STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146109	A. BUILDING _____ B. WING _____	08/05/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS Special Focus Facility Annual Certification and Licensure Validation Survey for Subpart U: Alzheimer Unit Meadows Mennonite Home is in compliance with Subpart U, 77 Illinois Administrative Code Section 300.7000.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to display written information on how to apply for and use Medicare and Medicaid benefits and the Elder Justice Act. This has the potential to affect all 107 residents in the facility. Findings include: On 8/2/26 through 8/4/16 between the hours of 8:30am and 4:00pm, the required Medicare/Medicaid and Elder Justice Act postings were unable to be located in the facility. On 8/4/16 at 12:30pm, 1:20pm and 3:30pm, E16 Maintenance, E15 Health Services Counselor, and E1 Administrator all verified the required postings were not posted. The Resident Census and Condition Report, dated 8/2/16, documents 107 residents reside at the facility.	F 156		

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F 167	Continued From page 3	F 167		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make survey results readily available for residents to examine. This has the potential to affect all 107 residents residing at the facility. Findings include: On 8/2/16 a sign was posted on the desk at the main entrance of the building stating "Survey results located in the lobby." On 8/2/16 through 8/4/16 between the hours of 8:30am and 4:00pm, the survey book was unable to be located in the lobby. On 8/3/16 at 12:30pm during the group interview, R15, R34, R43, and R44 verified they did not know the location of the survey results binder. On 8/4/16 at 1:20pm E15 Health Services Counselor stated the following: "The survey book	F 167		

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F 167	Continued From page 4 is located in the lobby on the side table and it is not there." At that same time, E15 walked over to the facility information desk, went behind the counter, and removed the survey book from behind the counter. The Resident Census and Condition Report, dated 8/2/16, documents 107 residents reside at the facility.	F 167		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve resident meals in a timely manner according to facility meal times for five of five residents (R6, R13, R15, R34, R35) reviewed for meal service times in a sample of 22 and two on the supplemental sample (R43 and R44). Findings include: The facility document titled "Meal Times", undated, documents facility meal times are as follows: Breakfast- 7:15 a.m., Lunch- 11:15 a.m., and Dinner- 5:15 p.m.	F 246		

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F 246	Continued From page 5	F 246		

On 8/3/16 at 7:50 a.m., R6 was seated at the dining room table and did not have a meal at the table setting. On 8/3/16 at 8:20 a.m., R6 was served R6's breakfast meal.

On 8/3/16 at 11:15 a.m., R13 and R15 were seated in the dining room and did not have meals. On 8/3/16 at 11:35 a.m., the nursing staff informed the dietary staff they were ready to start passing resident lunch meals. On 8/3/16 at 11:55 a.m., R15 was served R15's lunch meal plate; and on 8/3/16 at 12:00 p.m., R13 was served R13's lunch plate.

On 8/4/16 at 11:15 a.m., R35 was seated in a wheel chair at the dining room table. On 8/3/16 at 11:48 p.m., the nursing staff informed the dietary staff they were ready to start passing lunch trays. On 8/3/16 at 12:00 p.m., R35 was served R35's lunch plate.

On 8/5/16 at 9:20 a.m., E14 (Kitchen Department Head) stated "The dietary staff is not allowed to serve residents plated meals until at least a nursing staff member or a CNA (Certified Nursing Assistant) is in the dining room." At that same time E14 stated that ideally residents should be served shortly after arriving in the dining rooms.

On 8/5/16 at 9:40 a.m., E1 (Administrator) and E4 (Assistant Director of Nurses) verified nursing staff are to be present in the dining room for safety reasons before any resident can receive a food plate and a resident should not wait longer than 30 minutes after arriving in the dining room before their food plate is given to them.

