

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2025
NAME OF PROVIDER OR SUPPLIER  Prairie Village Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>(continued on next page)</p>

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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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure a residents' foot was free of insects for 1 of 3 residents (R2) reviewed for foot health. Findings include: R2's Undated Face Sheet, documents she was admitted to the facility on [DATE]. No diagnosis of wounds or bugs on R2's skin, including maggots. R2's Minimum Data Set (MDS) dated [DATE] documents she is alert. R2's Care Plan, dated 10/20/2025 documents R2 has an open lesion on the foot which appears to be small crack in the skin between her 4th and 5th toe on her right foot. Goal: lesion will show improvement by decreasing in size and showing no signs and symptoms of infection by next review date. Approaches: administer dressing/treatment to address/stabilize specific wound characteristics as ordered by the physician, encourage appropriate footwear is worn at all times and encourage R2 not to walk/propel chair around barefoot or in just socks/stockings, ensure footwear for proper sizing, ensure shoes are in good condition, inspect feet during ADL (activities of daily living) care and showers/bathing, report any abnormalities to physician, keep skin clean and dry, observe lesion characteristics weekly to monitor for effectiveness of treatment, notify physician if lesion shows evidence of decline, wound physician consult as needed per physician order and monitor for signs and symptoms of infection such as pain, odor, changes in exudate (drainage) characteristics, redness, edema, or cellulitis, notify physician if observed. No documentation of maggots on R2's feet documented. R2's Progress Note, dated 10/20/2025 at 12:45 PM, documents resident seen by podiatrist this AM, new area noted to right 5th toe. Appears to be a crack in skin. New order for TAO and dry dressing daily per physician. Also, daily skin checks to be completed. POA (Power of Attorney) aware of order. RD (Registered Dietitian) updated on new area. Verified that resident has properly fitting shoes a neatly trimmed nails. On 10/23/2025 at 11:30 AM R2 sitting up in wheelchair in her room. R2 was alert and stated she had a sore on her right foot, but she laughed and stated no bugs on her feet she's aware of. R2 stated staff do the dressing on her right foot daily and she's never had bugs or maggots on her feet that she's aware of. V4, LPN entered room and removed R2 slippers and socks. There was a 2 x 2 gauze between R2's 4th and 5th toe on her right foot at that time. V4 stated R2 had no wounds and no bugs on her feet and no other residents have bugs and she does wound treatments every day and follows physician's orders. Observation of R2's feet showed a very small cut between 4th and 5th digit on right foot and no wounds or redness on either heel. R2's left foot also assessed and no wounds and no maggots or bugs on either foot at that time. V7, LPN entered R2's room and stated she is the facility's wound nurse. V7 stated she returned to work from leave on 10/21/2025 and she received report that R2 had maggots on her feet but didn't have any additional information. R7 stated she never observed maggots on R2's feet. V7 showed a small cut like wound between R2's 4th and 5th digit and stated staff are cleaning the area with normal saline then apply TAO and gauze to the area. V7 stated she doesn't have access to R2's podiatry notes because the podiatrist doesn't send them to the facility for their review. V7 stated while she was on leave V5, LPN was the acting wound nurse and floor nurses were responsible for administering wound treatments to residents. R2's Physician's Order Sheet (POS), dated 10/20/2025 documents a new order right 5th toe cleanse area with normal saline pat dry apply TAO and place dry gauze between 4th and 5th toe change daily and PRN once a day. R2's POS, dated 10/21/2025 documents a new order for skin assessment daily. R2's Wound Management dated 10/20/2025 at 1:38 PM documents right pinky toe, 4th toe crack in skin that measured 0.2 centimeters (CM) x 0.2 cm. Staff documented, Area noted to be a small crack in the skin between 4th and 5th toe. R2's Treatment Administration Record (TAR) dated 10/20/2025 documents staff are providing skin assessments and wound treatment per physician's orders. On 10/23/2025 at 3:33 PM V5, LPN stated she works night shift at the facility and was at the facility early in the morning on 10/20/2025 when V13, Podiatrist entered to assess residents. V5 stated no staff round with V13 because he comes to the facility around 5:30 AM. V5 stated V13 reported to her that R2 had maggots in between her toes and he's never seen that before and R2 has a wound on her right foot between her 4th and 5th digit. V5 stated she assessed R2's feet as soon as V13 reported this to her. V5 stated she wiped between R2's toes and assessed maggots, V5 couldn't recall which foot had maggots but stated R2 had maggots between her toes. V5 stated she reported R2 had a newly identified wound and maggots between her toes to V1, V2 and V6. V5 stated she was very busy at that time and didn't document the assessment or removal of maggots from between R2's toes because she forgot. On 10/23/2025 at 12:30 PM V6, LPN stated she was the acting wound nurse while V7, LPN was on leave. When</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview the facility failed to maintain a complete and accurate medical record for 1 (R2) of 3 sampled residents in review of complete and accurate medical records. Findings include: R2's Undated Face Sheet, documents she was admitted to the facility on [DATE]. No diagnosis of wounds or bugs on R2's skin, including maggots. R2's Minimum Data Set (MDS) dated [DATE] documents she is alert. On 10/24/2025 at 3:33 PM V5, LPN stated V13, Facility Podiatrist entered the facility early in the morning on 10/20/2025 and assessed residents, including R2. R2's Electronic Medical Record (EMR) dated 10/23/2025 no documentation of V13's progress notes. On 10/23/2025 at 2:20 PM V1, Administrator stated V13, Facility Podiatrist doesn't share/send his progress notes with the facility, and he never has. On 10/24/2025 at 11:54 V13, R2's Podiatrist stated he is the facility podiatrist, and sees over 25 plus patients at the facility approximately four times a year. V13 stated his office sends the facility his progress notes within 2-3 days after he assesses the residents so his progress notes should be uploaded in the residents' medical records system. V13 stated he wasn't aware the facility wasn't receiving his progress notes or that his office wasn't forwarding his progress notes to the facility. The Facility's Charting and Documentation Policy, revised 8/2006 documents all observations and services performed must be documented in the resident's clinical record.</p>