nursing and noted with Erythema to her right shoulder blade.

21. 12/2/16 12:15pm - Facility received call from R1's Day Training program stating that R1 fell forward hitting her head and nose. Facility advised to send R1 to the Emergency Room. The facility noted that R1 returned from the hospital with a diagnosis of head injury and bruised rib. An abrasion was also noted to R1's head.

22. 12/20/16 5:25am - On 12/2016 at approximately 5:25am 911 was called and R1 was sent to the Emergency Department for further evaluation due to having a fall. R1 rolled out of bed while getting up in the morning and landed on her left side and having an injury to her head. R1 returned from the hospital with a diagnosis of Head Injury and Abrasion. Nursing staff documented that upon assessment R1 had a Laceration on Left Eyebrow and a Hematoma.

R1 was observed on 1/5/17 at 11:55am in the

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dining room of the facility. R1 was seated in a wheelchair. R1 was observed to have discoloration to her forehead and around both eyes. R1 was observed to have a bandage to her chin. R1 also had discoloration to her left cheek.
R1 was again observed on 1/6/17 at 11:02am. R1 was seated in a wheelchair. R1 was noted to have a scabbed abrasion to the left side of her chin. R1 also had discoloration to the left side of her face, forehead and around her eyes. R1 had a scabbed area on her left thumb and left pointer finger.

R1's nursing notes were reviewed. On 5/2/16, E4 (Nurse) documented that R1's physician was notified that R1 had 2 falls in the morning (7:30am and 8:30am). R1's physician called back and "ordered to monitor closely, will continue with neuro checks."
E4 documented, on 5/2/16 at 1700 that R1's physician was again contacted after R1 fell a 3rd time (at 3:45pm). R1's physician ordered R1 to be sent to the Emergency Room due to multiple falls in less than 12 hours.
R1 went to the Emergency Room and returned with a sling on her right arm. On 5/3/16 at 1450 the facility received X-Ray results that noted an impression of Humeral Head Neck Fracture of uncertain age.
R1 went to see an orthopedist on 5/4/16 and it was noted that there is no fracture, however, R1 had Osteoarthritis of Right Shoulder.
Nursing documented that on 5/11/16 R1 was seen by the physician. R1's physician ordered a PT (Physical Therapy) evaluation due to R1's difficulty walking after falls. On 5/18/16 R1's physician ordered a wheelchair as needed for R1 due to being unsteady.

R1's Physician progress notes were reviewed.

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Z9999	Continued From page 7 On 5/11/16 R1's Physician documented - "Pt (patient) has had difficulty walking lately. She is currently in wheelchair. She fell 3x last week. ... Gait abnormality - PT (Physical Therapy) eval and tx (treatment)." On 12/7/16 R1's physician documented - "Pt (patient) seen for ER follow up. she has had frequent falls. She is now in wheelchair. ... Gait disorder, PT eval and treatment, wheelchair prn (as needed)." Nursing staff completed a Fall Scale Assessment on 12/22/16, 9/11/16, 6/23/16 and 3/16/16. The Fall Scale Assessment notes if a client's score is greater than 51 then they are identified a "High Risk" for falls. On 12/22/16 R1 scored a 65, on 9/11, 6/23 and 3/16/16 R1 scored a 55. R1 has been identified as a High Risk since March 2016. E3 (DON - Director of Nursing) was interviewed on 1/6/17 at 11:42am. E3 verified that R1 has been identified as a High Risk for falls. E3 was asked what interventions or safeguards has the facility implemented for R1 since she has had 22 falls in the past year and is identified as a High Risk for falls. E3 stated, "We try to do interventions that we can here. Such as removing things from the floor, clean up spills, put the bed in a low position, use adaptive equipment as necessary, use of a call light." E3 was asked if R1's bed was in a low position when she fell out of bed on 12/20/16 resulting in a head injury and abrasions. E3 stated that R1's bed was already in a low position when she fell out of bed on 12/20/16. E2 (RSD - Resident Service Director and QIDP) was interviewed on 1/6/17 at 11:15am. E2 was was asked if any changes or safeguards have	Z9999		

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been implemented for R1 since she has fallen 22 times in the past year and has been assessed as a High Risk for falls.
E2 stated the facility obtained a Physical Therapy Evaluation for R1 on 6/2/16. E2 stated that R1 refused to cooperate with any programming, so the goal was discontinued on 9/16/16.
E2 stated that R1 has been provided with a wheelchair to use as needed.
E2 stated that on 11/30/16 the IDT (Inter Disciplinary Team) held a meeting to discuss R1's falls. The IDT documented R1's history of falls and then noted, "The IDT will continue to monitor falls regarding R1."
E2 stated that since R1 had no injuries from her falls, other than a scraped knee, the IDT did not want to take away any independence from R1.
E2 stated that after R1 fell out of bed on 12/20/16, (and sustained a head injury and abrasions) the facility obtained a hospital bed with side rails for R1.
E2 was interviewed on 1/6/17 at 1:35pm and was asked if staff have been trained on R1's hospital bed and or need for a wheelchair. E2 stated that staff have not been trained on when and how often R1 should be in a wheelchair or on the use of a hospital bed.

