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
	IL6011746	A. BUILDING: ____ B. WING ____	C 10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR NRSG & REHAB CTR	345 DIXIE HIGHWAY CHICAGO HEIGHTS, IL 60411

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S 000	Initial Comments Complaint Investigation 2092257/IL121327 2095606/IL124891 Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator,	S9999		

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employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview, and record review, the facility failed to monitor and supervise a high fall risk resident while in the dining room for 1 of 4 residents (R2,) reviewed for falls, and failed to develop a plan to prevent a fall incident for a high risk for falls resident for 1 of 4 residents (R3) reviewed for falls. These failure resulted in R2 being left unmonitored in the dining room and R2 fell from the wheel chair onto the floor, sent to the local hospital and diagnosed with an end-stage subarachnoid hemorrhage and R3 found on the floor in the bathroom R3 was sent to the hospital for evaluation and to include CT scan of facial bones documented bilateral nasal fractures.

Findings Include:

R2 is an 84 year old with the following diagnosis: difficulty in walking, dementia with behavioral disturbances, altered mental status, history of falling, traumatic subarachnoid hemorrhage - end stage. R2 admitted to the facility on 2/28/2020.

A note dated 3/9/20 documents R2 observed lying on the floor in a supine position. R2 alert and oriented times 1 which is baseline. Bleeding noted from the back of R2's head. Pressure was applied and bleeding was controlled. Swelling also noted to the back of the head and ice

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applied. R2 sent to the hospital for further evaluation.

The Fall Event dated 3/9/20 documents R2 was sitting in the dining room and had an unwitnessed fall. R2 noted to be calm right before the fall.

The Hospital Records dated 3/9/20 documents R2 apparently fell at the nursing home and the outside imaging showed an acute subarachnoid hemorrhage as well as a subdural hygroma with a 2 millimeter midline shift. R2 admitted to the intensive care unit.

The Minimum Data Set (MDS) dated 3/9/20 does not document any Brief Interview Mental Status (BIMS) score. Section G of the 3/9/2020 MDS documents R2 is an extensive assist for all activities of daily living.

The Incident Report dated 3/13/20 documents R2 was sitting at the dining room table with others waiting for the activity to start. V8 was present in the room at the time of the fall. V8 was setting up for the activity and had V8's back turned for a moment and suddenly heard a noise. V8 turned toward the noise and saw R2 lying on the floor in front of the wheelchair. Staff and the Nurse Practitioner provided first aid. R2 sent to the hospital and admitted with a laceration to the back of the head and subarachnoid hemorrhage. R2 returned to the facility on hospice per R2's family request.

On 10/28/20 at 118AM , V7 (Nurse) stated, "I dropped R2 off in the dining room for R2's morning activity. I believe there was 2 activity aides in there and 2 CNAs. I wasn't in there so I didn't see what happened but I heard a noise and someone call for the nurse, so myself and the

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nurse practitioner went in the dining room and R2 was on the ground. I think what they told me was they were going to help another resident and had their backs turned for a second and R2 stood up and fell. R2 was pushed up against the end of the table and if looked like R2 tried to get up and walk away but tripped over the wheelchair. We assessed R2 and R2 was bleeding from the back of R2's head. R2 wasn't having any aggressive behaviors that day. We were trying to having people watch R2 more because R2 was unsteady and was aggressive toward staff. Yes, R2 was a high fall risk from the beginning. R2 was high fall risk because R2 was unsteady and R2's behaviors. R2 was very impulsive."

On 10/28/20 at 1:29PM, V8 (Activity Aide) stated, "I was setting up my activity and the nurses and CNAs were bringing in people who were going to participate. There was maybe like 7 residents in there total. I was in there by myself. The CNAs will usually drop the residents off and go do their work or chart. They will tell me who is high fall risk and I just try to keep them engaged. If I can't handle someone, I call for the nurse or a CNA to come help me. I was setting up the tables for a game called table ball. I was pushing the tables together and I had my back turned to R2. It was turned for maybe 2-3 minutes while I was setting up. I can't remember what the CNAs told me about R2 when he was dropped off.

On 10/28/20 at 2:06PM, V9 (Fall Coordinator) stated, "For dementia residents, we try to manage their behaviors more. It can vary from day to day depending on what behavior they are having. It's really up to the nurse what to do but we walk with them in the hall to tire them out some, we sit with them at the nurse's station, and we try to keep them in activities. We just cluster them in

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supervised areas during the day. There is usually 1-2 activity aides in the dining room and 1 CNA. They should be constantly moving from resident to resident checking on them. Residents shouldn't be in the room during set up because the activity person can't really watch them and set up. They can't be left unsupervised if the aide leaves the room to get things for the activity. I know for that fall, V8 turned V8's back for a second and R2 got up and fell."

On 10/29/20 at 12:36PM, V11 (Medical Director) stated, "All the residents are on the second floor to be monitored better. The second floor are residents are confused and usually do have the ability to walk all over without some kind of help. Residents with behaviors and that are high fall risks are brought out into areas where they can be monitored better by all the staff. I know they keep them at the nurse's station and then they do activities in the dining room with them too. If they are in the dining room doing activities, then they should be monitored appropriately."

