STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 Incident Report Investigation to Incident of 7/23/15 / IL79744	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 225	Continued From page 1	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to identify, report, and investigate injuries of unknown origin for two of three (R1, R2) residents reviewed for abuse in the sample of three.

Findings Include:

1. R1's POS (Physician Order Sheet) dated 8/2015 lists the following Diagnoses: Alzheimers, and Dysphagia.

R1's MDS (Minimum Data Set) dated 8/11/2015 documents that R1 is severely cognitively impaired, requires total assist for bed mobility, personal hygiene and bathing, extensive assist of two for transfers, and is frequently incontinent of bladder and always incontinent of stool.

R1's Skin Injury Report dated 4/22/15 at 8:40 pm documents, "two cm (centimeter) by two cm bruise noted to (R1's) right inner thigh." R1's Skin Injury Report dated 8/10/2015 at 3:25 pm documents, "when getting (R1) up from bed for supper, new bruise noted to right inner thigh measuring one cm round, brown-green in color."

On 9/1/2015 at 10:45 am, E8 CNA (Certified Nursing Assistant) and Z1 (CNA) transferred R1 from R1's bed to a reclining chair using a mechanical lift with a full body sling and a blanket between R1 and the sling. E8 stated, "we always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 225	Continued From page 2	F 225		

pad the sling to help prevent any bruising...I have never used a sling that goes between the legs on (R1), she is always transferred with a full body sling."

On 9/1/2015 at 1:10 pm, E3 Unit Manager stated, "No investigation was done for the bruising on (R1's) inner thigh, for either dates {4/22/2015 and 8/10/2015}...(R1) is incontinent of urine and we thought it probably happened during cares." E3 confirmed that it would take a little force to bruise and that a bruise wouldn't happen from normal cares.

On 9/1/2015 at 1:13 pm, E4 Abuse Coordinator stated that no investigation was completed on 4/22/2015 and 8/10/2015 for the bruises to R1's inner thighs, and stated, "it wasn't reported as a bruise of unknown origin."

On 9/1/2015 at 1:20 pm, E1 Administrator stated that people do not just bruise during routine care and that the bruises should have been investigated as a bruise of unknown origin. E1 stated, "I heard what they {E3, E4} said, and with having bruises to the inner thigh, they should have investigated it."

On 9/1/2015 at 3:50 pm, E1 stated, "the staff are getting the skin {bruise} reports but they just aren't identifying them as a possible concern."

2. R2's Progress Notes dated 2/23/15 at 12:49pm document a bruise to the middle of R2's "butt crack."

The facilities Skin Injury report for R2 dated 2/23/15 at 7:30am documents a bruise to the middle of R2's "butt crack 1 cm (centimeter)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET** **DANFORTH, IL 60930**

(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 225	Continued From page 3 round dark purple in color." R2's Skin Injury report does not document notification of the bruise to E4, Abuse Coordinator and there is no documentation that a thorough investigation was completed. On 9/1/15 at 1:10pm, E3, Unit Manager stated R2's bruise found on 2/23/15 was not reported to Public Health. E3 also stated, "she {E3} did not think it needed to be reported because she {E3} thought the bruise was at the top of the buttocks which is not a suspicious area... (E3) did say that if the bruise was in the middle of R2's "butt crack" it should have been investigated and reported to Public Health." R2's Injury of Unknown Origin report dated 4/18/15 at 7:45am documents "bruise of unknown origin noted to left breast measuring 6cm (centimeters) by 4cm..." The untimed Accident Investigation/Interview Form dated 4/18/15 documents E12, Registered Nurse stated that on 4/17/15 at 12:30am the bruise to R2's breast was reported to him {E12}. There is no documentation that E12 notified E4, Abuse Coordinator of the bruise on R2's breast when it was found on 4/17/15. The Accident Investigation/Interview Form dated 4/18/15 at 4:45pm documents E9, Certified Nursing Assistant (CNA) said the bruise was present when she {E9} had given R2 a shower on 4/17/15 around 10:30am. E9 stated that she did not notify the nurse on duty because E10, CNA stated the bruise was old and had already been reported. The facility Abuse/Neglect Policy dated 6/2015	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 225	Continued From page 4 documents, "To assist one in recognizing incidents of abuse or suspected abuse, the following definitions are provided...Injury of Unknown Origin: the source of the injury was not observed by any persons or the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (the injury is located in an area not generally vulnerable to trauma)."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to operationalize it's Abuse Policy by failing to identify injuries of unknown origin and failing to protect the resident's safety during an investigation. This has the potential to affect twenty seven residents (R1 - R27) reviewed for abuse in a sample of 27. Findings Include: 1. The facility Abuse/Neglect Policy dated 6/2015 documents, "All reports of alleged abuse or suspected abuse shall be promptly and thoroughly investigated by facility management...until the investigation has been completed, facility employees who are suspected of resident abuse will be removed from the work	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 226	Continued From page 5	F 226		

site pending the results of the investigation....To assist one in recognizing incidents of abuse or suspected abuse, the following definitions are provided...Injury of Unknown Origin: the source of the injury was not observed by any persons or the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (the injury is located in an area not generally vulnerable to trauma)."

R1's POS (Physician Order Sheet) dated 8/2015 lists the following Diagnoses: Alzheimers, and Dysphagia.

R1's MDS (Minimum Data Set) dated 8/11/2015 documents that R1 is severely cognitively impaired, requires total assist for bed mobility, personal hygiene and bathing, extensive assist of two for transfers, and is frequently incontinent of bladder and always incontinent of stool.

The facility Injury of Unknown Origin Report dated 2015 documents, "7/23/2015 at 9:45 pm (R1)... bruise to labia."