R1's 9/8/16 IPP (Individual Program Plan) was reviewed. R1's IPP includes the following:
"(R1) had multiple incidents of falling in May of 2016, but demonstrates ability to walk to (?) assistance. Staff are aware of the issue and supervise her when she is walking."
"PT - R1 is not receiving Physical Therapy at this time and there are no recommendations."
Based on review of the Incident Reports, there is no documentation that staff were supervising R1 when she was walking and fell or was found after a fall.

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E2 (RSD - Resident Services Director and QIDP) was interviewed on 1/6/17 at 11:15am. E2 was asked about R1's supervision level and / or supervision needs. E2 stated that R1 is Supervision Level 2, which means general supervision inside of the facility. E2 stated no specific supervision needs have been identified for R1.

E2 (RSD / QIDP) was interviewed on 1/5/17 at 12:25pm. E2 stated that a PT Eval was completed on 6/2/16. E2 stated that PT was discontinued on 9/16/16 because R1 refused to participate in PT programming. R1's 9/18/16 IPP does not address that R1 was evaluated in June 2016 or that attempts were made for programming for R1 in the area of Physical Therapy.
E2 was interviewed on 1/6/17 at 11:15am. E2 was was asked if any changes or safeguards have been implemented for R1 since she has fallen 22 times in the past year and has been assessed as a High Risk for falls.
E2 stated the facility obtained a Physical Therapy Evaluation for R1 on 6/2/16. However R1 refused to participate in any PT services.
E2 stated that R1 has been provided with a wheelchair to use as needed.
E2 stated that on 11/30/16 the IDT (Inter Disciplinary Team) held a meeting to discuss R1's falls. The IDT documented R1's history of falls and then noted, "The IDT will continue to monitor falls regarding R1."
E2 stated that since R1 had no injuries from her falls, other than a scraped knee, the IDT did not want to take away any independence from R1.
E2 stated that after R1 fell out of bed on 12/20/16,(and sustained a head injury and abrasions) the facility obtained a hospital bed with side rails for R1.

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E2 was interviewed on 1/6/17 at 1:35pm and was asked if staff have been trained on R1's hospital bed and or need for a wheelchair. E2 stated that staff have not been trained on when and how often R1 should be in a wheelchair or on the use of a hospital bed.

R1's History and Physical Examination (H&P) completed by R1's physician on 10/5/16 was reviewed. R1's H&P includes R1's last and current diagnoses (Profound Intellectual Disability, Down Syndrome, Hypothyroidism, Bilateral Small Cataracts, Systolic Murmur, Edema and Hyperkalemia.
R1's H&P notes that R1 is a 70 year old female who was treated in 2006 for foot cellulitis and has a history of dry skin. In 2004 R1 was noted to have a heart murmur and R1 has a history of a perforated left eardrum.
R1's 10/5/16 H&P does not identify that R1 has had 18 falls between January 2016 and 10/5/16 (when her annual History and Physical Exam was completed). One of the falls resulted in a Fractured Wrist and after 3 falls in one day, R1 was ordered to go to the Emergency Room by R1's Physician.

On 1/6/17 at 11:15am E2 stated that, yesterday (1/5/17) the facility met to ensure R1 has a physician order for use of a wheelchair full time as opposed to prn (as needed).
R1's medical record was reviewed on 1/6/17 and there is no documentation that R1's physician was contacted to get an order for a wheelchair for full time use.

E3 (DON - Director of Nursing) was interviewed on 1/6/17 at 11:42am. E3 was asked if R1's physician was contacted regarding R1's need for

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Z9999	Continued From page 11 a wheelchair for full time use. E3 stated that they have not gotten an order from R1's physician for the wheelchair. E3 stated it is on the list of things to get done. E3 stated that staff can ambulate R1 until the order is received. The facility failed to implement their policy to prevent neglect of R1. From January 2016 thru 2/28/16 R1 fell 3 times and was diagnosed with a fractured wrist on 2/29/16. From March 2016 thru May 2016 R1 fell 8 times (3 times on May 2, 2016). R1 was sent to the Emergency Room on 5/2/16 after her 3rd fall in one day. From June 2016 thru December 2016 R1 fell 11 times. R1 went to the Emergency Room on 12/2/16 and was diagnosed with a Head Injury and Bruised Rib. On 12/20/16 R1 went to the Emergency Room and was diagnosed with a Head Injury and Abrasion. The facility failed to implement safeguards to protect R1 and prevent further falls. (B)	Z9999		