On 8/3/16 at 12:30 a.m., during the group interview, R15, R34, R43 and R44 verified that

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F 246	Continued From page 6 meals times are 7:15 a.m., 11:15 a.m., and 5:15 p.m and they sometimes have had to wait longer than an hour after the meal times before their meal is given to them.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan for the use of psychotropic medication for one of seven residents (R15) reviewed for care plans in a sample of 22. Findings include:	F 279		

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F 279	Continued From page 7 R15's Physician Orders, retrieved electronically on 8/2/16, documents orders "Lorazepam, 0.5 milligrams (mg), half a tablet every six hours, as needed." R15's Current Care Plan, dated 6/27/16, does not list a plan of care related to the use of lorazepam. On 8/4/16 at 3:10 p.m., E3 (Director of Nursing) stated, "We should always care plan psychotropic medications. I do not see (R15's) use of Lorazepam listed on (R15's) care plan. (R15) started Lorazepam on 11/3/15. (R15's) care plan was never updated to include this concern for the psychotropic medication."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update a resident care plan fall intervention for one (R21) of 22 residents reviewed for care plans in the sample of 22. Findings include: The fall investigative report dated 3/23/16 for R21 documents, "Root cause analysis done 7/7/16 with staff and cause of fall related to resident getting up unattended. Alarm put in place." R21's current Care Plan does not document a fall intervention of a personal alarm for R21. On 8-4-16, at 10:10 am, E3 (Director Of Nursing/DON) confirmed that R21's fall investigative report, dated 7-7-21, documents that an alarm is to be put in place for R21 and that the fall intervention of placing a personal alarm on R21 is not on R21's care plan. The facility's policy "Care Plans", revised 6-15-15, documents "Care plans will be reviewed and updated on an ongoing basis and within five days of identification of a change, but no less often than every 90 days."	F 280		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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F 371	Continued From page 9 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain thawed nutritional supplement shakes; and failed to wear gloves when feeding a resident to prevent contaminating food with bare fingers. This failure has the potential to affect 5 residents (R6, 8, 17, 60 and 64) identified with dietary concerns during the dietary observation. Findings include: 1. On 8/4/16 at 11:15 a.m., a single door cooler in the neighborhood two dining room had 22 nutritional supplement shakes on the top shelf that were thawed and unlabeled/undated. Manufacturer's instructions written on the cartons for the nutritional supplement shakes stated the shakes have a shelf life of 14 days once thawed. On 8/5/16 at 11:15 a.m., an under the counter cooler in the neighborhood one dining room had four nutritional supplements on the shelf that were thawed and unlabeled/undated. Manufacturer's instructions written on the cartons for the nutritional supplement shakes stated the shakes have a shelf life of 14 days once thawed. On 8/5/16 at 3:30 p.m., E14 (Kitchen Department Head) stated, "The kitchen staff pull the	F 371		

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F 371	Continued From page 10 (nutritional supplement shakes) out of the freezer daily based on how many physician orders we have for (nutrition supplement shakes). I didn't realize the shelf life was 14 days after being thawed." A facility Resident Diet List, dated 8/2/16, documents R8, R17, R60 and R64 have physician orders for nutritional supplement shakes. 2. On 8-3-16, at 8:20 am, R6 sat in the dining room while being assisted by E6 (Certified Nursing Assistant/CNA) with the breakfast meal. From 8:23 am to 8:33 am, E6/CNA fed R6 an entire piece of toast with E6's bare hand. On 8-5-16, at 10:08 am, E6/CNA stated, "I do normally pick up the toast with my bare hands. I probably should have worn gloves." The Resident Census and Condition Report, dated 8/2/16, documents 107 residents reside at the facility. 3. The facility's Dietary Cleaning Guideline "AM Cook's Help Checklist," undated, guides the AM cook to clean small kitchen equipment. On 8/2/16 at 8:30 a.m., the can opener had spots of red, gummy debris and the can opener holder attached to the counter was sticky to the touch. On 8/5/16 at 3:30 p.m., E14 stated, "The can opener should be washed daily and as needed, if dirty."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 11 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 12 Based on observation, interview and record review the facility failed to ensure that soiled gloves were removed before touching clean bandages and before touching environmental objects for three of 19 residents (R6, R10 and R21) reviewed for infection control in a sample of of 22. Findings include: The facility policy titled "Standard Precautions" dated 6/19/15 documents, "Gloves will be changed between resident contacts and when contaminated or between moving from dirty areas to clean areas." The CDC (Center for Disease Control) document (no date) titled "Guidance for the Selection and use of Personal Protection Equipment (PPE) in Healthcare Setting" documents, "Think about environment surfaces too and avoid unnecessarily touching them with contaminated gloves." 1. The current care plan dated 6/6/16 for R10 documents, "(R10) has a diabetic ulcer on my right heel." On 8/4/16 at 9:30 AM, E11/LPN (Licensed Practical Nurse) changed R10's dressing to his/her right heel with E12/LPN assisting. E11/LPN removed R10's soiled dressing, cleansed the wound and put a new dressing on per doctor order. Wearing gloves E11/LPN cleansed the wound, replaced the dressing (wearing soiled gloves) and then while wearing the same gloves put on R10's sock and adjusted R10's covers. E10 then removed his/her gloves and washed his/her hands.	F 441		

