STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145294	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Village Healthcare Ctr	1024 West Walnut Jacksonville, IL 62650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to follow physician's orders for twice-daily pulse oximetry checks for 2 of 3 residents (R1 and R2) reviewed for quality of care in the sample of 4. Findings include: 1. R2's undated face sheet documented he was admitted to the facility on [DATE] and has the following diagnoses polyneuropathy, diabetes, end stage renal disease, dependence on dialysis, right below the knee amputation, and obstructive sleep apnea. R2's minimal data set (MDS) dated [DATE] documented he is cognitively intact. R2's care plan updated 6/5/25 documented wound care interventions, depression, peripheral neuropathy, dialysis, pain, nutrition, and diabetes. There was no problem including oxygen saturation monitoring noted in his care plan. R2's physician order dated 4/21/25 documented Oxygen: Oxygen saturation (pulse oximetry) (SPO2) twice daily. R2's oxygen saturation recordings reviewed in the electronic medical record (EMR) and documented daily except for 6/5/25 and 6/18/25. Oxygen saturations were not performed twice daily as ordered 17 times during the first 25 days of June. 2. R1's undated face sheet documented she was admitted to the facility on [DATE] with the following diagnoses fibromyalgia, diabetes, chronic obstructive pulmonary disease, asthma, pulmonary hypertension, and congestive heart failure. R1's MDS dated [DATE] documented she is cognitively intact. R1's care plan last revised on 2/23/25 documented problems with chronic obstructive pulmonary disease, activity intolerance, and decreased cardiac output. R1's order dated 4/22/24 documented to monitor oxygen saturations every shift (twice per day) and as needed. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's oxygen saturation result documentations reviewed in the EMR for the first 25 days in June with only one day documenting twice daily reading and on 12 of the days there were no oxygen saturation levels recorded for that day at all. On 6/26/25 at 10:00 am, V8, Certified Nursing Assistant (CNA), stated that the CNA's take the routine pulse ox with the vital signs and chart it on a paper copy which is given to the nurse who puts it in the EMR. V8 added that the CNA's do not do any EMR charting. The resident's information is handed to the nurse who puts it in the EMR. On 6/26/25 at 10:05 am, V9 (CNA) stated pulse ox are obtained with the residents' scheduled regular vital signs between 7:00 am - 10:00 am and given to the nurse to put in the EMR. If a pulse ox was low or a resident was short of breath, V9 stated she would notify the nurse right away. On 6/26/25 at 10:20 am, V6 (CNA) stated that the residents needing vital signs/pulse ox for the day are listed on a paper vital sign sheet and that day's vital sign paper was shown. On 6/26/25 at 10:24 am, V10 (LPN) stated that the CNA's perform the routine vital signs with pulse ox and write them on a paper which they hand to her, and she puts them in the EMR. The policy titled pulse oximetry (assessing oxygen saturation) revised March 2004 documented that the purposed of this procedure is to monitor arterial blood oxygen saturation without the use of invasive devices. Steps in the procedure include explaining the procedure to the resident and record oxygen saturation reading. The following information should be recorded in the resident's medical record. The date and time the procedure was performed, and if the resident refused the procedure, the reason why and the intervention taken. Notify the supervisor if the resident refuses the procedure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to identify a stage 2 pressure ulcer on the upper intergluteal cleft in a timely manner for 1 of 3 (R2) residents reviewed for pressure ulcers in a sample of 4. Findings include: R2's undated face sheet documented he was admitted to the facility on [DATE] and has the following diagnoses polyneuropathy, diabetes, end stage renal disease, dependence on dialysis, and right below the knee amputation. On 6/25/25 at 9:40 am during skin check of R2's buttocks area with V3 Licensed Practical Nurse (LPN)/ wound nurse, V5 (LPN/wound nurse) and surveyor, a new pressure wound to upper intergluteal cleft was found measuring 0.5 cm x 0.2 cm which V3 acknowledged was a stage 2 pressure wound. V3 and V5 stated they were unaware of a pressure wound to this area. On 6/25/25 at 10:30 am, V3 stated she had received orders from V15 (Facility Physician) and was bringing in wound care supplies to provide wound care to the new upper intergluteal pressure wound. R2's minimum data sheet (MDS) dated [DATE] documented he is cognitively intact and requires use of a wheelchair for mobility. R2 requires staff set up for eating, oral hygiene, and upper body dressing. R2 requires supervision for toileting and personal hygiene, lower body dressing, putting on and removing footwear and showering. R2 is at risk of developing a pressure ulcer and has two unstageable pressure ulcers. On 6/25/25 at 2:15 PM, R2's shower sheet dated 6/25/25 had no documentation of any buttock wounds present on R2. No documentation on any shower sheet referenced a wound on the upper intergluteal cleft. On 6/25/25 reviewed R2's May and June TARs (Treatment Administration Record) were reviewed and showed for skin assessment no presence of a pressure wound to the buttocks at the last skin assessment performed on 6/22/25. R2's care plan last reviewed on 6/5/25 at 5:11 PM documented he has a penile wound infection, open lesion to penis, unstageable pressure ulcer to the left heel, hemodialysis, diabetes, pressure ulcer risk, fall risk. R2 is at risk for pressure ulcers related to impaired mobility. The goal is that skin will remain intact. The interventions include conduct a systematic skin inspection during shower days paying particular attention to the bony prominences. Maintain the head of the bed at the lowest degree of elevation possible. Remind and assist R2 to turn and reposition regularly. Report any signs of skin breakdown. Use moisture barrier product to perineal area. Use pressure reducing cushion for pressure reduction when R2 is in chair. Use pressure reducing mattress for pressure reduction when R2 is in bed. When R2 has episode of incontinence, provide incontinence care after each incontinent episode. Avoid hot water and use a mild cleansing agent that minimized irritation and dryness to the skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevention of Pressure Wounds policy with effective date of January 2017 documented the purpose of this procedure is to provide information regarding identification of pressure injury, risk factors and interventions for specific risk factors. Interventions and preventative measures include general preventive measures by identifying risk factors for pressure injury development. For a person in bed, change position at least every two hours or more frequently if needed, determine if resident needs a special mattress. For a person in a chair, change position at least every hour and use a foam, gel or air cushion as indicated to redirect pressure. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury.