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 05/10/2022

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 #2292981/IL145877 Investigation of Facility reported incident of 3/16/2022 #IL145099	S 000		
S9999	Final Observations Satement 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1220 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. These regulations were not met as evidenced by the following: Based on interview and record review, the facility	S9999		

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S9999	Continued From page 2 failed to modify the resident's plan of care to have effective interventions in place to keep a dependent resident free from repeated falls. This failure applied to one of one (R2) residents reviewed for accidents and supervision and resulted in R2 having five documented falls in a period of three and a half months with injuries including a fractured clavicle, scalp laceration that required sutures, and a left hip fracture. Findings include: R2 is an 85-year-old female who was admitted to the facility on 10/12/2021, with the following past medical history: Parkinson's disease, unspecified dementia without behavioral disturbance, Enthesopathy unspecified, dysphagia oral phase, laceration without foreign body of other parts of head, unspecified injury of head, weakness, generalized anxiety disorder, fracture of unspecified part of right clavicle, repeated falls, etc. R2's Minimum Data Set (MDS) assessment dated 1/04/2022 Section C (Cognition) documented a BIMs score of 2 (severe cognitive impairment); Section E (Behaviors) documented no behaviors, and section G (Functional Status) coded R2 as extensive assist with 2-person physical assist for bed mobility and transfers, extensive with one-person physical assist for dressing, eating, toilet use, and personal hygiene. R2's medical record documents the following falls since admission into the facility: 11/06/2021: R2 fell in her room; x-ray of right hip and pelvis was negative for fracture. 11/22/2021: R2 sustained a clavicle fracture from a fall in her room. 12/24/2021: R2 had a fall in her room with no	S9999		

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S9999	Continued From page 3 injuries. 1/04/2022: R2 had a fall in the dining room with no injuries. 2/24/2022: R2 was observed on the floor in the dining room and was sent to the hospital for bleeding to the forehead; hospital record documented the clinical impression as fall, head injury due to traumatic scalp laceration; R2 returned to the facility on 2/25/2022 with 4 sutures to her forehead. 3/16/2022: R2 sent to the hospital for complaint of left leg pain and facility's l hip x-ray report that was positive for left femoral neck subcapital fracture with overriding displacement; hospital record from 3/16/2022 showed that R2 underwent a surgical procedure of left hip hemiarthroplasty on 3/19/2022; resident did not return to the facility. R2's current fall care plan did not show any revision or update in her fall interventions after these falls. R2's care plan dated 10/13/2021states that resident is unable to make daily decision without cues/supervision related to dementia. The goal is that resident will not injure self-secondary to impaired decision making, interventions include provide cues and supervision for ADLs, redirect resident when potential for injury is evident, determine if decisions made by resident endanger the resident or others, intervene if necessary. 5/4/2022 at 3:22PM, V4 (RN) said that she remembers R2, she was confused and needed a lot of redirections, she was a very high fall risk some of the interventions she had was bed to the lowest position, floor mat and tapers to wheelchair, never had an alarm. V4 said that R2	S9999		

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S9999	Continued From page 4 fell in the evening (most recent fall) after dinner, she was sitting in a wheelchair in her room and was yelling out for help, V4 added that resident sometimes stays in her room by herself to calm her down, she does not recall any new interventions after the fall because resident was moved to another floor. 5/4/2022 at 3:32PM, V5 (LPN) said that R2 came to their floor from the first floor, she was confused, wanted to stand up and ambulate with an unsteady gait. R2 was a fall risk but she cannot remember what was in her care card. V5 said that on 2/24/2022, she responded to the dining room and observed R2 on the floor, she assessed resident and noticed that she was bleeding from her forehead, she called 911, they came immediately, and resident was sent out to the hospital. 5/4/2022 at 3:50PM, V7 (LPN) said that she did not witness the fall on 1/04/2022 but was informed by the Director of Nursing (DON) that R2 fell, she did her vitals and passed it on to the next shift. Resident always try to get up and walk and she sundowns quickly. V7 said that she was not sure if anything changed as far as resident's care plan or interventions after the fall, she was moved to the second floor. 5/9/2022 at 11:38AM, V11 (OTA) stated that she had a session with R2 and the session was sitting in the sink. R2 was complaining that her leg was hurting, and this was the resident's first session after she came back to therapy. V11 said that the session was completed, but maybe not for too long, she reported to the nurse that resident is continuously stating that she does not feel good and that her leg hurts. The nurse was already aware, there was no report of R2 falling that day	S9999		

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S9999	Continued From page 5 or since she came back from the hospital. 5/9/2022 at 11:51PM, V12 (OT), said that after the fall, R2 was very weak, and had a decline, she could not follow command and needed cues for everything. V12 added that she had only one session with R2 after the fall, she was restarted on therapy, she was not really participating, but did not complain of any pain during assessment. 5/9/2022 at 12:01PM, V13 (PT) said that she evaluated resident in February after the fall, she came back from the hospital and had shuffling gait, required moderate assist with transfer, did not complain of any pain during walking. V13 said that she only evaluated resident, she never had any therapy session with her. 5/9/2022 at 1:15PM, V15 (Nurse Practitioner) said that the nurse called her and said that resident was having pain at therapy, R2 had a fall in February, went to the hospital and came back with sutures. As far as she can recollect and according to staff, resident did not have another fall, during assessment after R2 was reported having some pain. V15 said that she assessed her (R2) and she would not let her touch her left lower leg, that's when she ordered the X-ray that came back positive for fracture. 5/10/2022 at 1:47PM, V19 (Attending physician/Medical Director) said that R2 has tremors, was confused, tends to fall and was wheelchair bound. V19 was asked if it is possible for R2 to have this fracture to her left hip from the fall that occurred on 2/24/2022 without any signs and symptoms and he said that under normal circumstances he will say no, but based on the resident's history, he really doesn't know. V19 said that this is probably a new fracture, and	S9999		

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S9999	Continued From page 6 since the resident is dependent on staff for all her ADL care, someone could have noticed some abnormalities. V19 added that the facility was very short staffed during the pandemic, now that the pandemic is over, he has told them that they need more staff and more supervision for the residents to reduce the number of falls and injuries. A document provided by V1 (Administrator) titled, Falls and Fall Risk Managing (undated), states as its policy statement that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Under policy interpretations and implementation, the policy states in part that if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Under monitoring for subsequent falls and fall risk, the policy also states in part that if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. (A)	S9999		