

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	---	---	---

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

(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 Survey 2290566/IL00142718	S 000		
S9999	Final Observations Complaint Survey 2290566/IL00142718 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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. 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	--	---	---

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

(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
S9999	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 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.</p> <p>These regulations were not met as evidenced by: Based on observations, interviews and records</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	--	---	---

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

(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
S9999	<p>Continued From page 2</p> <p>reviewed the facility failed to ensure there were effective fall prevention interventions in place to prevent/reduce the risk of falling for 1 of 5 residents reviewed for fall prevention protocol and procedures. This failure resulted in R1 having multiple falls incidents subsequently falling and sustaining a fracture to the left distal femur.</p> <p>Findings include:</p> <p>Review of R1's face sheet documents a 96 year that was admitted to the facility on 10/9/2020 with diagnoses that includes: cerebral ischemia, Syncope and collapse, bilateral primary osteoarthritis of hip, contracture, left hand, encounter for other orthopedic aftercare, unspecified fracture of unspecified femur, minimally displaced zone II fracture of sacrum, and other abnormalities of gait and mobility, and unspecified Altered Mental Status. R1's Brief Interview for Mental Status Score (BIMS) dated 11/22/21 documents a score of 4/15 which indicates severe impairment. R1 MDS Section G dated 11/22/21 documents R1 requires extensive 2 person assist with toileting and transfers. R1's fall risk assessment dated 11/20/2020 documents R1 as a high risk for falls. MDS documents Walking was not attempted and R1 is not able to stabilize self without staff assistance.</p> <p>Record review of R1 events log and root cause analysis of falls since 11/20/20 documents 7 of 9 falls were related to R1 trying to go the restroom:</p> <p>11/20/20 observed on the floor in bedroom. R1 stated "I'm going to the bathroom." Care plan documents intervention added as follows: U/A and C&S with labs r/t frequent c/o need to urinate</p> <p>1/10/21 resident was going to the restroom. She</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	--	---	---

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

(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
S9999	<p>Continued From page 3</p> <p>started walking towards the restroom and fell. Resulting in R1 complaining of coccyx pain. Care plan documents intervention added as follows: floor mats at bedside while resident in bed.</p> <p>2/26/2021 unwitnessed fall. Resident observed with black eye told staff she fell 2 weeks ago. R1's Fall root cause analysis documents resident was trying to go to the bathroom. Attend/supervise resident during toileting needs every 2hrs/PRN while in bed.</p> <p>3/9/2021 R1 was found crawling on the floor in her room.</p> <p>3/18/2021 R1 observed with her knee on the floor kneeling on the chair in her room. R1's Fall root cause analysis documents resident was trying to go the bathroom. Care plan documents intervention added as follows: observe frequently and place in supervised area when out of bed.</p> <p>3/28/2021 R1 found crawling to the bathroom. R1 was assisted to the toilet. Brief damp and resident voids moderate amount of yellow urine.</p> <p>7/19/2021 R1 found with a fracture to her left arm. Resident states she had fallen but not sure when.</p> <p>11/6/2021 R1 found on the floor laying on right side on the floor near the bathroom. V2 states I was at the facility and she said she was going to the restroom. Care plan documents intervention added as follows: Obtain PHYSICAL THERAPY consult for strength training, toning, positioning, transfer training, gait training, mobility devices, etc.</p> <p>12/8/2021 R1 found on the floor mat next to bed.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	--	---	---

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

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>As of 1/27/2022 at 10:34 AM there were no new interventions for this fall that occurred on 12/8/2021. V2 stated no R1's care plan had not been updated for the 12/2021 fall. The Root cause analysis dated 12/8/2021 documents R1 needed to use the restroom.</p> <p>Review of facility reported incident dated 11/8 /2021 documents R1 was found near the bathroom where she complained of knee pain and sent to the hospital. Hospital report of xray of left knee and left femur documents the following impression: Acute, oblique fracture through the distal left femoral metaphysis with mild medial displacement/angulation of the distal fracture fragment.</p> <p>On 1/27/2022 at 1:30 PM V2 (DON) V2 states, "I'm at a lost with what to do with her (R1)". Surveyor asks, if V2 believes Physical therapy/occupational therapy is appropriate intervention to address the cause of someone who keeps trying to get out of bed to urinate. V2 states "I guess we can round more frequently on her. Every hour." On 2/4/2022 at 1:55 Pm V2 states when R1 needs assistance she yells out that she needs help and her room is not next to the nurse's station.</p> <p>On 1/27/2022 10:50 AM V4 (LPN) states R1's is fall precaution and 2 person assist with ADL. Cast on leg from fall 2 months ago. R1 call light comes on as just before we enter the room. R1's room observed to be near the end of the hall away from the nurses station. R1 in the room and no staff present. R1 is observed in a wheelchair scooting herself forward. Half of call light tied to the left side of her wheelchair, the other half is hanging from the wall. It appears that R1's pull herself forward which triggered the</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	---	---	---

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

(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
S9999	<p>Continued From page 5 light to come.</p> <p>On 1/27/2022 at 11:00 AM 2nd floor V3 CNA worked here 11. V3 states R1 tries to get out of the chair all the time. We have to keep an eye on her. They have to stay in their rooms right now. Normally everyone in the dining room and watch them. 2/4/2022 at 1:14 V3 states R1 doesn't like being by herself. V3 states when R1 is alone she tries to go to bathroom by herself. V3 states, when R1 is with staff she will always let us know she has to go to bathroom. We physically take her to the restroom and try to have 2 people to do that. R1 is a fall risk. "I have told the nurses in the past that she tries to get out of the chair. I've told the nurse plenty of times."</p> <p>On 2/4/22 at 12:48 PM as surveyor approaches R1's room and as get to room here R1 screaming "help". find it to R1 and go in room. Everyone in rooms today. V11 states, she sees R1 trying to get out of chair or trying to maneuver herself to the restroom in her wheelchair. V11 states, "Yes, I've seen her ty to lift herself out of chair. When I see that I try to redirect her. I tell her she could hurt herself. I've told the nurse when I've seen her trying to lift out of the chair. V11 lets us know when she needs to be changed. She calls out. She doesn't use call light. Surveyor asks, how can R1 tell you she needs something if she doesn't use her call light. V11 states she always just calls out. V11 states when she hears R1 screaming, she goes to her room and see what she needs." V11 states, since she has worked at the facility R1 calls out.</p> <p>On 2/4/2022 at 12:58 PM V17 (LPN) states R1 "is confused, alert to self. At one point, she was a high fall risk, but has not fallen lately. She has fallen trying to go to the rest room. She does not</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/08/2022
--	--	--	---

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

(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
S9999	<p>Continued From page 6</p> <p>want to urinate in her depends. She prefers physically go to the rest room. When I've seen her up or trying to get up she says "I'm going to bathroom". "V17 states she has never found her on the floor but has assisted other nurses in assessing her after R1 was found on the floor. V17, states, "yes, I have seen her trying to lift herself up out of bed. I help put her back to bed. Sometimes I just catch her up or attempting to get up. I redirect her back to her bed or chair. To prevent her falls we have floor mats, bed low, and call lights but she doesn't use the call light. CNA's are toileting her every 2 hours. Since Covid outbreak we keep residents in their rooms."</p> <p>On 2/4/2022 at 1:55 PM V2 states when R1 needs assistance she yells out that she needs help and her room is not next to the nurse's station.</p> <p>The facility's falls and fall risk managing policy dated August 2008 documents the following:</p> <p>Policy Interpretation and implementation</p> <p>4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</p> <p>5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.</p> <p>6. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling.</p> <p>(A)</p>	S9999		