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
	IL6007082	A. BUILDING: ______ B. WING ______	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE ROSE HEALTH CARE CTR	900 SOUTH CHESTNUT PANA, IL 62557

(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) COMPLETE DATE
S 000	Initial Comments Complaint 2145852/IL137058 F689G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2)3) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999		

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S9999	Continued From page 2 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of	S9999		

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other residents and employees of the facility. (Section 3-612 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review 1) the facility failed to provide supervision to prevent resident to resident incidents for 9 residents (R1, R2, R3, R4, R5, R6, R7, R8, R10) reviewed for incidents. 2) the facility failed to provide supervision to prevent elopement (exit seeking behaviors) for 1 resident (R9) reviewed for elopement. This failure resulted in a resident to resident altercation in which R3 attacked R2 in her own room. R2 sustained bruises and scratches from R3, is now fearful of further attacks by R3, has withdrawn to her room and will only come out with staff escort.

Findings include:

1. On 8/17/2021 at 9:10 AM, R2 who is a 77 year old alert female stated, "I was sitting in my recliner and (R3) entered my room and began yanking at my dresser drawer." R2 stated that she told R3 to "Get out!" R2 stated that R3 then grabbed her walker and began shoving the walker into her legs which caused her to lose her balance and she landed on her bed. R2 stated, "I began to scoot across my bed so I could use my call light because no staff had responded to cries for help." R2 stated, "I then screamed out 'Help me!' about 5-6 times because (R3) began throwing full cans of soda at me striking my arm and I am becoming agitated." R2 stated, "(R3) used the "F" word stating 'F*** You'." R2 stated, "Yes, I am afraid of (R3), now I stay in my room."

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S9999	Continued From page 4 R2 stated, "I don't feel safe anymore and this is my home and I have been here about 8 years." R2 stated, "It's like having a rapist living next door." R2 stated, "I wait for staff to walk me into the dining room and activities because I am fearful of (R3)." R2 stated if staff is not available then she eats in her room or misses activities. R2 stated, "(V6, Licensed Practical Nurse/LPN) and (V2, Director of Nursing/DON) responded on 8/09/21 and removed (R3) from her room. R2 stated, (V6) took my vitals and I think made some phone calls." R2 stated, "I am getting anxious just talking about it, because I am reliving it." R2 stated that R3 had been in her room before. R2 stated there were soda cans under my bed and out in the hallway. R3's Face Sheet documents that R3 is a 73 year old male that was admitted to facility on 7/10/2021 with a diagnosis to include: Severe Alzheimers, Congestive Heart Failure, A-Fib, Hypertension and BPH (Benign prostatic hyperplasia). On 8/17/2021 at 8:08 AM, R3 stated, "I never threw a soda can at anybody." R3 stated, "I will go to jail first." R3 stated, "I am very hard headed about things I didn't do." On 8/17/2021 at 9:23 AM, R3 opened the closed dementia unit door setting off the alarm. On 8/17/2021 at 9:28 AM, R3 wheeled himself down the hallway with no staff interaction or intervention. On 8/17/2021 at 11:07 AM, R3 fed himself lunch sitting by himself at lunch table. On 8/17/2021 at 9:56 AM, V2, DON, stated, "(R3)	S9999		

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was just wheeling around in his wheelchair, then we heard 'Help' and I saw (R3) wheeling himself from (R2's) room." V2 stated that, "(R2) stated that (R3) had busted into her room." V2 stated, "I knew something had happened, (R2's) words were rushed, not making complete sentences, her eyes were big and she was scared." V2 stated, "We also saw dented cans." V2 stated, "No, (R3) was not sent out for a psych evaluation because (R3) is on hospice and they would not accept him."

On 8/17/2021 at 1:07 PM, V1, Administrator, stated, "I believe a additional medication was added for intervention." V1 stated, "(V9, Hospice Nurse) was going to address it through hospice." V1 stated, "(R3) was not sent out for psych eval due to being on hospice, they would not accept."

R3's Physician orders dated 8/9/2021 documents; Haldol 5mg/ml vial give 2mg intramuscular x 1 dose.

On 8/18/2021 at 10:17 AM, V9, Hospice Nurse, stated, "I called (V13, Hospice Medical Director) and he ordered medications for (R3)." V9 stated, "I advised (V13) that (R3) was being combative and physically aggressive." V9 stated, "I believe (V13) ordered Haldol."

On 8/17/2021 at 11:53 AM, V4, Certified Nursing Assistant (CNA), stated, "I am walking (R2) back to her room from the dining room, because she is afraid of (R3)."

On 8/18/2021 at 10:35 AM, V4 stated, "I found (R3's) shirt on (R6's) floor when I went inside her room today." V4 stated, "(R6) stated that (R3) came into her room and took off his shirt."

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On 8/18/2021 at 10:45 AM, R6, who is a 82 year old alert and oriented female stated, "(R3) has come into my room several times and I am scared to death of him." R6 stated, "Last night (R3) came into my room and took his shirt off." R6 stated, "One evening (R3) was in my room going through my night stand drawer." R6 stated, "I am scared to death of (R3)."

On 8/17/2021 at 10:10 AM V5, CNA, stated, "(R3) wanders a lot in his wheelchair." V5 stated, "It gets rough trying to watch him, by the end of the day you're dead." V5 stated, "Don't have enough help." V5 stated, "We don't have any behavior tracking for (R3)."

On 8/17/2021 at 10:20 AM, R4 an alert and oriented 77 year old male stated, "I'm scared of (R3) because he has hit people." R4 stated, "(R3) comes into my room all the time without permission."

