STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145629	A. Building B. Wing	12/23/2025

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. Based on observations, interviews, and record reviews, the facility failed to have the low air loss mattress at the correct weight setting for one resident (R2) with a stage 4 pressure ulcer, who is at risk for skin breakdown and requires extensive assistance with turning/repositioning, out of three residents reviewed for wound management in a sample of 6. Findings include:On 12/19/25 at 8:55 AM, this surveyor observed V3 (wound care nurse) provide wound care treatment for R2's sacral pressure ulcer. R2 was observed to have a low air loss mattress with the weight setting at 400 pounds. On 12/19/25 at 9:05 AM, V3 stated that the weight on R2's low air loss mattress is locked and V3 does not know how to unlock it to adjust the weight setting. V3 stated that the machine is set for a person weighing 400 pounds. V3 stated that she knows R2 does not weigh 400 pounds but would have to check R2's medical record to know what R2's current weight is. V3 stated that the weight setting on the mattress should be checked daily. V3 stated that she will have to ask maintenance to come fix the weight setting. V3 stated that the resident's weight determines how much air flows through the mattress. V3 stated that the specialty mattress would be more firm if the weight setting was set higher than the resident's actual weight causing more pressure on the resident's wound. V3 stated that you don't want too much pressure on wound d/t increased setting of weight. R2's medical record, dated 12/4/25, notes R2's weight was 265.8 pounds. R2's wound assessment details report, dated 12/15/25, notes R2 with a stage 4 pressure ulcer left buttock to sacrum to right buttock. Wound was identified on 5/7/24. Wound measures 5.5cm (centimeters) x 4cm x 1cm. R2's MDS (minimum data set), dated 11/7/25, notes R2 requires maximum assistance from staff with bed mobility. R2 is dependent on staff for toileting and transfers. The facility's pressure wound treatment policy, dated 01/2017, notes, in part, the pressure injury treatment program should focus on tissue load. Tissue load refers to the pressure, tension, and mechanical forces on injured skin and underlying tissues. CMS (Centers for Medicare & Medicaid Services) article titled pressure reducing support surfaces - group 2 policy article, dated 4/7/22, notes, in part, that styles of group 2 powered pressure reducing mattresses (alternating pressure, low air loss) which is characterized by all of the following: an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, ands a surface designed to reduce friction and shear, and can be placed directly on a hospital bed frame.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145629	A. Building B. Wing	12/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145629	A. Building B. Wing	12/23/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record reviews, the facility failed to follow its enhanced barrier precautions (EBP) policy and don appropriate PPE (personal protective equipment) prior to entering an EBP resident room to provide direct resident care and failed to perform hand hygiene before exiting a resident's room after providing direct resident care. These failures affected four residents (R2, R3, R4, and R5) out of five residents reviewed for infection control in a sample of 6. Findings include: On 12/18/25 at 11:04 AM, V10 CNA (certified nurse aide) was observed entering R3's EBP room and rearranging R3's personal items on bedside table. V10 then exited R3's room with R3's water pitcher and placed it on the counter at the nurses' station. V10 was then observed placing the mechanical lift device in the tub room and return to the nurses' station to wash hands. V10 then filled R3's water pitcher and brought into R3's room. On 12/18/25 at 11:25 AM, V6 CNA entered R2's EBP room to provide incontinence care. V6 did not don a gown prior to entering R2's room. At 11:31 AM, V6 exited R2's room, removed gloves, went to the tub room, opened the door and grabbed a soiled linen rolling cart. V6 brought cart to R2's room and placed soiled linen in cart then brought cart to tub room. V6 did not perform hand hygiene prior to exiting R2's room. V6 was then observed washing hands at sink in nurses' station. On 12/19/25 at 8:20 AM, this surveyor observed V4 (wound care nurse) enter R5's room to provide wound care treatment for R5's right buttock wound. The signage on R5's door notes EBP - wound care - any skin care requiring a dressing. V4 did not don a gown prior to entering R5's room. On 12/19/25 at 8:30 AM, V3 (wound care nurse) stated that R5 is not on enhanced barrier precautions; his roommate, R4, is due to having a colostomy. When questioned if R5 has a wound that requires a dressing, V3 responded yes but he is not on EBP. V3 stated that the facility interpreted the EBP policy to refer to chronic wounds. V3 stated that a resident's wound must be present for 90 days before the resident is placed on enhanced barrier precautions. On 12/19/25 at 10:20 AM, V9 LPN (licensed practical nurse) was observed providing colostomy care to R4. R4 is on EBP. V9 did not don a gown prior to preforming direct resident care. On 12/19/25 at 1:20 PM, V5 (infection prevention nurse) stated that if resident has a wound for 90 days, then we will place the resident on enhanced barrier precautions. V5 stated that this is the facility's EBP policy. V5 stated that she is not aware that the facility's EBP signage notes: wound care -- any skin care requiring a dressing. V5 stated that each resident room has a hand sanitizing dispenser, and a bathroom sink for staff to wash hands. V5 stated that staff are expected to perform hand hygiene prior to exiting any resident's room. V5 stated that staff should not exit the resident's room, go to tub room to grab a cart or return equipment, then perform hand hygiene at the nurses' station. R5's medical record notes R5 with a right buttock pressure ulcer identified on 11/3/25. Wound measures 3.6cm (centimeters) x 3.2cm x 0.1cm.R5 with diagnoses of chronic obstructive pulmonary disease, severe protein-calorie malnutrition, prostate cancer, adult failure to thrive, cancer of kidney, secondary cancer of other parts of the nervous system. These factors may delay or prevent wound healing and may put R5 at risk for further breakdown. On 11/24/25, R5's right buttock wound measured 2.2cm x 1.7cm x 0.1cm. On 12/1/25, V3 noted R5's Left buttock MASD (moisture associated skin damage) area and right buttock wound area have conjoined. On 12/15/25, R5's right buttock pressure ulcermeasured 3.6cm x 3.2cm x 0.1cm. R5's POS, dated 11/4/25, notes wound care: right buttock: cleanse with normal saline, pat dry, apply hydrogel to wound bed, secure with border gauze/dry dressing daily and as needed if soiled or dislodged.The facility's enhanced barrier precautions signage notes everyone must: clean their hands, including before entering and when leavingthe room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities. Dressing,bathing, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, wound care: any skin openingrequiring a dressing. The facility's enhanced barrier precautions policy, revised 3/21/24, notes, in part, enhanced barrier precautions refer to the use of gownand gloves for use during high-contact resident care activities for residents at increased risk of multidrug resistant organism acquisition (residents with wounds). Initiation of enhanced barrier precautions - implement enhanced barrier precautions for residents with any of the following: wounds. High-contact resident care activities include: dressing, bathing, transferring, providinghygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care: any skin opening requiring a dressing. On 12/19/25, V1 (administrator) presented the CMS (Centers for Medicare & Medicaid Services) memorandum, dated 3/20/24, enhanced barrier precautions in nursing homes. This guidance notes enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of