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 12/02/2021

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 2198472 / IL140295	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.750b)1) 350.1210 350.1230b) 350.1230d)1) 350.3240a) 350.3240d) 350.3240e) Section 350.750 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following d) Direct care personnel shall be trained in,	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of 1 client (R1) when the facility failed to: 1) Ensure the facility's Governing Body prevented an employee who was terminated from	Z9999		

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Z9999	Continued From page 2 having contact with client's who reside at another facility (owned and operated by the same company) to prevent further potential abuse. 2) Ensure 1 client (R1) is free from abuse after sustaining a left hip fracture after being pushed by staff. 3) Ensure to immediately contact law enforcement authorities (in accordance with State Law) after an allegation of abuse of 1 client (R1) who sustained a left hip fracture. 4) Ensure to thoroughly investigate an injury of unknown origin which led to an allegation of abuse of 1 client (R1) who sustained a Fractured Left Hip. Findings include: On Saturday 11/13/2021, entered facility and requested Incident Reports for review from E2 (QIDP). E2 was interviewed on 11/13/2021 at 1:22pm. E2 was asked to provide a resident roster that identifies current clients residing at the facility. E2 provided a list of clients and explained that R1 is no longer at the facility as he expired on 11/11/2021. E2 was asked about R1 and if he was recently hospitalized. E2 stated there was an incident with R1 that occurred on either 10/7 or 10/8/2021. E2 stated that R1 sustained a fractured left hip after an encounter with staff. E2 stated R1's encounter involved E4 (former Maintenance Supervisor). E2 stated that on 10/7/2021 he noticed R1 was limping. E2 stated an X-Ray was completed and R1 was diagnosed with a left hip fracture. R1 went to the hospital and had surgery.	Z9999		

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Z9999	Continued From page 3 E2 stated that on 10/13/2021 R1 failed a bedside swallow evaluation at the hospital, and he was diagnosed with Aspiration Pneumonia. E2 stated R1 returned to the facility on 10/19/2021 with Palliative Care, per guardian request. E2 stated R1 expired at the facility on 11/11/2021. E2 was asked to provide a copy of the facility's Incident Report and subsequent investigation. E2 stated he did not have access to the report. On 11/15/2021, E1 (Acting Administrator) provided the following Incident Report and investigation: E9 (former nurse) documented via Incident Report - 10/8/2021 time 2225 PM (10:25 PM) - Residents left hip X-Ray result received via fax from (X-Ray Provider) and resident has Impacted TransCervical Fracture of the Left Femoral Neck with Varus Deformity and no significant displacement. E9 documented the Physician was notified and R1 was sent to the hospital for treatment, via ambulance 911. E1 was interviewed on 11/17/2021 at 10:22am and stated E10 (former RSD - Residential Services Director) completed the facility's investigation (Summary of Incident). The facility's "Summary of Incident / Accident Reports and/or Fall Reports" involving R1 was reviewed and includes the following: The Residential Director, Doctor, and Guardian were immediately notified. On October 8, 2021 at approximately 10:25pm, Writer (E10) was notified that R1 was sent to the ED (Emergency Department) for further evaluation of a left hip fracture. An investigation was immediately initiated. On Thursday, October 7, 2021, QIDP (E2)	Z9999		

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Z9999	Continued From page 4	Z9999		

