STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010078	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation: 2298538/IL152623	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 observations, interviews, and records reviewed the facility failed to ensure fall prevention interventions were in place. This affected 2 of 3 residents (R9, R3) reviewed for fall prevention interventions. This failure resulted in R9 falling from her wheelchair and sustaining a closed left hip fracture that required surgical intervention. Findings include: 1. R9 is 94 years old with diagnosis including, but not limited to Dementia, Diabetes Mellitus, Low Back Pain, Hypertension, Muscle Wasting and Atrophy Right and Left Thighs, Major Depressive Disorder, Hyperlipidemia, History of Falling,	S9999		

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S9999	Continued From page 2 Abnormal Posture, Weakness, and Repeated Falls. R9 fell on 10/10/22 in the facility and was sent to the hospital for evaluation. R9 did not return to the facility during the survey. On 10/25/22 at 12:27PM V25, Certified Nursing Assistant (CNA), said R9 was in another resident's doorway leaning forward in her wheelchair. V25 said when she saw R9 entering another resident's room she approached her and noticed R9 was sitting on the edge of the chair. V25 said R9 was pulling on the doorway to maneuver herself into the room and sliding herself out of the wheelchair. V25 said I was trying to get R9 to release her grip from the doorway and she was resisting, yelling, and saying no. V25 said R9 was not responding to redirection. V25 said R9 was leaning forward and then she leaned to the left and fell out of her chair. V25 said she did not see a nonskid pad in R9's wheel chair when R9 fell. V25 said I called the nurse when R9 was on the floor V25 said V13, CNA, the nurse, and myself picked R9 off the floor. V25 said we did not use a lift to get R9 off the floor, after the nurse checked her. V25 said R9 was picked up off the floor, assisted into the wheelchair, and then placed in her bed. V25 said she was not assigned to R9 on 10/10/22. On 10/25/22 at 12:45PM V13, CNA, said I was at the computer when R9 fell. V13 said I did not see her fall, but I heard V25, CNA, make a sound and when I turned my head towards the sound, I saw R9 was on the floor. V13 said I went to where R9 was to help. V13 said the nurse checked R9 and then said we could get her up. V13 said the nurse had touched R9's legs and straightened her legs out when she was on the floor. V13 said when R9 was on the floor she was in the hallway near a door. V13 said R9 fell out of the	S9999		

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S9999	Continued From page 3	S9999		

wheelchair and was laying on her side, but I don't recall which side. V13 said we picked R9 up by her arms and put her in the wheelchair. V9 said the other CNA and herself grabbed R9 by an arm to get her in the wheelchair, and the nurse was helping. V13 said when R9 was in the chair she was saying her leg was hurting. V25 said I did not put R9 into bed before I left that day. V13 said I was not assigned to R9 that day. V13 said usually R9 was monitored by staff in the hall, and she would make her needs known.

On 10/25/22 at 1:33PM V26, Licensed Practical Nurse (LPN), said R9 was usually confused and pleasant. V26 said fall prevention interventions for R9 included a low bed. V26 said R9 did not have floor mats in her room. V26 said after R9 fell on 10/10/22 she was in the room providing care to R9 who was in the bed and there were no floor mats in place.

On 10/25/22 at 1:53PM V4, Director of Nursing, said R3 is a high fall risk and we use a low bed, floor mats, and he sits near the nurses station when out of bed for observation by staff. V4 said R9 fell on 10/10/22. V4 said she was told that R9 was trying to get into another resident's room. V4 said the CNA saw R9 and tried to redirect her and intervened. V4 said the CNA told her R9 was holding on each side of the door frame, and this prevented the CNA from repositioning R9 in her wheelchair. V4 said R9 then fell out of her wheelchair and onto her left side. V4 said the nurse told her that she assessed R9 and there was no injury or deformity. V4 said she was told that the staff got R9 off the floor using the full body mechanical lift. V4 said then R9 began having pain and an x-ray was ordered, but the radiology tech did not arrive, and the Nurse Practitioner was notified. V4 said the Nurse

