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 06/15/2017

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 Violations: 300.610a) 300.1210b) 300.3210a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act) (A, B)

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 by:

Based on interview and record review the facility failed to keep R2 free from mental abuse by E5 on May 14, 2017. This failure resulted in R2 being anxious and agitated throughout the day requiring an anti-anxiety medication to calm R2.

This applies to 1 of 3 residents (R2) reviewed for abuse in the sample of 19.

The findings include:

The facility's Final Report investigation dated May 17, 2017, shows E1(Administrator) was notified

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by E7(Licensed Practical Nurse) that R2 came out of her room yelling about her picture being taken and R2 did not like it. E7 approached R2 and R2 pointed at E5 (Certified Nursing Assistant) and said, "She took pictures of me and I didn't like it, I don't look like a bunny, I don't like it!" E5 stated she was using her phone and was showing R2 an application on her smart phone that made animal ears and faces appear on R2's face.

On June 14, 2017 at 9:35 AM, E1 stated an allegation of abuse was reported to her on May 14, 2017. E7 reported R2 was upset about her picture being taken and her looking like a bunny. E5 was alleged to have taken the pictures of R2.

On June 14, 2017 at 9:38 AM, E7 stated, "about three weeks ago R2 came out of her room yelling, 'that son of a b**ch, that girl took pictures of me when I was in the bathroom". R2 was pointing at E5." E7 said she asked E5 if she was taking pictures of R2. E5 told her she was showing R2 what she would look like with bunny ears and a face using her smart phone. R2 was sitting on the toilet at the time. R2 remained upset and was telling everyone all day long that the girl took her picture on the toilet and she had bunny ears and did not like it. R2 was upset for awhile. E7 stated she reported the incident to E1 and E6 (CNA supervisor).

On June 14, 2017 at 3:10 PM, E8 (CNA) stated she and E5 transferred R2 to the toilet on May 14, 2017. R2 was incontinent of stool. E8 left the bathroom with R2's wheel chair. E5 remained in the bathroom with R2. E8 cleaned R2's wheelchair of stool, located a brief and a clean pair of pants and returned to the bathroom. R2 was still on the toilet. R2 was upset and yelling that she did not like that a picture was taken of

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her. R2 was transferred to her wheelchair. R2 self propelled out into the hallway and was yelling to everyone about getting her picture taken on the toilet with ears. E8 stated E5 did have her cell phone but she did not see her take any pictures of R2.

On June 14, 2017 at 5:50 PM, E6 (CNA supervisor) stated R2 was yelling "that son of a b**ch girl took my picture with bunny ears while I was on the toilet". R2 was telling everyone that day. R2 told E6 she was upset that her picture was taken while she was on the toilet. R2 did not understand the smart phone application and believed that E5 had taken a picture of her on the toilet with bunny ears. E6 stated R2 was upset the entire day and 1:1 reassurance was offered. R2 was reassured that there was no picture. E6 stated she spoke with E5 that day about the incident. E5 told her she was using the camera on her smart phone and an application to put bunny ears and a face on R2 and showing the screen to R2 in the bathroom. R2 was sitting on the toilet. E6 said she told E5 that she could not do that with her phone especially when the resident was on the toilet.

On June 15, 2017 at 9:45 AM, Z1 (State Guardian representative) stated she had known R2 for years. Z1 visits with R2 at the facility on a quarterly basis. Z1 stated R2 was angry about the incident. R2 would not be aware that the smart phone application was not a real picture. R2 would have been humiliated by the experience.

R2's Minimum Data Set dated April 20, 2017, shows R2 has a diagnosis of non-Alzheimer's dementia that is severely cognitively impaired. R2 requires two persons for toileting and transfers. R2's face sheet dated June 15, 2017 shows R2

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has an anxiety disorder. R2's Physician Orders dated June 2017 shows R2 has an order for Lorazepam oral solution 2 milligrams per milliliter. Give 0.25 mls (0.5mg) by mouth every two hours as needed for agitation or restlessness.

R2's PRN (As needed) Medication Administration for May 2017 shows R2 received Lorazepam 0.25 mls (0.5mg) on May 14, 2017 at 4:00 PM for increased anxiety and agitation with a "helpful" response. R2 only received the one dose of her anti-anxiety medication during the month of May 2017 the day of the incident with the smart phone in her bathroom.

E5's Employees Warning report dated May 14, 2017 shows, "E5 was reported for using her cell phone in a resident bathroom while toileting R2. R2 stated she (E5) was taking pictures of her on the toilet. E5 will be suspended while investigation is in progress."

The facility's Abuse Prohibition and Reporting policy dated February 2017, shows, "the facility actively prohibits abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source and exploitation ... Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse also includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demeanor humiliate a resident(s)."

(B)