observed R1 sitting in hallway D outside of the activity room making a loud repetitive sound. E2 immediately went to R1's side. R1 stood up and attempted to ambulate towards E2. During ambulation E2 observed R1 limping. E2 immediately informed the nurse (E6).
Writer (E10) spoke with CNA (E3), regarding the incident. E3 informed writer (E10) that he did not witness a fall from R1 but saw him sitting on the ground outside of the laundry room on October 7, 2021 at approximately 1:15pm.
Writer (E10) immediately viewed the camera system. Per the camera footage, Writer (E10) observed R1 enter the laundry room using the dirty side door at approximately 1:16:18pm. At approximately 1:16:18pm, Maintenance Supervisor, (E4) exited his office and entered the laundry room using the dirty side door. At approximately 1:16:39pm, Writer (E10) observed Maintenance Supervisor, (E4): push R1 out of the laundry room It appeared that Maintenance Supervisor, (E4) pushed R1 by the right shoulder. R1 fell on the floor hitting his left hip to the ground.
CNA, (E3) approached R1 at approximately 1:17:35pm. E3 assisted R1 to his feet at approximately 1:18:05pm. E3 informed Writer (E10) that he observed R1 limping.
E3 immediately assisted R1 to a chair that was in the hallway, approximately 19 steps.
E3 immediately notified LPN (E5) of the findings. E5 assessed R1 for injuries and there was no apparent injuries noted. (No documentation in the nursing notes).

Conclusion: QIDP (E2), reported the observed limping to RN, (E6). (E6) failed to assess R1 for injuries, as stated by E6. E6 informed Writer that told (E9) about R1's limping. Writer spoke to E9 regarding the incident. E9 informed Writer that

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Z9999	Continued From page 5 E11 (CNA) stated to her that R1 was limping. This occurred around dinner time. Per the camera footage approximately 5:00pm. E9 (LPN) immediately assessed R1. Camera footage verified that it was approximately 5:06pm R1 was taken to his bedroom via a wheelchair. E9 stated to Writer that there was no discoloration and E9 was able to implement range of motion. During range of motion R1, did not grimace in bed. Writer informed E9 that there was no documentation of the assessment in R1's medical chart. E9 will write her assessment as a late entry. LPN (E8) worked the overnight shift (10/7/2021 - 10/8/2021) and received report from E9. E8 assessed R1 on the morning of October 8, 2021 after his morning medication pass. Noted discomfort when walking, no swelling, bruising, or history of a fall. (Physician) was notified and ordered an X-Ray of bilateral hips to rule out dislocation or fracture. R1's X-Ray results were received on October 8, 2021 at 10:02pm. Findings: examination reveals an Impacted TransCervical Fracture to the Left Femoral Neck with Varus Deformity and no Significant Displacement. Clinical correlation is requested to determine the exact age of this fracture. E9 notified the on-call doctor of the findings per the X-Ray. R1 was sent to the ED (Emergency Department) for further evaluation. On October 9, 2021 at 11:00am, report was received from the guardian. R1 will have a partial hip replacement. R1 will stay at the hospital for approximately 3 days and then will be transferred to a rehab for PT (Physical Therapy). Statements: E4 (Maintenance Supervisor) informed Writer (E10) and E1 (Acting Administrator) that he was in the laundry room laying on the floor as he was working on the sink.	Z9999		

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Z9999	Continued From page 6	Z9999		

He added that R1 came into the laundry room and then exited and the next thing he saw was R1 on the floor. E4 was asked if he saw R1 trip. Which he responded no. E4 was asked if he called the nurse after observing him on the floor. E4 responded that he notified E5 (nurse LPN) of R1 sitting on the floor.
E7 (Laundry Attendant) overheard E4 yelling at someone to "get out", but she did not witness the incident as she was folding clothes.

After finalizing the investigation, Writer informed guardian on the findings via telephone call on October 13, 2021 at approximately 9:45am. E4 was immediately suspended after viewing the camera footage and will be terminated. (reason not documented)
RN (E6) has been suspended for lack of an injury assessment with possible termination of her employment at Meadows. A report will be made to Illinois Financial and Professional Regulations of the investigation.
E5 will be given disciplinary actions for lack of documentation.
E3 will be given disciplinary actions for assisting R1 to his feet after an unwitnessed fall.
E9 will be given disciplinary action for lack of documentation.

The above noted report does not identify a date as to when the report was completed. The report lacks a signature that identifies who completed the report.
E10 (former RSD) was interviewed on 11/19/2021 at 10:29am. E10 verified that she completed the facility's investigation and is the author of the above noted facility investigation.

