Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010078	A. BUILDING: ______ B. WING ______	C 11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation 1998570/IL117714 1998575/IL117717 First Complaint Revisit to Survey date 10/3/19 Complaint #1997149/IL116151	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Electronically Signed | 12/09/19

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S9999	Continued From page 1	S9999		

These Regulations were not met as evidence by:

Based on interview and record review, the facility failed to provide staff supervision for one of six residents (R6) at risk for falls and with agitated behaviors reviewed in a total sample of 17 residents. This failure resulted in R6 falling on her face from her wheelchair, sustaining a laceration above her left eyebrow and requiring three sutures.

Findings include:

R6's diagnosis includes stroke, muscle weakness, cognitive communication deficit and lack of coordination.
Physical Therapy discharge summary dated 5/14/19 notes R6 requires moderate assistance with wheelchair mobility.

R6's fall care plan notes she has a deficit related to functional limitations due to stroke with left sided weakness, has cognitive impairments and requires extensive assistance. R6 can become agitated and swing legs over bed and has poor safety awareness and reasoning skills, Interventions include to assistant with transfers, ensure proper positioning while in chair, if agitated and trying to move legs, to reposition her.

11/20/19 at 12:05 pm, V1 (Administrator) stated that R6 had a fall from her wheelchair on 11/17/19 in front of the nurse's station. There was nobody at the nurse's station at the time of the fall. V14 (Licensed Practical Nurse, LPN) was assigned to R6 but was not on the unit when she fell. V4 (LPN) attended to R6 at first. She had a laceration on her head and was sent to the

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S9999	Continued From page 2 hospital where she was admitted with a head injury. 11/20/19 at 2:00 pm, V4 (LPN) stated that on Sunday, 11/17/19 around 8:30 am, I was monitoring residents in the dining room when V26 (Certified Nursing Assistant, CNA) yelled for me to come to the nurse's station. I was the only nurse on the unit at the time. R6 was laying on the floor and bleeding when I got to the nurse's station. I did not see her fall . V14 (assigned nurse) then came down the hall. V24 (CNA), V25 (CNA) and V26 (CNA) were with R6 when I arrived, and she was laying on the floor. V25's (CNA) written statement included in the facility investigation dated 11/17/19 notes, V25 got R6 up about 8:30 am and pushed her in the wheelchair to the desk (nurse's station). V24 and V26 were at the nurse's station. I went to get some socks. When I came back, R6 was on the floor. 11/21/19 at 10:30 am, V2 (Director of Nursing, DON) stated that I determined the cause of the R6's fall was that she was impulsive and agitated. V25 was taking care of her that day and stated V24 and V26 were at the nurse's station when she left to get her socks. I reviewed the video and saw R6 tried to stand up by herself. R6 has behaviors of agitation and tries to get up unassisted at times. 11/21/19 at 2:15pm, V24 (CNA) stated that V25 was assigned as R6's CNA and she brought her out in the wheelchair to the nurse's desk. V25 left the unit to get R6 socks. I went in my patient's room to care for her when R6 fell and did not see her fall.	S9999		

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S9999	Continued From page 3	S9999		

11/25/19 at 9:45am, V26 (CNA) stated that V25 brought R6 out in a wheelchair to the nurse's station. She left the unit to get socks for R6. I was in my patient's room and when I walked out of that room, I saw R6's empty wheelchair and R6 on the floor. Nobody was with R6 or at the nurse's station when I found her on the floor. She was bleeding from her head.

11/21/19 at 2:10 pm, V28 (CNA) stated that R6 requires a mechanical lift for transfer and 2-3 staff members. She gets combative at times. I always keep her with me or supervised in activities in the day room. R6 needs constant supervision so she does not hurt herself or have a fall. She does lean to the sides in wheelchair and will propel herself in a circle with her right hand only. She slides forward sometimes when she does this also.

11/21/19 at 2:30 pm, V12 (LPN) stated that I would not leave R6 in the hallway or at the nurse's station because I may have to walk away and do something. R6 should always be supervised. She came back to facility with sutures to her eyebrow.

11/25/19 at 11:20 am, V2 (DON) stated that V25 (assigned CNA) said that several times she wheeled R6 to the nurse's station and when she went to walk away to get her socks, R6 would start to propel self with her right hand down the hall. V25 would get her and put her back in front of the nurse's station. Per V2, V25 stated she was afraid R6 would fall. This happened several times before she left to get R6 socks. V25 stated she left R6 at the nurse's station when V24 and V26 were there. V25 believed that V24 and V26 were supervising R6 at the nurse's station when she fell. Surveyor made V2 aware that per interview with V24 and V26, they both stated that

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S9999	Continued From page 4	S9999		

they were in other resident rooms and not at the nurse's station when R6 fell. V2 then stated that R6 should have been supervised by staff when in the hallway. V25 should have specifically asked other staff to supervise R6 when she left the unit to get her socks. I did not see other staff in the video with R6 when she tried to get up by herself and fell.

V2 (DON)'s investigation note dated 11/18/19 notes R6 is alert and oriented to name only with confusion. R6 is impulsive attempting to stand up with assist while in wheelchair and attempts to get self out of bed unassisted. Compulsive behavior, does not understand safety risks or preventative measures done to keep her safe. Redirection given by staff was unsuccessful. R6 stood from wheelchair unassisted losing balance and sustaining a fall. Staff at desk were unable to reach resident in time prior to falling per interviews.

V14's incident report on 11/17/19 notes R6 was oriented to person and had a fall with laceration to her left forehead. R6 was in her wheelchair with predisposing factors of impulsiveness, gait imbalance, decreased safety awareness, combative behavior with the wheelchair wheels unlocked at time of fall.

R6's functional status dated 10/21/19 notes she requires extensive assistance with one staff physical assistance for transfers and locomotion on the unit in her wheelchair.

R6's cognitive function dated 10/21/19 notes a score of 3 out of 15 which indicates severely impaired.

V12's readmission nursing screening dated

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S9999	Continued From page 5	S9999		

11/11/19 notes R6 requires total dependence with transferring and locomotion on and off unit with a wheelchair.

V4's note (LPN) on 11/17/19 at 8:30 am, notes she was summoned to nurse's station and observed resident lying on her left side on the floor in front of her wheelchair. R6's left eye appeared to be bleeding from a laceration above her left eyebrow.

V14 (Assigned LPN) note on 11/17/19 at 8:57 am, notes R6 observed on the floor near the nursing station around 8:15am, laceration observed on left eyebrow. R6 is alert and oriented to self. An ambulance was called, and she was sent to hospital for further evaluation. At 3:11 pm, R6 was admitted to hospital for head trauma.

R6's hospital records documented on 11/17/19, R6 was in the emergency room with a laceration in the middle of her left eyebrow.

V27 (Wound Care Nurse) progress notes on 11/20/19 at 8:34pm note that R6 was readmitted with three sutures in place over left eyebrow.

(B)