On 8/17/2021 at 10:48 AM, R5 an alert and oriented 64 year old, stated, "(R3) comes into my room all the time."

On 8/17/2021 at 11:00 AM, V4, CNA, stated, "When it comes to (R3), we just redirect." V4 stated, " No, (V10, Maintenance) is not always watching (R3) like he is today."

On 8/17/2021 at 11:05 AM, R1 an alert and oriented 75 year old, stated, "(R3) is kinda demented." R1 stated, "(R3) comes into my room, he's a nuisance." R1 stated, "(R3) he doesn't know what he is doing." R1 stated, "(R3) is all the time trying to get out of the building and staff try to keep him in."

On 8/17/2021 at 2:07 PM, R8, a 93 year old alert

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S9999	Continued From page 7 and oriented male, stated, "I am aggravated, someone in charge lets him loose." R7 (R8's wife), a 93 year old alert and oriented female stated, "One time (R3) entered our room and (R8) was in the bathroom and (R3) blocked the bathroom door to where (R8) couldn't come out, until staff arrived." On 8/17/2021 at 2:18 PM, V7, CNA, stated R3 has been violent with her many times. V7 stated, "I try snacks, TV and take outside and nothing works." On 8/18/2021 at 9:54 AM, V6, LPN, stated, "(R2) started screaming, so I started running down to her room (located at the end of the hallway next to exit doors) and saw (R3) propelling out of (R2)'s room." V6 stated, "(R2) was a panic mess, red marks on her arm and sodas on the floor." V6 stated, "Yes, it changed (R2) she is more withdrawn now and (R2) is not wanting to come out of her room alone anymore." R3's Progress note dated 8/9/2021 documents, (R3) has been exit seeking, hitting staff, another resident states (R3) hit him but it was not witnessed, cursing and being very hard to keep under control. Family was notified. Hospice was notified. awaiting return call from hospice. R3's Progress note dated 8/13/2021 documents; (R3) has been trying all afternoon to get outdoors-refusing to take meds- threatening to knock staff out-all staff. Keeps going in other residents rooms and trying to take their stuff. R3's Progress note dated 8/15/2021 documents; Hospice continues. (R3) up in wheelchair propelling self; exit seeking, talking about events in distant past. Talking a lot about guns and killing	S9999		

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of animals and people.

R3's Care Plan dated 7/10/2021 documents; (R3) known to wander may seek to leave home. Interventions start date 7/20/2021; Validate residents need to complete task and assist resident to "find" what/who is being sought, eventually redirecting Resident back to unit/facility/room.
15 minutes checks Start date 8/17/2021. There is no documentation there were any new interventions implemented after the incident (altercations between resident to resident) on 8/11/2021 or the other incident which occurred on 8/9/2021 which involved (R3) hitting.

On 8/18/2021 at 11:30 AM, V1, Administrator, stated, "There is no policy and procedure for supervision."

Facility's Final investigation involving R3 and R10 dated 8/16/2021 documents; On 8/9/2021 at 3:30 PM, staff reported an alleged resident to resident altercation. During the investigation, R10 stated that resident (R3) hit him. (R10) stated that he and resident (R3) were in hallway near nurses' station when resident (R3) hit him.

On 8/19/2021 at 1:40 PM, V1, Administrator, stated, "We are working on trying to find a way to supervise (R3)." V1 stated, "We are looking at his medications, and a way to have (R3) be seen for his behavioral health." V1 stated, "We are doing visual checks but don't know when it started." V1 stated, "We are constantly revaluating."

2. R9's Care Plan dated 8/4/2020 documents; (R9) known to wander may seek to leave the home. (R9) specific information Wandering worse in the evening. Interventions: Seek

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S9999	Continued From page 9 alternative/diversional activities for exit seeking behaviors. Share successful strategies with others as needed. No new interventions have been added since 8/4/2020. R9's Progress note dated 6/17/2021 documents; (R9) exited building 2nd time. Was assisted by CNA and redirected back. R9's Progress note dated 6/19/2021 documents; (R9) exited building on 200 hall trying to go home. (R9) redirected back inside building. R9's Progress note dated 6/20/2021 documents; (R9) has exited the facility numerous times. R9's Progress note dated 7/16/2021 documents; (R9) exited the building times one, redirected back inside. R9's Progress note dated 7/31/2021 documents; (R9) redirected back into building. On 8/17/2021 at various times between 9:00 AM-12:30 PM, R9 observed walking to the end of hallway and exiting out of building without staff intervention stopping resident from exiting. On 8/18/2021 at various times between 9:00 AM-1:00 PM, R9 observed walking to end of hallway unsupervised and exiting out the building. On 8/19/2021 at various times between 8:00 AM-9:00 AM, R9 observed walking to end of hallway and exiting out building without staff supervision. On 8/19/2021 at 12:40 PM, R9 observed walking out the exit doors with no staff stopping R9 before she got outside the facility.	S9999		

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S9999	Continued From page 10 On 8/19/2021 at 09:25 AM, V14, MDS/LPN, stated, "The floor nurses are responsible to update Care Plans after an incident, then I believe it's V2, DON, responsiblity to check Care Plans. V14 stated, "When I receive the Care Plans, I add all the written interventions and print out the new Care Plan." On 8/19/2021 at 1:45 PM, V2, DON, stated that V14, MDS/LPN, is responsible for updating the residents care plan with new interventions. The Facility's Abuse Prevention Program Policy and Procedure dated 11/28/2016, documents; This facility affirms the right of out residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect, and abuse of residents. Dementia management and resident abuse prevention. (B)	S9999		