PRINTED: 07/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		146109	B. WING			C 07/13/2016	
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	13/2010
MEADOV	VS MENNONITE HON	ME.		2	24588 CHURCH STREET		
MEASONS MEINTONIE			(CHENOA, IL 61726			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	FO	000			
F 241 SS=E	INDIVIDÚALITY	74/ÎL86793 YAND RESPECT OF	F 2	241			
	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on observareview the facility fareful of eight residents (were incontinent of incontinent care in R6, R7, R8 were w	NT is not met as evidenced tion, interview and record ailed to provide dignity for six R1, R2, R5, R6, R7, R8) who bladder and reviewed for the sample of 10. R1, R2, R5, earing a urine-saturated, it, which leaked onto the outer					
	Findings include:						
	documents R1 is converged requires the extension to ileting. R1's Care "I (R1) am inconting to my cognitive imp	ata Set dated 7/3/16 ognitively impaired and sive assistance of two staff for e Plan dated 7/6/16 documents ent of bowel and bladder due pairment. I wear an incontinent nity. I am on a structured					
	dining table and E1 Assistant) put a gai R1 to his room. E1	PM R1 stood up from the 4, CNA (Certified Nursing it belt around R1 and walked 4 assisted R1 into bed without					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	-	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IL6006001

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE C	COMPLETED			
	146109 B. WING			C 07/13/2016			
	NAME OF PROVIDER OR SUPPLIER MEADOWS MENNONITE HOME			2458	EET ADDRESS, CITY, STATE, ZIP CODE 8 CHURCH STREET NOA, IL 61726	<u> </u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	"we take (R1) to the ansywe wait for hole he hole he hole of the land of th	et. At this time E14 stated, et toilet when (R1) gets im to show signs [that (R1) pathroom]. We toileted (R1) at only sleeps an hour." ained in R1's bed sleeping at :52PM, 2:03PM, 2:12PM, :44PM, 2:51PM, 3:15PM. At ately six hours after the last d, E9 and E15, CNAs, were in R1 and R1 was on the toilet. had soaked through R1's be changed. When R1 stood of the toilet seat and odor of BM in the room. ata Set dated 6/5/16 everely cognitively impaired sistance of one staff for e Plan dated 6/9/16 documents urine due to cognitive are plan documents "I (R2) to garment for my dignity. I age those (incontinent		241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		146109	B. WING	B. WING			C 07/13/2016	
	PROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 588 CHURCH STREET HENOA, IL 61726	1 017	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 241	with the wet brief of 5:10PM, 5:20PM,	still in bed. R2 remained in bed on the floor at 4:47PM, 5:03PM, and 5:28PM. At 5:37PM, E16 is eif R2 was eating supper. In all hours after assisting R2 to a g R2, at 5:40PM, E9 and E16 is bed. E16 confirmed that R2 is on in bed, R2 had removed it is efloor. R2's bed linens and R2's brief that was lying on the Data Set dated 7/10/16 is juires extensive assistance of a g. R5's Care Plan dated "I (R5) am incontinent of bowel id dary to cognitive decline. I wear an incontinent garment. I wear an incontinent garment. I wear an incontinent garment. I wear staff member. E17 came in and went to R5's room and in clothing. E17 confirmed that urine through R5's clothing and a ged. Data Set dated 4/24/16 is everely cognitively impaired, seistance of one staff for the Plan dated 6/6/16 documents arent of urine due to my we deficit. I wear an incontinent gaityI need your assistance to	F 2	241				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		146109	B. WING	B. WING			C 13/2016
_	PROVIDER OR SUPPLIER	IE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 14588 CHURCH STREET CHENOA, IL 61726	1 017	10/2010
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	5. R7's Minimum D documents R7 is seand requires the exfor toileting. R7's C documents "I (R7) abowel secondary to an incontinent garm to change the garm On 7/11/16 at 2:18 walk out of the televants were soaked back. E18, CNA sta 11:00AM when R7 stated staff toilet the indications that they stated, "with shift clis difficult to change 6. R8's Minimum D documents R8 is seand requires the exfor toileting. R8's C documents, "I (R8) am incontine to my cognitive imp garment for my digit change (the incontine to T/11/16 at 4:10 dining room and R8 prompted to check pants were wet and room to change R8	ata Set dated 6/16/16 everely cognitively impaired tensive assistance of one staff are Plan dated 6/6/16 am incontinent of bladder and my cognitive deficit. I wear nent for my dignityAssist me ent" PM R7 was being assisted to vision lounge by staff. R7's through in the front and the sted it was probably close to was last toileted. E18 also e residents if they have y need to be toileted. E18 nange from 1:30PM-2:30PM it e residents at that time." Pata Set dated 6/27/16 everely cognitively impaired tensive assistance of one staff care Plan dated 6/26/16 ent of bowel and bladder due airmentI wear an incontinent nity. I need your assistance to nent garment)" PM R8 was walking to the 8's pants were wet. E17 was R8's pants and confirmed the I E17 assisted R8 to R8's	F 2	241			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		146109	B. WING	B. WING		C 07/13/2016		
	NAME OF PROVIDER OR SUPPLIER MEADOWS MENNONITE HOME			24	TREET ADDRESS, CITY, STATE, ZIP CODE 4588 CHURCH STREET HENOA, IL 61726	017	.0,2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 241	residents to be allo incontinence. On 7/13/16 at 1:15 Nurse/Chief Nursin	"It's not a good thing" for wed to be wet from pm E19, Registered g Officer stated when	F 2	<u>'</u> 41				
	residents are incontinent of urine there is "a reduction of their dignity" causing the resident embarrassment. E19 stated "that is way we try to keep them (residents) warm and dry."							
