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 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR NRSG & REHAB CTR	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 Facility Reported Investigation IL00162704 incident of 8/4/23	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Regulations were not met as evidenced by: Based on interviews and records reviewed the facility failed to prevent an incident of resident-to-resident physical assault. This affected two of three residents (R1, R2) reviewed for physical abuse. This failure resulted in R2 attacking R1 unprovoked with a belt to R1's leg. R1 being a severely cognitive resident it is reasonable to conclude this resulted in R1 suffering psychological feelings of fear after being attacked by R2. The Findings include: R1 has diagnosis including but not limited to Dementia, Major Depressive Disorder, Alzheimer's Disease, Generalized Anxiety Disorder, and Weakness. R1's cognitive assessment dated 7/16/23 is a 6, severely impaired. R2 has diagnosis including but not limited to Unspecified Dementia and Alzheimer's Disease. R2's cognitive assessment dated 5/27/23 is a 0, severely impaired. On 8/15/23 at 10:49AM R1 observed in the dining room but did not provide statement. On 8/15/23 at 11:28AM V1, Licensed Practical	S9999		

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S9999	Continued From page 2 Nurse (LPN), said during the night shift in the morning hours, V7, Certified Nursing Assistant (CNA), called me I was passing medications. V7 said R2 is on the floor. She said R2 was in the room of another patient. V1 said R2 was agitated. V1 said R2's lip was bleeding, and she was trying to administer care and R2 grabbed my hand and twisted it backwards and he was twisting my legs around his. V1 said R2 is very strong he just kept bending my right hand. V1 said this is the second time he attacked me. V1 said the first time he pulled down my pants. He had been refusing to get out of a patient room. I was trying to get him out and he grabbed my pants and pulled them down. V1 said R2 twisted my right wrist. V1 said the first time he attacked me was earlier this year. V1 said R2 gets confused around 5:00 or 6:00PM. V1 said in the mornings he was very combative, and it seems like the medicine has worn off and you can't control and reason with him. V1 said R2 needs constant redirection because he goes into others' rooms and lays in other peoples' beds. V1 said all I saw was R2 was on the floor on his side talking gibberish. V1 said I didn't see him with anything in his hands. V1 said the male CNA was still in the room when she entered. V1 said R1 was in bed sleeping and she woke up when R2 was in the room. V1 said one of the CNAs had said R1 was screaming "ahh, someone is in my room". On 8/15/23 at 12:44PM V2, Social Services, said I don't know if R2 ever physically harmed any resident or staff in the facility. On 8/15/23 at 1:20 PM V3, Director of Social Services, prior to this (incident 7/17/23) I did not know R2 had been aggressive in the past. I should know because I am the director of social services.	S9999		

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S9999	Continued From page 3 On 8/15/23 at 4:01PM V4, CNA, said V4 said I went into another resident's room and then I heard R1 screaming. V4 said the last time he saw R2 before the incident R2 was in his room. V4 said I heard R1 screaming, loud like someone was hurting her. V4 said I saw R2 hit R1 on the leg with the belt one time. V4 said I saw R2 swinging the belt over R1 to hit her again. On 8/17/23 at 10:29AM V5, R1's family, said the facility called me the day it happened (7/17/23). V5 said I went to see R1 the following day. V5 said R1 told me a man was in her room and he was swinging a belt. V5 said R1 said she was sleeping when he came in. V5 said R1 said she got hit with the belt. On 8/17/23 at 11:45AM V6, Administrator, said I completed the investigation for R1 and R2. I spoke with V4 and V7, CNA. V6 said V7 said she was in a room and V4 had walked out of the room and heard a yell. V6 said V7 said V4 went to see what was going on. V7 said she did not see anything but got the wheelchair to get R2 out of the room. V6 said R2 was R1's room. V6 said R2 should not be in R1's room. V6 said V4 said he heard the yell and went to see what was happening. V6 said V4 said when he got to R1's room he saw R2 in the room standing at the side of R1's bed and R2 was swinging a belt. V6 said V4 had her arms up. V6 said the men do have belts. V6 said during the investigation abuse was substantiated. V6 said R2 has a belt hitting someone, I would say yes that is abuse. On 8/17/23 at 12:05 PM V8, Nurse Practitioner, was asked if it is reasonable to conclude that R1 would have felt fear when she woke up to see a man swinging a belt at her. V8 said it is	S9999		

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S9999	Continued From page 4 reasonable to think R1 felt fear, they are feeling threatened in that situation. V8 said R1 may not remember the situation but at that moment it would be reasonable for R1, even with Dementia, to feel fear. R1's Abuse Risk Review dated 7/14/23 states R1 has the following risk factors Frailty or total dependence. R1's progress notes dated 7/17/23 at 4:50PM states R1 had an altercation with another resident. R2's progress notes dated 6/22/23 written by V8 state R2 seen for Complaint: sundowning. R2 still having periods of agitation and hard to redirect once a month. Assessment and plan: Dementia with Psychotic Disturbances. R2's care plan dated 12/26/22 states R2 grabbed at the uniform of a nurse. Interventions include redirect and intervene during periods of increased agitation. Separate resident from others as needed. Social Services to assess for aggression. The facility Abuse Prevention Policy Dated 10/24/2022, in part, states the facility affirms the right of our residents to be free from abuse. Physical Abuse includes hitting. (B)	S9999		