On 11/17/2021 at 10:50am attempts were made, with E1, to review video camera footage of

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Z9999	Continued From page 7 10/7/2021 when the facility noted R1 was on the floor in Hallway D. The video camera footage could not be viewed as it was no longer accessible. E1 then showed surveyor video footage that she had on her cell phone. This video was observed with E1 present. E1 also provided verbal affirmation as to what was being observed. The video shows R1 entering the laundry room (dirty side door) and then R1 forcefully falling to the floor. E1 stated E4 was already in the laundry room and from previous views of the camera footage R1 was pushed out of the laundry room by E4. E1 affirmed that E4 made physical contact with R1. E10 (former RSD) was interviewed, via a phone call, on 11/19/2021 at 10:29am. E10 stated she was initially informed, via a text, (does not recall the staff who sent the text) on Friday 10/8/2021 that R1 was sent to the hospital for a fractured left hip. Cause of injury was unknown at this time. E10 stated that on Tuesday 10/12/2021 she reviewed the facility's video camera footage, however, she did not find the cause of R1's injury. E10 stated that on Wednesday 10/13/2021, she again reviewed the facility video camera footage and observed E4's arm extending out while forcefully pushing R1. E10 stated that she texted the facility's owners and the owner's family member that E4 needed to be suspended and terminated for abusing R1. E10 was asked if E4's actions towards R1 were abusive. E10 stated, "100% this is abuse." E10 stated she texted the facility owner's Family Member (Z1) about notifying the police. E10 stated Z1 told her this is not abuse. E10 stated Z1 wanted the above noted facility report and investigation changed so there would not be a	Z9999		

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Z9999	Continued From page 8	Z9999		

lawsuit or a fine and possible job loss.
E10 stated Z1 wanted the report to sound better - because she did not think it was an intentional act.
E10 was asked how Z1 knew that E4's actions were not intentional. E10 stated Z1 did not want a lawsuit or fine and had no evidence that E4's actions were not intentional.
E10 stated Z1 wanted the wording "pushed" changed to "removed" and Z1 did edit the facility's investigation into a 2nd report.

On 10/18/2021, Facility owner's Family member (Z1) documented a letter to E4 that identifies his termination. The letter is signed by E4 and Z1 on 10/19/2021. The letter notes the reason for E4's termination as: "As a result of the male resident (R1) sustaining an injury during their interaction with you, Meadows has reached the conclusion that your employment should be terminated effective immediately as a result of the resident's direct injury and your violations of Meadows' protocol and policies."

Review of E4's Individual Timecard and personnel file identifies E4 was suspended from employment on 10/13/2021. E4 was terminated from his employment on 10/19/2021.
E1 was interviewed and asked if E4 worked at any time after he was suspended. E1 stated E4 showed up to work at another facility that is owned by the same people/company that own and operate this facility. E1 identified the other home as a 16 bed ICF/IID facility.
E1 explained E4 went to work at the other facility on 11/6/2021. E1 stated she was informed by a staff member at the facility that E4 had been there on 11/6/2021. E1 was asked if any clients were present when E4 went to the other facility. E1 stated clients were present and the other

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Z9999	Continued From page 9 facility was not informed that E4 was terminated. E1 stated that all staff have since been told to contact the police if E4 shows up at the facility. On 11/18/2021 at approximately 11:20am, E1 (Acting Administrator) provided a 2nd facility investigation as well as a copy of the facility's investigation that was received on 11/15/2021. E1 stated this report was filed at the facility. E1 stated the report notes "... (E4) in an attempt to remove R1 out of the laundry room, E4 made contact with R1's right shoulder." The first investigation notes, "... Writer observed Maintenance Supervisor (E4) push R1 out of the laundry room." E10 (former RSD) was interviewed on 11/19/2021 at 10:29am regarding the different language used on the 2 reports. E10 stated Z1 edited the report. E1 was asked who was responsible for conducting the facility's investigation of R1's left hip fracture. E1 stated E10 conducted the facility's investigation. E1 was asked about the facility's use of the video camera footage. E1 confirmed the facility does use the video camera footage to assist in their investigations. The facility's investigation of R1's injury (Fractured left Hip) was not thoroughly investigated. On 11/15/2021, E1 provided the facility's Incident Report and investigation. On 11/18/2021, E1 provided a 2nd investigation. The facility did not identify why wording was changed, from the first report to the 2nd report that initially noted E4 pushed R1 to E4 attempted to remove R1 from the laundry room. The facility did not provide documentation of all staff interviewed.	Z9999		

