

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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 11/15/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35380 Based on interview and record review, the facility failed to accurately obtain weights, obtain daily weights as ordered, and report significant weight changes to appropriate staff for one resident (R25) of one resident reviewed for weight loss in the sample list of 27. Findings include: R25's Physician Order Sheet (POS) dated November 2024, documents an order for daily weights every day shift every Monday, Wednesday, Friday, with an order start date of 9/30/24. R25's Electronic Medical Record (EMR) weight tracking from 9/30/24 through 11/11/24, documents various means of obtaining weights which include standing, sitting, and wheelchair. R25's EMR weights dated 10/4/24 is 107 pounds, and R25's weight documented on 11/11/24 is 96.0 pounds. This is an 11.46% weight loss from 10/4/24 and 11/11/24. There is no documentation in R25's medical record of this weight loss being reported to anyone. On 11/13/24 at 2:48 PM, V13 Licensed Dietician stated weights should be consistent with the same scale, around the same time of day, and with similar clothing on. V13 also stated if there is a weight differential it should be reported to a nurse and then followed through. The facility's Resident Weights Policy dated 2011 Edition, documents residents with significant weight changes or questionable weights will be re-weighed for verification and weight change of 5% in one month should be reported to the physician.		

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to ensure adequate pain management was available, by failing repeatedly to schedule a pain clinic appointment for a medication pump refill. This failure affected one of two residents (R1) reviewed for pain on the sample list of 27. Findings Include: On 11/12/24 at 12:15 pm, R1 was seated in a motorized wheelchair, bedside. R1 stated R1 has a pain pump in her abdomen that has not been filled in months. R1 said R1 is reliant on this pain pump to stop the burning in her feet. R1 stated, I have pain pills but they don't work to relieve the burning pain in feet. My doctor retired and the facility has done nothing to help me find a new doctor to provide refills (surgically implanted pain pump medications). I was going out to my doctor about every six weeks. R1's Medical Device Identification (card) documents R1 had Drug Infusion System implanted on 7/16/24. R1's Physician Order Summary sheet (POS) dated 11/1-11/30/24 documents the following diagnoses: Multiple Sclerosis, Muscle Weakness Generalized, Paralytic Gait, Other Chronic Pain, Presence of Other Devices, Paraplegia, Unspecified, Other Signs and Symptoms, Unspecified Lack of Coordination, Other Reduced Mobility, Dependence on Wheelchair, Other Fatigue, and Contracture Unspecified Joint. R1's same POS documents monitoring as follows: Check pain pump site every day shift notify MD (physician) of any swelling. R1's same POS documents the following medications for pain management Morphine (25.0 mg/ml) infused at 13.552 mg (milligrams) /day via intrathecal pain pump; managed per (V21, Physician)/Universal Pain Management Institute (clinic), (status Hold), Bupivacaine (3.7 mg/ml) infused at 2.0057 mg/day via intrathecal pain pump; managed per (V21)/Universal Pain Management Institute (status Hold), Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain management, Acetaminophen 500 mg caplet, Give 1 capsule orally every 4 hours as needed for pain, fever, Gabapentin Capsule 400 MG Give 1 capsule by mouth four times a day for nerve pain, Carbamazepine 100 mg tab Chewable, Give 1 tablet orally two times a day for nerve pain, and Baclofen Tablet 10 MG, Give 1 tablet by mouth three times a day for muscle spasms. R1's Medication Administration Record dated 11/1/24-11/30/24 does not document R1 received PRN Acetaminophen, but did receive Hydrocodone -Acetaminophen PRN for a severe pain level of seven out of ten, one time on 11/10/24. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Minimum Data Set, dated dated [DATE] documents the following: Brief Interview of Mental Status score as 15 out of a possible 15, indicating no cognitive impairment. Same MDS documents R1 has pain occasionally at four out of ten level (mild-moderate). R1's Care Plan updated 10/29/24 documents the following: (R1) has chronic pain r/t (related to) MS (Multiple Sclerosis) and Arthritis. She has a implanted pain pump. Interventions include: Notify MD PRN (as needed) for increased or uncontrolled pain. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Follow up with pain clinic, (V21, Pain Clinic Physician) as ordered for pain pump refill (delayed refill appointment scheduling, post insertion of pain pump insertion 7/16/24). Evaluate the effectiveness of pain interventions every shift and after administration of PRN medication. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. R1's Social Service note signed by V9, Social Service Director, dated 9/12/24 at 8:24 am, documents the following: 1:1 (one on one) Resident was a little upset this morning, the pain doctor canceled her appointment. She is waiting for her pain pump to be filled. I explained to her that our scheduler (V19, Certified Nursing Assistant) is aware, and she will be making her a new appointment. R1's Appointment Note signed by V19, Certified Nursing Assistant dated 9/12/24 at 9:02 am, documents the following: Contacted (V21, Pain Clinic Physician) office regarding (R1's) follow up appointment. Office staff stated that the nurses (unidentified) and (V21) were in a procedure at this time and a nurse will be calling me back. Awaiting call back at this time. No other documentation of pain clinic notification to schedule appointment for R1 in R1's medical record. On 11/13/24 at 11:30 am, R1 was seated in her motorized wheelchair in the dining room. R1 motioned for this surveyor to come over to her table. R1 stated Are you going to get me an appointment for my pain pump refill. My feet and spine don't burn all the time, but the pills I take only take the edge off. I really need an appointment. No one has said a word to me about getting my pain pump refill. It doesn't matter who I talk to. No one has scheduled an appointment. It has been months and I was getting refills every 6 weeks or so. On 11/13/24 at 2:10 pm, V2 Director of Nursing (DON) confirmed there has not been a pain clinic appointment made for R1's pain medication pump refills. V2 stated R1's pain pump medication was put on hold, and there was no documentation since 9/12/24. V2 also stated she would have followed-up with the the pain clinic had she known there was a delay in getting the appointment. On 11/14/24 at 10:50 am, V19 Certified Nursing Assistant /Ancillary Clerk acknowledged she had not scheduled R1's appointment at the pain clinic for R1's pain pump refill. V19 also confirmed she had not documented any attempts to contact the pain clinic but had left numerous messages. V19 also stated V19 did not tell V2, Director of Nursing, so V2 could follow-up. The facility's undated Pain Management Policy documents: (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If the resident's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support. If a consultant is involved in managing pain, the attending physician will maintain an active role by reviewing the consultant's recommendations, addressing medical issues that affect pain, monitoring for complications related to treatment, and evaluating subsequent progress. The physician should not simply defer to the consultant for all pain-related issues.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31642 Based on record review and interview the facility repeatedly failed to follow their policy to maintain complete and accurate medical records for two (R1, R25) of 18 residents reviewed for medical records on the sample list of 27. Findings include: The facility policy Charting and Documentation dated as revised July 2017, documents the following: Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Charting and Documentation. The same policy documents: 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting. 1.) On 11/14/24 at 1:30 pm, V28 Receptionist provided unsigned R1's SOAP (Subjective, Objective, Assess, and Plan) notes that did not include a full assessment of R1's past medical history, current status, diagnoses, medications, or review of systems. V28 stated V2, Director of Nursing provided the documents and said they were R1's physician progress notes. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 10:10 am, V2 Director of Nursing stated We (the facility) do not have R1's Physician Visit (Progress Notes) documentation, for the last three months. V2 then stated when (V17, Medical Director) assessed (R1) monthly. The nursing (department) just made SOAP (Subjective, Objective, Assess, and Plan) notes. Therefore, there is no full documentation of R1's assessments for the last three months (8/16/24, 9/20/24 and 10/16/24). V2 also confirmed V17 did not sign the nurses SOAP notes of R1's visits (8/16/24, 9/20/24 and 10/16/24), until 11/14/24. 35380 2. R25's Physician Progress Notes dated effective date 8/23/24, 9/27/24, and 10/25/24, all document R25's temperature, pulse, respirations, blood pressure, oxygen saturation, and weights, all having a November 2024 date. There are no current vital assessments documented for the actual vitals that were completed on the actual assessment dates of 8/23/24, 9/27/24, and 10/25/24. On 11/15/24 at 10:32 AM, V11 Administrator stated the Physician Progress Notes dated effective dates are the dates the actual assessment was completed by the physician (V27), and the vital sign information is not correct for the dates of the completed assessments.		