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F 441	Continued From page 13 On 8/4/16 at 9:45 AM, E11/LPN verified that s/he did not change gloves after cleansing the wound and then pulled up R10's socks and adjusted his/her covers. E11/LPN stated, "I hesitated and thought about it (changing gloves after cleansing wound) but I was thinking it would be OK because my gloves were sterile." 2. On 8-3-16, at 8:45 am, E7 and E8, (Certified Nursing Assistants/CNA) provided incontinence care for R6. E7 cleansed R6's perineal area. With the same soiled gloves, E7 touched R6's bare skin to assist R6 to turn onto R6's side, removed R6's soiled brief, then cleansed R6's rectal area. With the same soiled gloves, E7 applied a clean incontinence brief under R6. On 8-3-16, at 12:55 pm, E7/CNA stated that E7 should have changed gloves before touching (R6) and when going from dirty to clean. 3. On 8-3-16 at 12:40 pm, E9/CNA and E10/CNA provided incontinence care while toileting R21. E9 cleansed R21's perineal area then with the same soiled gloves, E9 pulled up R21's clean brief and pants. On 8-3-16, at 12:45 pm, E9/CNA stated that E9 normally performs incontinence care in this manner then said "My gloves were contaminated after wiping her."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146109	A. BUILDING _____ B. WING _____	08/05/2016

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) COMPLETION DATE
F 465	Continued From page 14	F 465		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain one of three medication rooms in a sanitary manner. This failure has the potential to affect 12 of 22 residents (R6, R13-R15, R18, R21, R28-R31, R33, R34) reviewed for sanitary conditions in the medication preparation area in the sample of 22, and 32 residents in the supplemental sample (R40, R43-R73).

Findings include:

On 8/4/16 at 1:37pm, the Neighborhood 2 (two) medication room sink contained a plate of dry, congealed potatoes and a sandwich. The medication room counter top contained one sandwich and an opened container of cookies. One backpack laid on the floor of the medication room.

On 8/4/16 at 1:37pm, E17, Licensed Practical Nurse (LPN), confirmed the presence of the food in the sink, on the counter top, and backpack on the floor of the medication room.

On 8/4/16 at 1:45pm, E4, Assistant Director of Nursing (ADON), confirmed the presence of the food in the sink, on the counter top, and backpack on the floor of the medication room, and stated staff "was trying to get their lunch," and the backpack should not be in the medication room. On 8/5/16 at 9:05am, E4 stated the Neighborhood 2 medication room provides medications and supplies for all residents residing in Neighborhood 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146109	A. BUILDING _____ B. WING _____	08/05/2016

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) COMPLETION DATE
F 465	Continued From page 15 On 8/4/16 at 2:50pm, E1, Administrator, stated staff should not leave left over food in the medication room or store purses or backpacks in the medication room. The "Resident Room Assignment" sheet dated 8/2/16 and provided by E4 on 8/2/16, documents 44 residents (R6, R13-R15, R18, R21, R28-R31, R33, R34, R40, R43-R73) reside in Neighborhood 2.	F 465		