STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	C 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CROSSING LVG & REHAB	409 WEST COMANCHE ROAD SHABBONA, IL 60550

(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	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.810a) 300.1210b) 300.1230d)1) 300.3240a) 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 300.810 General a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 duty at all times. (A, B) Section 300.1210 General Requirements for Nursing and Personal Care b) 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 resident to meet the total nursing and personal care needs of the resident. Section 300.1230 Direct Care Staffing d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced	S9999		

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by:

Based on observation, interview, and record review, the facility failed to provide services in a manner to maintain the dignity of a resident. This failure resulted in R4 being incontinent and feeling degraded and humiliated.

This applies to 1 of 12 residents (R4) reviewed for dignity in the sample of 12.

The findings include:

R4's Minimum Data Set (MD) assessment of 8/28/18 shows she requires extensive assist of 2 staff members for transfers, bed mobility and toileting. The MDS shows R4 is cognitively intact and has bilateral range of motion limitations on her upper and lower extremities. The MDS shows R4 is always continent of bowel and bladder.

On September 11, 2018 at 6:30 PM, R4 was observed sitting in the dining room talking with her table mates at the supper table. R4 was alert, oriented and very social with the other residents. At 12:20 PM, R4 was observed in her room, lying in bed using a bed pan. R4 had 2 areas of darker skin on her coccyx area. V5 (Certified Nursing Assistant-CNA) said it was from a previously opened area, present on admit.

On September 11, 2018 at 7:57 PM, R4 was sitting in her wheel chair in her room. R4 said "This last holiday weekend they (the facility) had the cluster mess of a century." R4 said there was just a couple of CNAs (Certified Nursing Assistants) working, that had to take care of everyone in the facility. R4 said it was 9:25 PM on 9/3/18 before she was removed from the dining

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room after supper and put into bed. R4 said she had been incontinent of urine because she could no longer hold her urine. "I felt very degraded, humiliated and disgusted." R4 said not only was she tired and exhausted from sitting in the dining room that long but her tail bone hurt and she was incontinent. R4 said she has been in the facility for about three weeks and this is not the first time she had been incontinent due to not being able to hold her urine because staff were taking too long to assist her. R4 said sometimes she is left sitting in her pee for hours and hours.

On September 11, 2018 at 11:56 AM, V3 (Agency Certified Nursing Assistant-CNA) said she worked on September 3, 2018 on the second and third shift. V3 said there was only herself and V4 (CNA) who were responsible for the residents located on the north and south halls. V3 said residents sat in the dining room for so long because her and V4 could not get to them. V3 said "Everyone had to suffer and wait until we could get to them." V3 said some of the residents sat up in the dining room after supper until after 10:30 PM. V3 said she believes they laid the last resident down in bed at 11:15 PM that night.

On September 12, 2018 at 9:41 AM, V4 CNA said on September 3, 2018, herself and V3 were responsible for the north and south halls and it was V3's first day in the facility. V4 said she felt so bad, "The residents were so saturated by the time we laid them down." V4 said she stayed until 11:15 PM (an hour and 15 minutes past her shift) to help. V4 said the last resident was taken out of the dining room and laid down around 11:15 PM. V4 said "They were sore from having to sit in urine because they had to sit there for so long." V4 said it was chaos. V4 said she was in tears that shift because she was so frustrated with the

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situation. V4 said she does not work at the facility any longer. "That was my last night. I quit. The way management handled that, I was livid, it was like they just didn't care

On September 12, 2018 at 10:11 AM, V6 (Licensed Practical Nurse-LPN) said the residents were in the dining room very late on September 3, 2018. V6 said "I know when it was going on 10:00 PM there were residents still in the dining room from supper time. There was not enough staff that was a fact."

On September 11, 2018 at 1:10 AM, V2 (Director of Nursing) said a couple of times the facility has had to work one CNA on each hall. V2 added, "That is not enough staff."

The facility's undated Dignity policy shows "The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."

(B)