

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 07/12/2024
NAME OF PROVIDER OR SUPPLIER Prairie Manor Nrsng & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39781</p> <p>Based on observation, interview, and record review the facility failed to monitor and record daily freezer and refrigerator temperatures for food safety. This deficiency may potentially affect all 123 residents receiving food from the facility.</p> <p>Findings include:</p> <p>On 7/9/2024 at 10:02AM, Rounds made to kitchen with V5 Dietary Manager (DM). Observed Freezer and Cooler/Refrigerator temperature were not monitored today. V5 said that the cook should monitor and record the temperature today at 5am. It was not done because they were short this morning. V5 read the current temperature of freezer at -3F (Fahrenheit) and Cooler/Refrigerator at 32F.</p> <p>Daily Freezer/Refrigerator temperature log July 2024. No temperature recording made for 7/9/24. Instruction: This log will be maintained for each refrigerator and freezer (both walk in and reach in units) in the facility. A designated food service employee will record the time, air temperature and their initials. The food service supervisor for each facility will verify that the food service employees have taken the required temperatures by visually monitoring food service employees and reviewing, initialing, and dating a sample of logs each month. Maintain this log for minimum of three years and until given permission to discard it. If corrective action is required on any day, circle the date in the first column and explain action taken on back of the chart or an attached sheet of paper. Refrigerators should be between 36F and 41F. Freezer should be between -10F to 0F.</p> <p>On 7/11/24 at 1:10PM, V5 DM said that they have only 1 resident on NPO (nothing by mouth).</p> <p>On 7/11/24 at 2:30PM, Informed V1 Administrator and V2 Director of Nursing of above concerns.</p> <p>On 7/12/24 at 10:35AM, Informed V12 [NAME] President of Culinary Services of concerns identified in kitchen that Freezer and Refrigerator temperature were not monitored and recorded on 7/9/24. The Refrigerator temperature was at 32F and it was not within the acceptable range per facility's policy. V12 said that refrigerator temperature should be between 36F to 40F, he will have maintenance look at it.</p> <p>Facility's policy on Food storage revised June 2023 indicates:</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>It is the policy of Extended Care LLC that all food products will be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.</p> <p>Purpose: To meet all federal and state guidelines and protecting the safety of the resident from any cross contamination and food born illnesses.</p> <p>Process:</p> <p>6. All readily perishable foods or beverages shall be maintained at temperatures of 7 degrees C (41 degrees F or below or at 60 degrees C (140 degrees F) or above, at all times, except for very short times during necessary periods of preparation or service.</p> <p>7. Frozen foods shall be stored at minus) degrees or below at all times. (There is an accurate thermometer in each refrigerator and freezer)</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure coordinated care was implemented by failure to document hospice services rendered to resident's medical record that is available and accessible to interdisciplinary team (IDT). This deficiency affects two (R22 and R45) of three residents in the sample of 25 reviewed for Hospice care Management.</p> <p>Findings include:</p> <p>On 7/9/2024 at 11:00AM, V8 LPN (Licensed Practical Nurse) and V9 LPN said that R22 and R45 are both on hospice care. V9 showed the hospice binder/charts for both residents. Reviewed both hospice binder charts with V9. Noted no documents found for R22. The folder is empty, only visits log from 6/12/24 to 7/4/24. No IDT progress notes found. Noted R45 hospice documents in binder but missing IDT progress notes. Noted R45's hospice visit log from 6/10/24 to 7/9/24. V9 said usually when hospice care staff comes to visit hospice resident, they document in the hospice binder. V9 said that usually Social Services coordinate with hospice care management.</p> <p>On 7/9/24 at 11:33AM, V10 Social Service said that she is only responsible for referral to hospice vendors/services, the Social Service Director is the one responsible for making sure all hospice documents for coordinated care are in the hospice binder.</p> <p>On 7/9/24 at 11:48AM, V11 Hospice Social Service (HSS) said that he comes to see both R22 and R45. He said that the last time she visited both was last month but cannot remember the date. He said he did not log in and did not document his visit and services provided last month. He said that he cannot find the hospice binder and he cannot find a nurse from the unit to ask. He added that only the hospice nurses are required to document, he is social service, and he does not need to document in the hospice progress notes. V9 LPN overheard what V11 HSS told the surveyor, and she denied that there is no nurse available in the unit. V9 said that the binder is placed in the nursing station desk and there are always staff available in the unit if he needs assistance.</p> <p>On 7/9/24 at 11:53AM, V6 Medical Record said that she is responsible to make sure all hospice coordinated care documents are in place and updated in the hospice binder. She should be monitoring it weekly and uploading it in resident electronic chart. She said that she has not been doing it for a while. Reviewed R22 and R45 hospice records with V6. Noted no hospice documents/assessments/IDT progress notes in R22's folder. R45 does not have IDT progress notes, last progress notes dated 6/12/24 done by RN.</p> <p>On 7/11/24 at 10:00AM, Reviewed R22's hospice medical records with V9 LPN and noted that all documents were faxed by hospice provider dated 7/9/24 after the surveyor found out that there are no hospice documents in chart.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R22 was admitted on [DATE] with diagnosis listed in part but not limited to History of Malignant neoplasm of breast, Chronic obstructive pulmonary disease, Vascular dementia with psychotic disturbance, history of transient ischemic attack and cerebral infarction. Active physician order sheet indicates she was admitted to hospice care on 4/24/24. Care plan indicates that she is admitted to hospice care due to overall decline in health. Hospice binder does not have hospice record documents except for IDT visit log from 6/12/24 to 7/4/24.</p> <p>R45 was admitted on [DATE] with diagnosis listed in part but not limited to Alzheimer's disease, Dementia with behavioral disturbance, Oral phase dysphagia, Acute Kidney disease, Peripheral vascular disease. Active physician order sheet indicates she was admitted to hospice care on 1/10/24. Care plan indicates that she is admitted to hospice care due to overall decline in health. Hospice binder does not have IDT progress notes documentation except for visit log dated from 6/10/24 to 7/9/24.</p> <p>Facility's policy on Hospice services indicates:</p> <p>Policy: It is the policy of this facility to honor the advance directives and care alternatives residents may desire when terminally ill and to afford residents with care that allows for dignity and comfort during the end of their lives. The facility will provide hospice services either directly or through arrangements with a qualified service provider.</p> <p>Standards:</p> <p>6. All hospice service staff will write a progress note for each resident visit indicating treatment provided and pertinent information related to the resident's condition which is available in the medical record for all interdisciplinary staff to access.</p> <p>Hospice provider single patient agreement for residential hospice services provided in the nursing facility for R22 and R45 indicates:</p> <p>7. Communications concerning hospice patient: The parties will communicate pertinent information with each other either verbally or in the hospice patient's record at least weekly or at each hospice patient visit to ensure that the needs of each hospice patient are addressed and met 24 hours per day.</p> <p>11. Clinical Record. Each clinical record shall completely, promptly, and accurately document all services provided to and events concerning, the hospice patient (including . progress notes) as required by this agreement.</p>