

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145953	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Prairieview Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 403 North Fourth Street Danforth, IL 60930	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to protect the resident's right to be free from abuse by failing to prevent misappropriation of a resident's narcotic pain medication. This failure affected one of three residents (R4) reviewed for abuse in the sample of six. Findings Include: The Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy dated 12/23/21 documents the term Abuse can includes misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The Incident Report for incident of 7/12/24 documents R4 had an order for Hydrocodone (Opioid) to be taken every 6 hours. On 7/12/24, V9 Registered Nurse contacted Hospice to attempt to refill the Hydrocodone. At that time there were only 26 tablets remaining. V12 Hospice Nurse informed V9 that a refill of 60 Hydrocodone was delivered to the facility on [DATE]. Upon an initial investigation, it was determined that 60 tablets of R4's Hydrocodone were missing, along with the corresponding Controlled Drug Received/Record/Disposition Form. Based on the facility's investigation, it is believed that V5 Agency Registered Nurse stole 60 tablets of R4's Hydrocodone and the corresponding Controlled Drug Received/Record/Disposition Form. R4's Physician Order Sheet dated July 2024 documents R4 is diagnosed Alzheimer's Disease, Dementia, Behavioral Disturbance, Mood Disturbance, Anxiety, Seizures, Major Depressive Disorder, Heart Disease, and Muscle Weakness. R4's Physician Order dated 4/24/24 documents R4 was prescribed Hydrocodone-Acetaminophen 5-325 (Opioid) milligrams (mg) by mouth four times a day for pain. R4's Minimum Data Set, dated dated dated [DATE] documents R4 is severely cognitively impaired. R4 receives scheduled pain medication and uses non-verbal sounds to indicate pain. R4's Care Plan dated 7/10/24 documents R4 has the potential to experience pain. R4 is under the care of Hospice Services. R4's Controlled Drug Received/Record/Disposition Form documents on 6/26/24, the facility received 60 tablets of Hydrocodone/Acetaminophen 5-325 mg to be given to R4 four times per day. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Controlled Drug Received/Record/Disposition Form documents on 7/3/24, the facility received 60 more tablets of Hydrocodone/Acetaminophen 5-325 mg to be given to R4 four times per day. On 7/24/24 at 4:00 PM, V7 Licensed Practical Nurse (LPN) stated when he worked on the night shift from 7/9/24 to 7/10/24 he completed a narcotic medication count with the oncoming nurse (V5 Agency Registered Nurse) on the morning of 7/10/24. V7 stated the count for R4's Hydrocodone was 84 tablets. V7 stated there was a count sheet for 60 tablets that were delivered early July (none of which had been used yet) and then there was another count sheet that was currently being used for 60 tablets that had been delivered in June (24 tablets left). On 7/30/24 at 11:25 AM, V8 Agency Licensed Practical Nurse stated she completed a narcotic medication count at the start of her shift on the evening of 7/10/24 with V5 Agency Registered Nurse. V8 stated there were 22 tablets of R4's Hydrocodone at the start of her shift. V8 stated there was only one count sheet for R4's Hydrocodone and 22 tablets left. On 7/30/24 at 12:00 PM, V9 Registered Nurse stated she worked on the day shift on 7/12/24. When she started her shift the count for R4's Hydrocodone was 17 pills and V9 stated she called R4's Hospice for a refill. V12 Hospice Nurse informed V9 that a refill of 60 tablets had been sent on 7/3/24 and another refill should not be needed. V9 stated this is when she realized something was wrong and there were 60 tablets of Hydrocodone missing. V9 stated she notified V1 Administrator and V2 Director of Nurses. On 7/30/24 at 2:30 PM, V1 Administrator confirmed 60 tablets of R4's Hydrocodone and the corresponding Controlled Drug Received/Record/Disposition Form went missing on 7/10/24 and the medication hasn't been found. V1 confirmed they believe V5 Agency Registered Nurse is the alleged perpetrator who stole R4's Hydrocodone.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to accurately maintain narcotic administration records for one of three residents (R4) reviewed for narcotic medication use on the sample of six. Findings Include: The facility's Controlled Substances policy dated 6/11/21 documents controlled substances (narcotic medications) are reconciled upon receipt, administration, disposition, and at the end of each shift. The nurse administering the medication is responsible for recording the time of administration, method of administration, quantity of the medication remaining, and signature of nurse administering the medication. R4's Physician Order Sheet dated July 2024 documents R4 is diagnosed Alzheimer's Disease, Dementia, Behavioral Disturbance, Mood Disturbance, Anxiety, Seizures, Major Depressive Disorder, Heart Disease, and Muscle Weakness. R4's Physician Order dated 4/24/24 documents R4 was prescribed Hydrocodone-Acetaminophen 5-325 (Opioid) milligrams (mg) by mouth four times a day for pain. R4's Minimum Data Set, dated dated dated [DATE] documents R4 is severely cognitively impaired. R4 receives scheduled pain medication and uses non-verbal sounds to indicate pain. R4's Hydrocodone Administration Details Record dated 7/24/24 documents V10 Agency Registered Nurse administered Hydrocodone to R4 on 7/12/24 at 2:00 AM. R4's Controlled Drug Received/Record/Disposition Form does not document a dose of Hydrocodone administered to R4 on 7/12/24 at 2:00 AM. This administration was not recorded on the medication count sheet. On 7/30/24 at 2:30 PM, V2 Director of Nurses confirmed when a narcotic medication is administered, the administration should be documented on the residents medication administration record and the dose should be documented on the resident's narcotic medication count sheet (Controlled Drug Received/Record/Disposition Form). V2 confirmed the 7/12/24, 2:00 AM dose of R4's Hydrocodone was not documented on the corresponding narcotic medication count sheet as it should have been.		