STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007082	A. BUILDING: ______ B. WING ______	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE ROSE HEALTH CARE CTR	900 SOUTH CHESTNUT PANA, IL 62557

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. This REQUIREMENT is not met as evidenced by:	S9999		

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Continued From page 2

Based on observation, interview, and record review, the facility failed to ensure there was sufficient supervision to prevent falls and ensure care plan interventions were appropriately in place for 2 out of 3 (R28, R36) reviewed for falls in a sample of 31. This failure resulted in R28 being sent to local emergency room with an acute to subacute right lateral 9th rib fracture, subacute to acute right anterolateral 3rd rib fracture and also had multiple healed rib fractures from other falls.

Findings include:

1. R28's Face Sheet, print date of 11/16/23 documents R28 has the following diagnose Type II diabetes mellitus with hyperglycemia, multiple fractures of ribs, Alzheimer's disease, dementia, Hypertension.

R28's Minimum Data Set (MDS), dated 10/07/23, documents R28 is severely cognitively impaired and requires substantial/maximal assistance with transferring, oral hygiene, toileting hygiene, shower/bath, dressing, and personal hygiene, he is frequently incontinent of bladder, and always continent of bowel.

R28's Care Plan, not dated, documents the resident has had an actual fall. Root cause may be related to (r/t) Cognitive Impairment- Does not understand limits, Cognitive Impairment- unaware of safety needs, poor Balance, and unsteady gait. Interventions include but are not limited to for no apparent acute injury, determine and address causative factors of the fall, Major injury-

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S9999	Continued From page 3 Pressure alarm under buttocks and under torso while in bed, and Major injury- signage posted in room to use call light for assist. R28's Physician's Orders, dated 05/10/23, documents pressure pad alarm at all times. R28's Incident Audit Report, dated 10/06/23 at 5:38 AM, documents R28 had an unwitnessed fall. He was found face down on the floor beside his bed. R28 attempted to get up to the bathroom without calling for assistance. He had a hematoma noted to the top of his scalp. It further documents in the notes section root cause of this fall noted to be resident attempting to get out of bed to toilet self without assistance. Resident had shut off pressure alarm. Intervention is to place a pressure alarm under resident's bottom and another under his torso. R28's Progress Notes, dated 10/06/23 at 8:57 AM, documents the writer received in report R28 had and unwitnessed fall in his bedroom. He was found in the prone position attempting to roll over and get his self-up. He was noted to have a hematoma on his forehead above his left eye and he complained of pain and discomfort to his right arm/shoulder when the writer was assessing and doing range of motion. Neuro checks were in place due to it being an unwitnessed fall. His blood pressure at 6:25 AM was 158/101 and his pulse was 98. He was able to recall the fall to writer without difficulty he agreed to be sent out to the local hospital to be evaluated and treated, and doctor and his power of attorney was notified. R28's Hospital Report, dated 10/06/23 at 9:24 AM, documents Computed Tomography (CT) scan report impression: Acute to subacute right lateral 9th rib fracture. Subacute to acute right	S9999		

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anterolateral 3rd rib fracture. Multiple healed rib fractures.

On 11/14/23 at 1:43 PM, R28 is up and in his wheelchair. Tab alarm noted to be attached to the back of his shirt. No pressure pad alarm noted in his wheelchair.

On 11/15/23 at 1:20 PM, R28 is lying in bed with his eyes open. Fall mat beside his bed, bed in low position, there was a tab alarm observed hooked to his shirt and the other end lying in his bed. There were no pressure pad alarms observed by this surveyor.

On 11/15/23 at 1:22 PM, this surveyor went and asked V2 (Director of Nursing/DON) if R28 was supposed to have pressure pad alarms under him while he was in bed and she stated, "yes". This surveyor asked V2 if she could please come down to R28's room. This surveyor and V2 went down to R28's room and V2 checked under R28 to see if he had pressure pad alarms under him and there wasn't any noted at this time.