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S9999	Continued From page 4 Practitioner said to send R9 to the hospital for evaluation. V4 said when someone falls on the floor, we are a non-lift facility, so the appropriate lift is used to get them off the floor. V4 said at the time of the fall R9 had been being monitored near the nurses' station, she had appropriate footwear on, and a pressure relieving cushion in her wheelchair. V4 said the identified safety devices are checked for placement once a week or every 2 weeks. V4 said we do rounds every day. We check for fall devices, low beds, and or call lights in reach. V4 said the facility uses the nonskid pads on the wheelchairs. V4 said the staff is made aware of safety interventions by checking the care plan and we verbally tell the staff. V4 said the Assistant Director of Nursing and I will implement the nonskid device, if needed. V4 said we have a big roll of the nonskid device in the office. V4 said I think the roll maybe green. V4 said not everyone automatically gets a nonskid device implemented. V4 checked the schedule and said V13 was assigned to R9 on 10/10/22. At 2:41PM V4 and the surveyor observed the roll of nonskid pad that is dark blue. On 10/26/22 at 8:59AM via phone interview, V27, LPN, said on 10/10/22 she was at the nursing cart in the hallway and when she turned around, she saw R9 on the floor and the CNA was with her. V27 said R9 was laying on her left side and was saying get me off the floor. V27 said I assessed R9's head and upper and lower extremity movements. V27 said when R9 was on the floor she said her left leg hurt. V27 said we got the full body mechanical lift and got R9 off the floor and moved her to her bed. V27 said she assisted the patient while her and the CNA transported R9 from the hall floor to her bed. V27 said the CNA steered the lift and operated the controls. V27 said she has worked at the facility	S9999		

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S9999	Continued From page 5 for about 4 months and she has not been trained on the use of the facility's mechanical lift. V27 said R9 fell in front of the nurses' station. V27 said she called the DON, the doctor, and was given an order for an X-ray. V27 said she called to schedule the X-ray. V27 said R9 remained in the facility during her shift. Facility Incident Report dated 10/10/22 3:02PM written by V27 states R9 was being pushed to her room in her wheelchair and R9 fell on her left side to the floor. No injuries noted at this time. Head to toe assessment completed, R9 complained of pain in her left upper and lower extremities. R9's Progress Notes dated 10/22/22 at 2:46AM document R9 was transferred to hospital via 911 for complaints of pain to the left hip. R9's Progress Notes dated 10/18/22 document she remains in the hospital as she is a status post pinning of her left hip fracture. R9's emergency room hospital record dated 10/11/22 documents Range of motion of the left leg is limited secondary to pain. R9's X-Ray pelvis dated 10/11/22 documents reason for exam: fall Findings: suspicious for impacted left femoral neck fracture. ED Course notes document X-ray of the pelvis suggests an impacted left femoral neck fracture. Clinical Impression: 1. Closed left hip fracture, initial encounter. Hospitalists History and Physical dated 10/11/22 documents Orthopedics consulted for subcapital femur fracture. R9's Monthly Summary dated 9/7/22 section 9 Safety Precautions notes at risk for falls. Floor mats and Low bed, and Protective gear are not	S9999		

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S9999	Continued From page 6 marked. R9's cognitive assessment dated 7/18/22 score is 3, severely impaired. Functional Status dated 7/18/22 documents R9 requires extensive assist with transfers, total dependence for locomotion while in the unit (moving between locations in her room and adjacent corridors). Balance test documents R9 is only able to balance with assistance from staff when standing or during transfer. R9's care plan documents at risk for falls related to I may be unaware of safety limits due to diagnosis of dementia, I am using a wheelchair for mobility. I also have a history of falls. Interventions include, but not limited to revised on 4/22/22 Non-skid placed on top of wheelchair cushion to help prevent resident from sliding out of her wheelchair. Revised on 4/11/22 Floor mats at bedside. 2. R3 is 79 years old with diagnosis including, but not limited to Altered Mental Status, Dementia, Schizophrenia, Encephalopathy, and Unspecified fall. On 10/25/22 the surveyor toured the units. At 1:46PM the surveyor observed R3 in his bed. R3's bed was lower than normal height and no floor mat was observed. On 10/25/22 at 1:46PM V2, MDS Coordinator, was at the medication cart on R3's unit. V2 accompanied the surveyor to R3's room. V2 demonstrated the bed was in the lowest position. The surveyor asked V2 about the floor mats for R3. V2 responded I am looking for them. No floor mats were observed in R3's room.	S9999		

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S9999	Continued From page 7 On 10/25/22 at 1:53PM V4, Director of Nursing, said R3 is a high fall risk. V4 said fall prevention interventions for R3 include a low bed, floor mats when in the bed, and observation at the nurse's station. R3's care plan revised on 7/12/22 documents he is at risk for falls. R3 has a behavior of getting out of bed and sitting on floor mattress. Review of the facility fall list documents R3 fell on 8/1/22; 9/30/22; 10/7/22; and 10/9/22. The facility Fall Prevention Policy dated 2/18/14 notes the program will include measures which determine the individual needs for each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Standards 3. Safety interventions will be implemented for each resident at risk using a standard protocol. 4. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. (A)	S9999		