Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Nrsg & Rehab Ctr	345 Dixie Highway Chicago Heights, IL 60411

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 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** 50469 Based on observation, interview, and record review the facility failed to assess and monitor for pressure ulcers for a resident who is at high risk for pressure ulcers. This deficiency affects one (R2) of three residents reviewed for Pressure Ulcer Prevention Program. Findings include: On 2/13/25 at 11:25 AM, V4 (Wound Care Nurse) said that R2 was sent to the hospital on 1/24/25 for change in condition, R2 was observed unresponsive and abnormal vital signs. V4 said R2 only had scar tissue to the sacral area but no open skin. When R2 returned to the facility on [DATE], R2 returned with an unstageable wound that the hospital did debridement. V4 said that R2's son and husband were made aware of resident change of condition and hospital transfer. V4 said that R2's wound care is done weekly, and measurements are also done on a weekly basis and weekly wound rounds with MD. On 2/13/25 at 1:45PM, V2 (Director of Nursing) said that weekly skin assessments are completed during wound care treatments and are documented on shower sheets. V2 said she was unaware of R2 having a sacral wound, no staff verbalized any concerns for R2. On 2/13/25 at 1:45 PM, V11(Licensed Practical Nurse) said she was the nurse that sent R2 to the hospital at the start of her evening shift. R2 was observed with a change in condition, not her normal self. V11 notified Nurse practitioner and obtained orders to transfer to hospital. V11 said that she did wound treatment to bilateral lower extremities, but did not do a full body assessment before R2 left to hospital. V11 notified R2's son and husband of transfer. V11 said that skin assessments are done weekly and also when she has a shower a skin assessment is done and documented on the shower sheets. On 2/14/24 at 12:27 PM, V16 (Nurse Practitioner) said that on 1/24/25 when R2 was transferred to the hospital she was unaware of any wounds to the sacral area. R2 had multiple wounds on her legs, but not sacral area, V16 said that her expectations of the facility generally should be doing skin assessments on residents that are high at risk for developing ulcers more frequently than weekly skin assessments. (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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	145629	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Nrsg & Rehab Ctr	345 Dixie Highway Chicago Heights, IL 60411

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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	R2 was initially admitted on [DATE] and was readmitted on [DATE] with diagnosis listed in part but not limited to: CVA with left hemiparesis, Cognitive Communication deficit, muscle weakness with atrophy, PVD, epilepsy, dysphagia, metabolic encephalopathy, GERD, pulmonary nodule, anemia, T2DM, protein calorie malnutrition, Vit D deficiency, hyperlipidemia, hypertension, CKD, Encounter for change or removal of surgical wound dressing. Admission and current Braden/skin assessment indicated that she is at high risk for developing pressure ulcers/skin impairments. Active physician order sheet indicated: Peri area/Buttocks: May apply Barrier cream after each incontinence episode. May keep at beside, CNA may apply. Pressure redistribution mattress, ProStat 30ml twice a day, Reposition as needed, Skin assessment weekly on shower days. Wound Care: Sacrum: Cleanse with Normal Saline, pat dry, apply Medi Honey with gauze to wound bed, gently fill wound space with fluffed gauze; apply Medi Honey gauze to open Peri wound areas, cover with Border gauze daily and as needed one time day. Comprehensive care plan indicates that she has pressure ulcer which increases her potential for additional pressure ulcer development. Intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown. R2 wound care observation made with V4 and V11. R2 medical record reviewed, Wound measurements, skin assessments, dietary notes, Progress notes, and Care plan. Wound Report from 7/2024 to 2/11/2025, Prevention of Pressure Wounds Policy, Accidents/Incidents logs from 10/2024 to 1/2025 and Shower Sheets from 11/01/24 to 1/25/25. Facility's policy on Prevention of Pressure Wounds. Effective March 2024.Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. 9. 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. 3. For those unable to change own position, change position at least every 1 hour. 9. A healed injury. The history of a healed pressure injury and its stage (if known) is important, since areas of healed Stage III or IV pressure injuries are more likely to have recurrent breakdown. 1. Tools for assessing skin and pressure injury risk: a. Braden Risk Assessment Form b. Intervention Prevention Measures.