On 9/1/2015 at 10:45 am, E8 CNA (Certified Nursing Assistant) and Z1, CNA transferred R1 from R1's bed to a reclining chair using a mechanical lift with a full body sling and a blanket between R1 and the sling. E8 stated, "we always pad the sling to help prevent any bruising...I have never used a sling that goes between the legs on (R1), she is always transferred with a full body sling."

R1's 7/23/2015 Nurses Notes by E11, LPN (Licensed Practical Nurse) at 9:45 pm documents, "CNA called this nurse to (R1's)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930

(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 226	Continued From page 6	F 226		

room...two bruises noted to residents labia, one on the left labia measuring one cm (centimeter) by one cm dark purple in color, and one to right labia measuring 0.02 cm by 0.02 cm purplish red in color...head to toe completed with no other injuries noted...9:50 pm (E3 Unit Manager) notified, 9:55pm (E1 Administrator) called and message left, 9:56 pm (Z2 Physician) notified, ... 10:30 pm (E4 Abuse Coordinator) notified."

R1's Final Abuse Investigation Report dated 7/28/15 documents, "two CNA's assisted with (R1's) bath that morning {7/23/15} and reported how they transferred (R1) and that (R1's) periarea was reddened when they transferred her ....no bruising was observed...pericare was performed by the hospice CNA and staff CNA about 9:00 am...pericare was given throughout the day with no further redness noted until 9:45 pm when staff reported the area."

On 9/1/2015 at 11:30 am, E4 stated, "I didn't recieve the call {to report the bruising to the labia on 7/23/2015} until after the shift was already over {10:30 pm}, the staff was out of the building by then, so nobody had to be removed from cares....we started doing interviews with staff the next morning...at 8:00 am {on 7/24/2015} (E3) and I went to assess (R1) ourselves."

On 9/1/2015 at 11:40 am, E3 Unit manager stated, "(E6 CNA) was assigned to (R1) that evening {7/23/2015} and (E7 CNA) was the CNA that assisted with cares...(E13 and E14 CNA's) were doing rounds for shift change, and found the bruise on (R1's) labia, and reported it to (E11)... (E6 and E7) did not have any further contact with R1 that evening as they were taking the garbage out and then it was the end of their shift...all the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930

(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 226	Continued From page 7	F 226		

staff interviews were completed on 7/24/2015 but the investigation as to how or what actually happened was ongoing, hence the inservice I did on 7/27/2015."

The 7/2015 schedule and times of work for 7/23/2015 - 7/28/2015 provided by E1 documents that E6 CNA worked on 7/24/2015 and clocked in at 12:51 pm. E6's interview for the abuse investigtion was completed on 7/24/2015 at 3:05 pm.

The 7/2015 schedule and times of work for 7/23/2015 - 7/28/2015 provided by E1 documents that E7 CNA worked on 7/24/2015 and clocked in at 1:55 pm. E7's interview for the abuse investigation was completed on 7/24/2015 at 2:45 pm.

On 9/1/2015 at 12:15 pm, E1 confirmed that E6 and E7 worked on 7/24/15, "if they punched in, they were here...I didn't realize that they hadn't been interviewed prior to being allowed back to work, but they should not have been."

On 9/2/2015 at 8:50 am, E1 confirmed that E6 and E7 only work on the wing that R1 - R27 reside.

R1's Skin Injury Report dated 4/22/15 at 8:40 pm documents, "two cm (centimeter) by two cm bruise noted to (R1's) right inner thigh." R1's Skin Injury Report dated 8/10/2015 at 3:25 pm documents, "when getting (R1) up from bed for supper, new bruise noted to right inner thigh measuring one cm round, brown-green in color."

On 9/1/2015 at 1:10 pm, E3 stated, "No investigation was done for the bruising on (R1's)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 226	Continued From page 8	F 226		

inner thigh, for either dates {4/22/15 and 8/10/15}...(R1) is incontinent of urine and we thought it probably happened during cares." E3 confirmed that it would take "a little force" to bruise and that a bruise wouldn't happend from normal cares.

On 9/1/2015 at 1:13 pm, E4 Abuse Coordinator confirmed that no investigation was completed on 4/22/2015 and 8/10/2015 for the bruises to R1's inner thighs, and stated, "it wasn't reported as a bruise of unknown origin."

On 9/1/2015 at 1:20 pm, E1 confirmed that people do not just bruise during routine care and that the bruises should have been investigated as a bruise of unknown origin and stated, "I heard what they {E3, E4} said, and with having bruises to the inner thigh, they should have investigated it."

On 9/1/2015 at 3:50 pm, E1 stated, "the staff are getting the skin {bruise} reports but they just aren't identifying them as a possible concern."

On 9/2/2015 at 8:40 am, E1 stated, "(E4) was not reporting things that she should have, and was jeopardizing the resident body by allowing staff who were working during an abuse accusation to continue working during the investigation."

2. R2's Injury of Unknown Origin report dated 4/18/15 at 7:45am documents "bruise of unknown origin noted to left breast measuring 6cm (centimeters) by 4cm..."

On 9/1/15 at 12:00pm, E4, Abuse Coordinator stated the report sent to Public Health dated 4/22/15 documents the investigation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. BUILDING ______ B. WING ______	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	**P O BOX 4, 403 NORTH FOURTH STREET DANFORTH, IL 60930**

(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 226	Continued From page 9 conclusions. The same report does not identify which staff were idenitified to have had contact with R2 during the time frame investigated or that any staff had been suspended while the bruise was being investigated. E4 also stated no staff were suspended while investigation was being performed.	F 226		