| 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 12/30/2021 |

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| PRAIRIE MANOR NRSG & REHAB CTR | 345 DIXIE HIGHWAY CHICAGO HEIGHTS, IL 60411 |

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| S 000 | Initial Comments<br><br>Complaint investigation:<br><br>2199417/ 141508 | S 000 | | |
| S9999 | Final Observations<br><br>Complaint investigation:2199417/ 141508<br><br>STATEMENT OF LICENSURE VIOLATIONS:<br><br>300.610c)4)A)B)F)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br>c) 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.<br>4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:<br><br>A)Analysis of the risk of injury to residents and nurses and other health care workers taking into | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs;<br><br>B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling;<br><br>F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br><br>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:<br>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.<br><br>These Regulations were not met as evidenced | S9999 | | |

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| S9999 | Continued From page 2<br>by:<br><br>Based on interview and record review the facility failed to follow the MDS (minimum data set) assessment and care card and utilize 2 staff while providing direct care and bed mobility for 1 of 3 residents (R2). This failure resulted in R2 being rolled off the bed, and sent to the local hospital where R2 was treated for blunt head trauma subdural hemorrhage.<br><br>Findings includes:<br><br>R2 has the diagnosis of subdural hemorrhage with loss of consciousness of unspecified duration. Section G (functional status) dated 10/4/21 documents: R2 required extensive assistance with two plus person physical assist with bed mobility. Care card updated 4/29 documents: Mobility extensive times 2 staff. Nursing note dated 12/16/2021 documents: R2 was observed on the floor in a supine position with a swollen left forehead and scant amount blood on the right nose. Hospital paperwork dated 12/16/21 documents: R2 reported being rolled in bed and was rolled off the bed and fell about 2 feet.<br><br>On 12/22/21 at 1:23pm, R2 who was assessed to be alert and oriented person, place and time said, V5 (cna) threw me out of the bed when changing my diaper. I had lumps on both side of my head and a scar under my eye. I felt like V5 must have hated me to throw me out of the bed like that. I felt bad. V5 was changing my diaper by herself.<br><br>On 12/22/21 at 3:18pm, V2 (DON) said, R2 was being assisted with incontinence care by V5 (cna). V5 rolled R2 onto R2 side, felt the air loss mattress deflating, R2 rolled onto the floor | S9999 | | |

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| S9999 | Continued From page 3<br>sustaining a subdural hematoma. V5 was assisting R2 by herself. R2 required two person physical assist. It should have been two staff members assisting R2 incontinence care.<br><br>On 12/22/21 at 3:33pm, V5 (cna) said, R2's fall was done in error, by mistake. R2 had an air mattress. I pulled the flat sheet to rolled R2. I thought R2 was going to roll in the center of the bed but R2 rolled on the floor. R2 sustained a knot on her head the size of a goose egg with a scant amount of blood. I was assisting R2 by myself.<br><br>On 12/22/21 at 4:24pm, V10 (nurse) said, R2 does not reposition self. R2 should always have 2 person physical assist. I saw R2 on the floor. V5 said, she was changing R2 when R2 slipped off the air mattress and slid to the floor. V5 said, she could not find any staff to help with R2. I asked V5 why she did call me to help provide care. We called 911 at R2's bedside. R2 was discharged from one hospital to another due to a bleed on the brain. I told, V5 she was neglectful in taking care of R2. I wrote V5 a corrective active form.<br><br>On 12/23/21 at 12:40pm, V2 (DON) said, certified nursing assistance get information on how to take care of a resident from the care cards, if the card care is not available the aide should seek out the nurse for any questions about a resident's care needs.<br>Corrective action form dated 12/16/21 documents: Staff failed to use a two person assist to care for R2.<br><br>Hospital paperwork dated 12/16/21 documents: R2 had a 4x5 centimeter (cm) left frontal lobes hematoma (collection of blood outside the blood vessels) measuring 8 millimeters in thickness and | S9999 | | |

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| S9999 | Continued From page 4<br>right cheek laceration measuring 1 cm.<br><br>Hospital paperwork dated 12/17/21 documents: Diagnosis of blunt head trauma. Head CT documents: Tiny subdural hemorrhage along the left parieto-occipital lobe and right frontal lobe.<br><br>(B) | S9999 | | |