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 _____	12/11/2015

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 Annual Licensure and Certification Survey Validation Survey for Subpart U: Alzheimer's Unit Prairieview Lutheran Home is in substantial complaince with Subpart U, 77 Illinois Administrative Code 300.7000	F 000		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 _____	12/11/2015

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F 159	Continued From page 1	F 159		

of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure residents receiving Medicaid benefits were notified that their trust fund account reached $200 less than the Supplemental Security Income (SSI) limit of $2000.00 and failed to ensure a spend down plan was in place. This applies to one resident (R6) reviewed for resident funds in the sample of ten.

The findings include:

R6's Admission Record, dated January 19, 2015, states Z2 (R6's Brother) is R6's Guardian and Responsible Party. R6's Admission Record also states R6's Primary Payer is Medicaid.

The facility's Trust-Current Account Balance as of 12/8/15 states R6 had a resident funds balance of $8,034.92. The facility's Trust-Transaction History from 11/1/14-12/9/15 states R6 has had a

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 _____	12/11/2015

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F 159	Continued From page 2 resident funds balance in excess of $2000 since 3/3/15 ($2931.56). The facility's Trust-Transaction History from 11/1/14-12/9/15, also states R6 has had the following additional balances above $2000: 1/2/15- $2,043.20, 1/9/15- $2,058.76, and 2/3/15- $2,554.06. On 12/10/15 at 9:30 AM, R6 stated she was not informed her trust fund balance was $8,034.92, nor had she been informed in the past that her trust fund balance was $2000 or more. R6 stated she receives statements but was unsure of the balance. On 12/10/15 at 9:50 AM, Z2 stated he was not informed that R6's trust fund balance was in excess of the SSI limit. Z2 stated R6 receives her own trust fund statements, per R6's request. On 12/10/15 at 1:15 PM, E8 (Accounting Staff) stated R6 has been on Medicaid since 4/1/14. E8 stated she was unaware of any plan for R6 or R6's family to spend down the money in R6's resident funds account. On 12/10/15, E7 (Administrative Assistant) stated she was unaware if R6 was informed that R6's resident funds balance was in excess of the SSI limit. The facility's Individual Accounting Records of Resident Funds, updated 10/29/15, states a representative of the business office will inform the resident of the balance in his/her personal funds account when the balance reaches $200 of the resident's SSI resource limit.	F 159		
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161		

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 _____	12/11/2015

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(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 161	Continued From page 3 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the surety bond for resident funds was at or above the highest potential balance to protect the resident trust funds from possible misappropriation of funds. This has the ability to affect one (R6) resident in the sample of ten and five residents (R14-18) in the supplemental sample, for whom the facility is managing funds. The findings include: The Surety Report of Renewal, registered 2/5/15, states the facility has a bond amount of $6,000.00 during the bond period of 5/6/15-5/6/16. The facility's Trust-Current Account Balance as of 12/8/15 states the balance of all residents' funds was $8,470.38. Previous residents' funds balances that were above the surety bond amount during the bond period were: 10/31/15- $8,035.58, 6/30/15- $6,517.25, and 5/31/15-$9,629.79. On 12/10/15 at 10:00 AM, E7 (Administrative Assistant) stated the surety bond is reviewed and renewed annually. E7 stated the facility was unaware the residents' funds were above the surety bond amount. The facility's Surety Bond policy, updated	F 161		

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	145953	A. BUILDING _____ B. WING _____	12/11/2015

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F 161	Continued From page 4 10/29/15, states the facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of its residents.....The purpose of the surety bond is to guarantee the facility will pay for losses occurring from any failure by the facility to hold, safeguard, manage, and account for residents' funds.	F 161		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor and assess a pressure ulcer and notify the physician of a worsening pressure ulcer for one of two residents (R2) reviewed for Pressure Ulcers in a sample of ten. Findings include: The Skin Care Policy 11/4/12 documents, "Progress of above skin conditions (Pressure Ulcers) will be documented in nursing notes weekly or more often as needed. A skin report will be generated each week that contains measurements of pressure, venous stasis and arterial wounds, wound descriptions, staging and	F 314		

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 _____	12/11/2015

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F 314	Continued From page 5	F 314		

current treatment being done. The doctor should be updated periodically, and should be notified if a decline occurs."

The facility Wound Report dated 8/30/15 documents R2 with recurring Pressure Ulcers first observed on 8/24/15; one stage II Pressure Ulcer measuring 1.3 centimeters (cm) by 1.5 cm by 0.1 cm to the left superior buttock and one stage II Pressure Ulcer measuring 0.3 cm by 1.3 cm by 0.1 cm to the left inferior buttock.

The Wound Report dated 8/30/15 documents R2 with recurring Pressure Ulcers first observed on 8/25/15; one stage II Pressure Ulcer measuring 0.5 cm by 0.5 cm by 0.1 cm to the right superior buttock and one stage II Pressure Ulcer measuring 0.5 cm by 0.3 cm by 0.1 cm to the right inferior buttock.

