

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146038		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/22/2016	
NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C				STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 325 SS=D	<p>Original investigation of complaints 1622008/IL84788 and 1622060/IL84849.</p> <p>F325 cited for both complaints.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to accurately monitor and recognize a significant weight loss for one of three residents (R1) reviewed for weight loss in a sample of three.</p> <p>Findings include:</p> <p>R1's physician's order sheets dated 2/2/16 notes that R1 was admitted on 2/2/16 with diagnosis including: Major Vascular Neurocognitive Disorder with Behavioral Disturbance, Cellulitis, Diabetes Mellitus, Chronic Venous Stasis Dermatitis, Obesity, Mood Disorder, Bullous Pemphigoid with mixed thickness wounds.</p>			F 325			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 325	<p>Continued From page 1</p> <p>According to R1's weight sheets, R1 weighed 261 pounds on admission on 2/2/16, and then at the beginning of March R1 weighed 251 pounds. R1's April weights list 5 weights, 196 pounds with no date, 219 pounds with no date, 239 pounds on 4/6/16, 177 pounds on 4/10/16 and then 215 pounds on 4/11/16.</p> <p>On 4/21/16 at 10:15 A.M. E1 (Administrator) stated that R1's physician and Dietician were not notified of R1's weight loss since the facility never got an accurate weight on R1 in April.</p> <p>Hospital records dated 4/12/16 notes that R1's weight at that time was 213 pounds. A 38 pound weight loss from March to April.</p>	F 325			