STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007561	A. BUILDING: _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CITY REHAB & H C	825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470

(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 FRI of 5/24/2022/IL147523	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 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 resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 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. These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to provide supervision to a resident with known wandering/elopement and aggressive behaviors, failed to implement additional/increased interventions after a resident's previous attempts to wander into other residents' rooms and failed to accurately assess a resident for 15 minute checks for one of three residents (R1) reviewed for supervision in the sample of three. This failure resulted in R1 wandering into R2's room, being shoved by R2, and causing R1 to fall to the ground and hit R1's head. R1 was sent to the local area hospital, diagnosed with two brain bleeds and admitted back to the facility under hospice care. Findings include: The facility's "Resident Monitoring" policy, revised 10/06, states, "It is the policy of (facility company name) to initiate monitoring of residents as a nursing measure upon the clinical decision of the Charge Nurse and/or Interdisciplinary Team to	S9999		

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S9999	Continued From page 2 assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. Procedure: 1. Assess the resident and document the need and rationale for monitoring. 2. Initiate resident monitoring and document date, time, resident location, and as deemed necessary, behavior and response to monitoring." R1's current Facesheet documents R1 was admitted to the facility on 2/1/22 with diagnoses to include but not limited to: Anxiety, Major Depressive Disorder, Traumatic Hemorrhage of Cerebrum with Loss of Consciousness, and Gait Disorder." R1's Cognitive Assessment/Brief Interview for Mental Status (BIMS) on 5/13/22 documents R1 with severe cognitive impairment. R1's Skilled Progress Notes on 2/4/22 at 3:00 P.M., states, "(R1) very confused wandering halls naked going in and out of other residents' rooms. Easily redirected." R1's Skilled Progress Notes on 2/5/22 at 5:45 P.M., states, "(R1) ambulates in hall naked going in and out of other residents' rooms. Very confused with often disjointed thought process. Frequent nude walks in hallway with redirection temporarily." R1's Nursing Notes on 3/30/22 at 6:30 P.M., states, "(R1) has exited through different doors x 5 (times five) since my shift started at 1800 (6:00 P.M.) Usually takes two staff to persuade (R1) to come back inside. (R1) beginning to be a little aggressive verbally and physically with staff and other residents. Notified (V8/R1's Physician).	S9999		

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S9999	Continued From page 3 R1's Nursing Notes on 3/31/22 at 1:45 P.M. states, "(R1) continues to exit seek. Makes threats to staff and other residents." R1's Nursing Notes on 3/31/22 at 5:00 P.M., states, "(R1) had a verbal altercation with a resident." R1's A.I.M. (Assess, Intercommunicate, Manage) for Wellness form on 5/24/22 states, "Alleged fall hit head. 2. Behavioral Evaluation: Belligerent." R1's Nursing Home to Hospital Transfer Form documents R1 was sent to the local area hospital on 5/24/22 after a fall and hitting R1's head. R1's Final Report to the local state agency documents on 5/24/22 at 8:30 A.M., R1 entered R2's room unannounced, startling R2. V4 (Housekeeping) witnessed R1 enter R2's room and attempted to redirect R1 into R1's room. R1 "swung" at V4. This same report states, "(R2) became upset that (R1) swung at (V4) and became defensive towards (R1) pushing (R1) out of (R2's) room. (R1) stumbled backwards, losing (R1's) balance and falling to the floor hitting (R1's) head. (R1) was immediately assessed and neuro checks initiated. (V3/Director of Nursing) called 911. Upon arrival (R1) was combative with paramedics, IM (Intramuscular) Versed (sedative) given and (R1) was transported to the hospital per POA (V9/R1's Power of Attorney) request." R1's Computed Tomography of the brain on 5/24/22 at 10:24 A.M. documents an impression of "acute appearing hemorrhages in the left frontal region as well as left subdural hemorrhage." R1's Nursing Notes on 5/24/22 at 3:30 P.M.,	S9999		