There are no further documented measurements of these four Pressure Ulcers in the Progress Notes or facility Wound Reports until 9/21/15. The Progress Note dated 9/21/15 documents R2, "Pressure Wound assessed. Rt (right) inferior and superior buttock wounds have become one.....Lt (left) inferior and superior buttock wounds have become one...."

The facility Wound History Report dated 9/21/15 documents the left inferior buttock Pressure Ulcer as measuring 2.5 cm by 3.0 cm by 0.1 cm and the right inferior buttock Pressure Ulcer as measuring 1.0 cm by 0.5 cm by 0.1 cm.

On 12/10/15 at 11:05am, E4 (Wound Nurse) confirmed there is no documentation of Pressure Ulcer assessment, including measurements for R2's Pressure Ulcers between 8/31/15 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 _____	12/11/2015

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F 314	Continued From page 6 9/20/15. E4 stated at the time of the assessment 9/21/15 R2's Pressure Ulcers had merged into two areas from the existing four which were present at the last assessment on 8/30/15. E4 also stated there is no evidence the physician was contacted to report a change in R2's wound which was identified on the 9/21/15 assessment.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement preventative fall interventions for two of seven residents (R2 and R5) reviewed for falls in a sample of ten. Findings include: 1) The Incident Report dated 6/14/15 documents R2's upper body on the floor incurring redness to the forehead area. This report documents the plan as a mat placed on the floor next to the bed. R2's Care Plan for Falls dated 9/7/15 documents R2 at high risk for falls with intervention to include mat on floor beside the bed implemented on 6/15/15.	F 323		

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 _____	12/11/2015

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F 323	Continued From page 7 On 12/8/15 at 9:15am and 1:30pm and 12/9/15 at 8:15am, R2 lay in a low bed with the right side of the bed against the wall; no mat was present on the floor by R2's left side. On 12/9/15 at 12:45pm, E3 (Nursing Assistant) stated R2 does not require a mat by the bed. On 12/10/15 at 9:02am, E2 (Director of Nursing) confirmed R2 was assessed and had a care plan to utilize a mat on 12/8/15 and 12/9/15. The Fall Assessment 11/24/15 documents R2 at high risk for falls. 2) The facility Incident Report dated 8/30/2015 at 8:45PM, documents R5 slid out of the wheelchair while trying to scoot self up in the wheelchair. This report documents the plan as a non-skid mat under the chair cushion placed in the wheelchair. R5's care plan for Falls dated 9/16/2015 documents R5 is at risk for falls with an intervention to include a non-skid mat to wheelchair seat implemented on 8/31/2015. On 12/10/2015 at 12:50PM, R5 was sitting in the wheelchair; no non-skid mat was in place per E3 and E5 (Nursing Assistants). On 12/10/2015 at 12:50PM, both E3 and E5 (Nursing Assistants) concurred that R5 does not utilize a non-skid mat in R5's wheelchair under the seat cushion. On 12/10/2015 at 1:30PM, E2 (Director of Nursing) confirmed R5 was assessed and had a care plan to utilize a non-skid mat under the seat cushion of R5's wheelchair. E2 stated " the non-skid mat was in the drawer in (R5's)	F 323		

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 _____	12/11/2015

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F 323	Continued From page 8 bedroom. The non-skid mat should have been on the wheelchair." The Fall Assessment dated 10/15/2015 documents R5 is at high risk for falls. The facility's Managing Falls and Fall Risk policy, dated December 2007, documents "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling...."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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 _____	12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 9	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to attempt non-pharmacological interventions prior to use of emergency anti-anxiety medications, failed to monitor behaviors and failed to monitor the effectiveness of emergency anti-anxiety medication use . These failures affect three of five residents (R3, R5, R12) reviewed for use of psychotropic medication use in a sample of ten.
Findings include:
1) The Nursing Note and Physician Order Sheet dated 5/15/15 documents R3 with a new order for Lorazepam 0.5 milligrams once a day as needed for Anxiety.
The Care Plan documents R3 as becoming more anxious after Z1 (wife) leaves for the day which is exhibited by increased anxiety/restlessness, crying and agitation. R3's Care Plan for Anxiety documents interventions to include during periods of anxiety, agitation, and crying - try to redirect R3 to a topic of interest and assist R3 to call Z1 as needed.
The PRN (as needed) Medication Information Sheets document R3 receiving Lorazepam 0.5 milligrams (mg) given 6/15/15 5:30pm, 6/22/15 2pm, 7/23/15 11:15am, and 8/13/15 10pm, for increased anxiety; documentation of the result/effectiveness is blank.
R3's Progress Notes 6/15/15, 6/22/15, 7/23/15, and 8/13/15 do not document the effectiveness after the use of the emergency anti-anxiety medication.
The PRN Medication Information Sheets document R3 receiving Lorazepam 0.5 mg on