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Z9999	Continued From page 10 The facility does not conclude if abuse occurred or that E4 was attempting to remove R1 from the laundry room. There is no statement from E4 that he was attempting to remove R1 from the laundry room. E10 documented E4 informed E10 and E1 he was laying on the floor as he was working on the sink. He (E4) added that R1 came into the laundry room and then exited and the next thing he saw was R1 on the floor. On 11/17/2021 at 10:22am E1 was interviewed. E1 was asked why the facility did not call the police regarding R1. E1 stated, "That's a good question." E1 was again interviewed on 11/18/2021 at 11:20am. E1 wanted to clarify why the facility did not call the police. E1 stated the facility's investigation (2nd report) did not identify that R1 was pushed by E4. The 2nd report identifies E4 had contact with R1. E1 stated this Incident (R1's fracture left hip) was an accident. E1 stated there was no reason to call the police because there was no intent. E1 was asked how she determined E4 did not intentionally push R1 out of the laundry room. E1 stated based on working with E4 for 21 years. E5 (nurse) was interviewed on 11/18/2021 at 9:35am via phone call. E5 was asked about his interaction with R1 on 10/7/2021. E5 stated that he was notified, either by phone call or page, by E3 (Supervisor) that R1 was found on the floor in the hallway by the laundry room. E5 stated this occurred on 10/7/2021 in the afternoon. E5 stated when he arrived in the hallway R1 was seated on a chair. E5 stated he assessed R1 and took his vital signs. E5 said R1 did not appear to be in pain, he had no facial grimacing.	Z9999		

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Z9999	Continued From page 11 E5 stated this was towards the end of his shift so he told E6 (RN nurse) to follow up with R1. E5 was asked if he documented the assessment and vital signs of R1. E5 stated, "I agree I should have." R1's nursing progress notes were reviewed. The following is noted: - On 10/8/2021 (no time documented) E8 (LPN - Nurse Manager) documented, (Resident R1) noted with discomfort when walking, no swelling, bruising or history of fall. (Physician) notified and ordered X-Ray both hips to rule out dislocation or fracture. Vitals were also documented. - On 10/8/2021 2225 (10:25 PM) E9 (LPN) documented, Resident's hip X-Ray results received via fax from (Medical company). Exam reveals R1 has an Impacted TransCervical Fracture on the Left Femoral Neck with Varus Deformity and no Significant Displacement. R1 sent to local hospital ER per doctor. E8 (Nurse Manager) was interviewed on 11/17/2021 at 12:20pm. E8 reviewed R1's nursing progress notes. E8 was asked if E5 documented vitals and an assessment of R1 after he was found sitting on the floor on 10/7/2021. E8 stated there is no documentation by E5 in R1's nursing notes. E8 stated that on 10/8/2021 at approximately midnight he was told by E9 (LPN) that R1 had discomfort. E8 stated E9 did not document her assessment at the time. E8 stated that on 10/8/2021 at approximately 6am he notified the Physician that R1 was in discomfort when walking and the Physician ordered portable X-Rays. E8 was asked where he documented this telephone order for X-Rays. E8 stated he only documented this in the nursing progress notes.	Z9999		

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Z9999	Continued From page 12 There is no written telephone order form completed. E6 (Nurse) did not document an assessment of R1 after being asked to follow up by E5 (nurse) on 10/7/2021. (A)	Z9999		