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S9999	Continued From page 4 states, "(R1) returned from ER (Emergency Room) on (name of hospice agency) subdural hematoma. R1's Social Service Notes on 5/24/22 states, "(R1) had a significant change. (R1) was placed on (name of hospice agency). (R1) has two small brain bleeds." R1's Hospice Admission Contract and Consent Form signed by V9 (R1's POA/Power of Attorney) documents R1 was admitted to the hospice agency on 5/24/22. The facility's list of residents on frequent checks provided by V3 (Director of Nursing) documents R1 and R2 are on 15 minute checks. On 6/2/22 at 1:45 P.M. V3 stated R1 and R2 were to be on 15 minute checks prior to the 5/24/22 altercation. V3 stated R1 was on 15 minute checks for R1's history of elopement/wandering. R1's "Resident Monitoring-15 Minute Form" on 5/24/22 between the hours of 10:00 A.M. and 3:30 P.M. documents R1 in various activities and various locations in the facility for the time period in which R1 was in the local area hospital. On 6/3/22 at 10:22 A.M., V3 (Director of Nursing) verified these checks were inaccurate and that R1 was in the hospital at that time and that the staff should have documented R1 as out of the facility. On 6/2/22 at 10:10 A.M., V5 (Certified Nursing Assistant/CNA), V6 (CNA), and V7 (CNA) verified that R1 wanders into other resident's rooms. V5-V7 stated they were the CNAs working on 5/24/22 when R2 pushed R1. V5-V7 stated they did not witness the altercation because they were in other resident's rooms but that they had heard	S9999		

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S9999	Continued From page 5 about it from V4 (Housekeeping). On 6/2/22 at 10:18 A.M., V10 (Licensed Practical Nurse/LPN) stated R1 can be "irate" at times and that R1 has a tendency to wander throughout the facility and into residents' rooms. On 6/2/22 at 10:34 A.M., V4 (Housekeeping) stated, "I was in the hallway behind (R1) with my cleaning cart. (R1) went into (R2's) room. R2 jumped up out of his bed and said, 'get the hell out of my room.' I said to (R1), 'come on let's go' and (R1) got mad and swung at me. I dodged his punch. That is when (R2) pushed (R1). (R1) fell backwards. I yelled, '(R1's) on the floor and that's when they (nursing staff) came. (R1) is known to wander into other residents' rooms. I told (V2/Administrator Assistant) what happened right away." At this time, V4 verified V4 did not call for help until after R2 had pushed R1. On 6/2/22 at 10:15 A.M., R2 stated, "I was sleeping in my bed and (R1) came into my room. He really scared me because I was in the middle of sleeping. Someone came and tried to get (R2) out and (R2) swung at her (V4). We were in the doorway and I pushed him after he tried to hit (V4). (R1) comes into my room a lot." On 6/3/22 at 10:20 A.M., V3 (Director of Nursing) stated V3 was sitting at the nurse's station when V3 heard a noise and went towards R2's room. V3 stated it was then that V3 saw R1 on the ground. V3 stated V4 (Housekeeping) was in R2's room with R1 and R2. V3 does not recall hearing V4 state R1 and R2 had an altercation. V3 stated R1 was sent to the hospital and was there for "some time". V3 verified R1 is on 15 minute checks and that the 15 minute checks could not have been completed for the timeframe	S9999		

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S9999	Continued From page 6 when R1 was in the hospital. On 6/3/22 at 12:19 P.M., V5 (CNA) verified R1 should have been marked as out of the facility on 5/24/22 when R1 was at the hospital. On 6/2/22 at 11:13 A.M., V2 (Administrator Assistant) stated that V4 reported to V2 what had happened between R1 and R2. V2 stated the final investigation report to the local state agency substantiated that R2 pushed R1, causing R1 to fall. On 6/3/22 at 3:29 P.M., V2 stated that V5 was educated that 15 minute checks should not be completed without physically laying eyes on the resident being monitored. V2 stated V5 was responsible for R1's 15 minute checks on 5/24/22. (A)	S9999		