F 315 SS=E	Ombudsman Progr Septemeber 2014 of your rights as a citiz Illinois because you facilityYou have the dignity and respect	HETER, PREVENT UTI,	F3	115				
33=L	assessment, the fa resident who enters indwelling catheter resident's clinical of catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.						
	by: Based on observat review the facility fa	NT is not met as evidenced tion, interview and record alled to timely toilet six (6) of (R1, R2, R5, R6, R7, R8)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
	146109 B. WING				C 07/13/2016	
	PROVIDER OR SUPPLIER VS MENNONITE HON	IE		STREET ADDRESS, CITY, STATE, 24588 CHURCH STREET CHENOA, IL 61726		16/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 315	reviewed for incont R7, and R8's urine-undergarment (disp wetted the resident Findings include: 1. R1's Minimum D documents R1 is continued the extensive assist and is at risk for de R1's "Bowel and BI 6/30/16 documents schedule (timed vo 7/6/16 documents bladder due to cognincontinent garmentoileting program." was diagnosed with 6/14/16 and was tramilligrams (mg) by 6/14/16 to 6/20/16. dated 6/13/16 documents action for the scherichia coli great (Colony Forming U). On 7/11/16 at 1:06 dining table and E1 Assistant) put a gain R1 to his room. E1 taking R1 to the toil "we take (R1) to the ansywe wait for his needs to go to the R10:00AM and (R1).	inence care. R1, R2, R5, R6, saturated, incontinent posable brief) leaked onto and its outer clothing. ata Set dated 7/3/16 pagnitively impaired, requires tance of two staff for toileting, veloping pressure ulcers. adder Assessment" dated R1 is a candidate for toileting iding). R1's Care Plan dated R1 is incontinent of bowel and nitive impairment, wears and tand is on a "structured The care plan documents R1 in a Urinary Tract Infection on eated with Keflex 500 mouth three times a day from R1's Urine Culture report ments bacteria growth of eater than 100,000 CFU	F3	315		
	1:30PM, 1:45PM, 1	:52PM, 2:03PM, 2:12PM, :44PM, 2:51PM, 3:15PM. At				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	146109 B. WING		07	C 7/13/2016		
	PROVIDER OR SUPPLIER VS MENNONITE HON	IE		STREET ADDRESS, CITY, STATE, ZIP COI 24588 CHURCH STREET CHENOA, IL 61726		710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	time R1 was toilete the bathroom with FE15 stated that R1 clothing and had to up there was a sign movement) on the lathere was a strong 2. R2's Minimum D documents R2 is serequires the assista on a urinary toileting developing pressur dated 6/9/16 documents R2 wear undergarment and (diuretic) and Triam care plan document was the bathroom umorning, frequently before going to be doneeded)." On 7/11/16 at 1:58F on the bed. E16, LF asked R2 if she needed she did in down in bed and Eapproach R2 again go to the bathroom 3:00PM, 4:09PM, a had a wet brief laying the same strong the same strong the same strong the same strong to the bathroom 3:00PM, 4:09PM, a had a wet brief laying the same strong th	attely six hours after the last d, E9 and E15, CNAs, were in R1 and R1 was on the toilet. had soaked through R1's be changed. When R1 stood ifficant amount of BM (bowel back of the toilet seat and odor of BM in the room. ata Set dated 6/5/16 everely cognitively impaired, ance of one staff for toileting, is g program, and is at risk for e ulcers. R2's Care Plan nents R2 is incontinent of urine pairment. The care plan	F3	15		
	5:10PM, 5:20PM, a was prompted to se	n the floor at 4:47PM, 5:03PM, nd 5:28PM. At 5:37PM, E16 be if R2 was eating supper. alf hours after assisting R2 to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146109		` '	IPLE CONSTRUCTION IG		COMPLETED	
		146109	B. WING			C 07/13/2016
	PROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP CO 24588 CHURCH STREET CHENOA, IL 61726		710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 315	assisted R2 out of did not have a brief and thrown it on the clothing were wet. I floor was wet. 3. R5's Minimum D documents R5 required two staff for toileting pressure ulcers. R documents R5 is in bladder secondary plan documents R5 wears an incontine "toileting program" bathroom upon rising the day and evening the night and PRN Bladder Assessment	ge 7 g R2, at 5:40PM, E9 and E16 bed. E16 confirmed that R2 fon in bed, R2 had removed it e floor. R2's bed linens and R2's brief that was lying on the ata Set dated 7/10/16 uires extensive assistance of g and is at risk for developing 5's Care Plan dated 6/6/16 continent of bowel and to cognitive decline. The care takes Lasix (diuretic) daily, int undergarment and is on a and to "Take me (R5) to the ing from bed, frequently during g, before going to bed, during (as needed)." R5's "Bowel and int" dated 7/8/16 documents R5 bileting schedule (timed	F 31	5		