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 _____	12/11/2015

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 329	Continued From page 10 6/12/15 8pm, 6/28/15 9pm, 7/13/15 6:30am, 7/25/15 8am, 8/6/15 9:30pm, 8/11/15 1:45am, 8/18/15 7am, 8/19/15 10:15pm, 8/21/15 10pm, 8/24/15 11:45pm, 9/16/15 12:30am, 10/4/15 2am, 10/14/15 7pm, and 10/17/15 12:15am. R3's Progress Notes dated 6/12/15, 6/15/15, 6/22/15, 6/28/15, 7/13/15, 7/23/15, 7/25/15, 8/6/15, 8/11/15, 8/13/15, 8/18/15, 8/19/15, 8/21/15, 8/24/15, 9/16/15, 10/4/15, 10/14/15 and 10/17/15 do not document non-pharmacological interventions prior to the use of emergency anti-anxiety medication. 2) The Physicians Order Sheet dated 8/18/2015 documents R5 with a new order for Lorazepam 0.5 milligrams twice a day as needed for Anxiety. The care plan dated 9/8/2015 documents R5 has Anxiety. The intervention is to reassure and encourage R5. The PRN Medication Information Sheets document R5 received Lorazepam 0.5 mg PRN, 31 times in the last five months (8/19, 8/20, 8/23, 8/25, 9/13, 9/14,10/10,10/12,10/20, 10/21, 10/23, 10/28, 11/1, 11/5, 11/6, 11/7, 11/8 times 2, 11/11, 11/12, 11/14, 11/15, 11/24, 11/27, 11/28, 12/2, 12/3, 12/4, 12/7 times 2, and 12/8/2015). The behavioral documentation sheets for R5 from 8/2015 through 12/8/2015 have no behaviors documented for any of the times the Lorazepam 0.5 mg PRN was given. The Progress note for R5 from 8/18/2015 through 12/8/2015 have no non-pharmacological interventions attempted documented prior to use of the emergency Lorazepam 0.5 mg. Additionally the PRN Medication Sheet nor the progress notes have effectiveness/results documented after utilization of the Lorazepam 0.5 mg on 8/25/2015 or 10/23/2015.	F 329		

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 _____	12/11/2015

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 329	Continued From page 11 On 12/9/2015 at 1:30PM, R5 was sitting quietly in the recliner watching television in R5's room, no anxious behavior noted. On 12/10/2015 at 12:50PM, R5 was eating lunch visiting with a table of peers, no anxious behavior noted. On 12/10/2015 at 12:40PM, E3 (Nursing Assistant) stated "(R5) does not display any behaviors. (R5) does get more confused at times but that's all." On 12/10/2015 at 2:45PM, E6 (Nursing Assistant) stated " I really have never seen (R5) exhibit any behaviors other than confusion at night." 3) The Physicians Order Sheet dated 5/26/2015 for R12, documents a new order for Clonazepam 0.5 mg twice a day as needed for anxiety in addition to the routine Clonazepam 0.5 mg every night at bedtime. The care plan dated 8/18/2015 for Anxiety documents the intervention is to allow R12 to vent and express feelings and assure R12 that staff is empathetic. The PRN Medication Information Sheets document R12 received Clonazepam 0.5 mg as needed five times in the last six months (7/11, 7/19, 8/1, 8/7, 9/8). The behavioral documentation sheets for R12 from 9/2015 through 12/8/2015 have no behaviors documented for any of the times the Clonazepam 0.5 mg PRN was given. On 12/10/2015 at 2:45PM E2 stated " There are no behavior sheets available in R12's record for 7/2015, or 8/2015.	F 329		

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 _____	12/11/2015

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 329	Continued From page 12	F 329		

The Progress note for R12 from 7/2015 through 12/8/2015 have no non-pharmacological interventions attempted documented prior to use of the emergency Clonazepam 0.5 mg. Additionally the PRN Medication Sheet nor the progress notes have effectiveness/results documented after utilization of the Clonazepam 0.5 mg on 7/19/2015 , 8/7/2015 or 9/8/2015.

On 12/10/2015 at 12:57PM, R12 was sitting talking with table mates in the dining room, no behavior displayed.

On 12/10/2015 at 12:40PM, E5 (Nursing Assistant) stated " I have never seen (R12) exhibit any behaviors. (R12) is very cooperative and pleasant."

On 12/2015 at 2:45PM, E6 (Nursing Assistant) stated "(R12) never has any behaviors."

On 12/9/15 at 2:40pm, E2 (Director of Nursing) stated prior to the use of emergency anti-anxiety medications non-pharmacological measures are to be attempted and documented in the progress notes. E2 stated examples of non-pharmacological interventions which could be attempted include care planned interventions, warm blankets, one to one interaction and bringing the resident to the nurses station. E2 also stated effectiveness after the receipt of an emergency anti-anxiety medication is to be documented either in Progress Notes or the PRN Medication Information Sheets.

The facility's Psychotropic Medication Policy dated 9/23/13 documents "1. Psychotropic medications include: antianxiety....., 3. The interdisciplinary team will determine the root

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 _____	12/11/2015

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 329	Continued From page 13 cause of behavior symptoms in order to develop the appropriate treatment of environmental, medical or behavioral interventions in order to meet the needs of the individual resident. Psychotropic medications always being the last considered intervention."	F 329		