The Care Plan dated 3/4/20 documents R2 has a diagnosis of dementia with behavior disturbance. R2 is unable to make daily decisions without cues/supervision. R2 is at risk for falling related to psychosis, dementia, history of falls, hypertension, anxiety, dysphagia, weakness, and high cholesterol. Interventions in place include: provide environment free of clutter and observe frequently and place in supervised areas when out of bed.

R3 is a 97 year old with the following diagnosis: dementia, history of falling, nasal fracture, and chronic kidney disease stage 3. R3 admitted to

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S9999	Continued From page 6 the facility on 3/6/2020. A note dated 3/6/2020 documents R3 admitted to the facility and is a limited to extensive assist with most ADLs. The Minimum Data Set (MDS) dated 3/12/20 documents R3's Brief Interview for Mental Status Score (BIMS) as 2 (severely cognitively impaired). Section G of the MDS dated 3/12/20 documents R3 needs limited to extensive assist with walking and transfers. R3 needs a 2 person assist for walking and transfers. The Fall Risk Observation Sheet dated 3/18/20 documents R3 is a high fall risk. A note dated 3/21/20 documents the CNA found R3 with lower extremities hanging out of the bed. R3 educated that hanging legs out of the bed can lead to falls. R3 expressed understanding. The Fall Event dated 3/29/20 documents R3 found on the ground around 1:20PM. R3 calm and confused. R3 noted with laceration to the nose. Pain assessed and R3 denied pain at this time. R3 put back in bed. A note dated 3/29/20 documents R3 found on the floor by the bathroom. R3 reported being ok and put back to bed. R3 with a cut to the nose. The nurse notified the nurse practitioner and orders received. STAT labs drawn at around 4:30PM. At 8:30PM, a critical lab result was reported to the facility and R3 was sent out to the hospital for evaluation. R3 left the facility around 9:20PM. The Laboratory report dated 3/29/20 documents the specimen was collected at 4:20PM and the results were reported to the facility at 8:08PM.	S9999		

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S9999	Continued From page 7 The Hospital Records dated 3/29/20 documents R3 arrived to the emergency department at 9:42PM. R3 presented to the emergency department for a ground level fall and abnormal labs. R3 does not remember the fall. R3 reported pain around the nose area but has no other complaints. A laceration over the bridge of the nose and bruising around the left eye noted. The CT scan of the facial bones showed nasal fractures. R3 admitted to the intensive care unit. The Incident Report dated 4/2/20 documents R3 fell while walking to the bathroom and was found down during rounds. STAT orders for x-ray and labs received by the nurse practitioner. R3 sent to the hospital for abnormal lab values. Record review revealed bilateral nose fractures. On 10/28/20 at 2:06PM, V9 (Fall Coordinator) stated, "Everyone on the second floor is a high fall risk. R3 was specifically a fall risk because of dementia, weakness, and altered mental status. R3 should not have been ambulating alone. We go verbal reminders to make sure R3 was calling before getting up for help. R3 should not have been getting up alone. For resident like R3 I would say they probably would be doing more frequent checks on R3. No it's not in R3's care plan. I don't know why R3's room was moved. It may have been the only room available." On 10/28/20 at 2:48PM, V10 (Nurse) stated, "R3 was found on the floor by the bathroom. The CNA found R3. She came to get me and I went to assess R3. I called the NP and an x-ray and labs were ordered. R3 did have a little cut that was bleeding on R3's nose. It didn't looked deformed. R3 could tell you R3's needs but R3 was confused. R3 knew his name, R3 could tell you if R3 needed to use the bathroom or something like that but R3 didn't really know what	S9999		

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was happening. R3 was a high fall risk. R3 was very unsteady when R3 walked. R3 always was trying to get out of bed. R3 would have his legs out and we would have to tell R3 to get back in bed. We got around in a wheelchair all the time. R3 never really walked. They normally would be in the hallway or at the nurse's station with us but they had to stay in their rooms then because of COVID. We do rounding on them every hour. No, it was still every hour during COVID. Some residents were every 30 minutes. I don't remember if R3 was every 30 minutes."

On 10/29/20 at 12:36PM, V11 (Medical Director) stated, "Residents were all supposed to be in their rooms but you had some residents that didn't understand so they were having behaviors. They were getting up before anyone could get to them. Everyone was more focused on COVID and managing that during that time period."

R3 made a room change on 3/23/20 from room 150 (a room directly across from the nurse's station) to room 241 (a room that is second to last room down the hall). Room change much further away from the nurse's station than the previous room.

The Care Plan dated 3/9/20 documents R3 is at risk for falls due to dementia, weakness, hypertension, chronic kidney disease, anxiety, and altered mental status. Interventions include: give verbal reminders not to ambulate/transfer without assistance, keep call light in reach, provide an environment free of clutter, and encourage resident to stand slowly.

The Policy titled, "Fall and Fall Risk, Managing," dated 08/2008 documents, "Staff will identify and implement relevant interventions (e.g., hip

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S9999	Continued From page 9 padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. (A)	S9999		