	bathroom with anot out of the bathroom returned with clean	PM E17, CNA took R5 to the ther staff member. E17 came and went to R5's room and clothing. E17 confirmed that trine through R5's clothing and ged.				
	documents R6 is so requires the assista on a urinary toiletin developing pressur dated 6/6/16 documents R6 wear documents R6 wear requirements R6 wear requi	ata Set dated 4/24/16 everely cognitively impaired, ance of one staff for toileting, is g program, and is at risk for e ulcers. R6's Care Plannents R6 is incontinent of urine cognitive deficit. The care planurs an incontinent to "Remind me (R6) to go to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	146109 B. WING				07	C 7/13/2016
	PROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, Z 24588 CHURCH STREET CHENOA, IL 61726		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 315	the bathroom upon morning, frequently before going to bed needed)." On 7/11/16 at 5:35F a bag of bed linen a any linen. E16 conf R6's bed linens with have to bed change 5. R7's Minimum D documents R7 is serequires the extens toileting, is on a uril at risk for developin Plan dated 6/6/16 c bowel and bladder deficit. The care plincontinent undergate to go to the bathroom morning, frequently before going to bed needed)." R7's "Bodated 6/14/16 docu candidate for individed to morning to go to the bathroom morning	rising from bed in the during the day and evening, I, during the night and PRN (as PM, E16 exited R6's room with and R6's bed was stripped of irmed that R6 had saturated a urine and that the bed linens	F3	315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
146109 B. WING				07	C / 13/2016	
	PROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP 24588 CHURCH STREET CHENOA, IL 61726	•	713/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 315	requires the extens toileting, is on a uril at risk for developin Plan dated 6/26/16 of incontinent undergato go to the bathroomorning, frequently before going to bedneeded)." R8's "Bodated 6/28/16 docucandidate for individed on 7/11/16 at 4:10 dining room and R8 prompted to check pants were wet and room to change R8 On 7/12/16 at 2:07 stated the restorative residents are toileted "residents are toileted "resid	ive assistance of one staff for hary toileting program, and is ag pressure ulcers. R8's Care documents R8 is incontinent wel and bladder, wears an arment and to "Assist me (R6) om upon rising from bed in the during the day and evening, during the night and PRN (as owel and Bladder Assessment" ments R8 is a "Good dualized (toileting) training." PM R8 was walking to the B's pants were wet. E17 was R8's pants and confirmed the dE17 assisted R8 to R8's 's clothing. PM E8, Restorative Nurse, we toileting program means and frequently. E8 stated and program the day and evening, during the day and evening, during the night and PRN (as that can't toilet themselves pairment or physical ed R1, R2, R5, R6, R7, and		315		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
146109 B. WIR			B. WING	B. WING			C 07/13/2016	
	PROVIDER OR SUPPLIER	IE		STREET ADDRES 24588 CHURCH CHENOA, IL			16/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRE I CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	dated 6/3/15 document continence will be reached the continence will be reached the continence will be reached the continence will be designed to the continence will be designed to the continence will be designed to the continence will be reached to the continence will be reach	ge 10 lence Management policy nents, "Resident's nanaged effectively" by dated 6/15/16 documents I plan of care (also called the eveloped and implemented by ning shall be coordinated es providing services to the	F3	15				