On 11/15/23 at 1:24 PM, V2 stated she would expect for the pressure pad alarms to be placed under R28 when he was in bed.

On 11/16/23 at 10:00 AM, V4 (MDS Coordinator) stated they discontinued R28's tab alarm on 06/28/23, due to him taking it off and carrying it and then they ordered him the one pressure pad alarm. She said after the fall on 10/06/23, is when they ordered the second pressure pad alarm for him. V4 stated R28 should not have a tab alarm on.

On 11/16/23 at 10:05 AM, this surveyor and V4 went down to R28's room together. R28 was

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observed to be sitting up in his wheelchair with a tab alarm placed on the back of his wheelchair and hooked to the back of his shirt. There was no pressure pad alarm noted to be under him at this time. V4 stated R28 should have a pressure pad alarm placed in his wheelchair and she said they are supposed to put it on R28 every time they change his position.

On 11/16/23 at 10:35 AM, V4 stated she was just made aware the pressure pad alarms are broken and will be fixed and here within the next couple of hours. She said until the new/fixed pads get here they are using the pull tab alarm and doing 15-minute visual checks on R28. She said she isn't sure how long the pressure pad alarms have been broken she was just made aware of it today when she questioned staff about them. She said she would expect the Certified Nursing Assistants (CNAs) to notify the nurses and the nurses to notify management about the pressure alarms being broken so they could rectify the situation.

2. R36's face sheet documents that R36 was admitted to the facility on 4/28/2023 with a diagnosis of right hip fracture, C5 compression fracture and L1 compression fracture resulting from a fall at home.

R36's other medical diagnosis includes Unspecified Dementia, Anxiety Disorder, Major Depressive Disorder, Hypertension, and Hyperlipidemia.

R36's Minimum Data Set (MDS), dated 11/14/2023, documents R36 is severely cognitively impaired and is totally dependent on at least two staff members for bed mobility and transfers.

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The facilities incidents by incident type report, dated 11/13/2023, documents R36 has had a fall on 7/21/2023, 9/4/2023, 9/13/2023, 9/14/2023, and 10/19/2023.

R36's Care Plan, dated 7/5/2023, documents the resident has had an actual fall. The root cause may be related to cognitive impairments as she does not understand limits, unaware of safety needs, poor balance, poor communication/comprehension and has an unsteady gait. Interventions: bed to be in low position, fall mat placed beside bed, bed against wall, foam positioning aids on both sides, staff educated on safe resident positioning, and continue interventions on the at-risk plan.

R36's progress notes dated 7/21/2023 at 9:28 AM, documents, during breakfast resident rolled out of bed, no injuries from fall, and the right hip incision had nothing to do with the fall.

The facility Incident Audit Report, dated 7/21/1023, documents the root cause of this fall was resident was not positioned in the center of the bed and rolled off edge of bed into floor. Intervention is staff education of safe positioning of residents.

R36's progress notes, dated 9/4/2023, documents on doing rounds, CNAs found resident on the floor beside her bed, lying on her left side, head was rested up against bedside table and bleeding noted from right ear. Ambulance was called and resident was transported to the local emergency room. R36's ear injury was treated with medical glue and R36 returned to the facility.

The facility Incident Audit Report, dated 9/4/23,

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S9999	Continued From page 7 documents the root cause of this fall was resident fell out of bed. Intervention is a fall mat on floor beside bed. Bed also to be in lowest position. R36's progress notes dated 9/13/2023 at 8:20 PM, documents resident noted on floor in her room. Laying on left side beside bed. Clothes and linens saturated with urine. Bed not in low position. Floor mat not in place. Small skin tear to left elbow. Cleansed and band aid applied. Resident assisted back to bed and care given. The facility Incident Audit Report, dated 9/14/2023, documents R36's bed was not in low position, floor mat was not in place and R36 was saturated with urine. Root cause of this fall was resident rolled out of bed. Intervention is foam positioning aids on each side of resident's bed while resident is in bed. R36's progress notes dated 9/14/2023, documents resident was on the floor next to her bed, nurse checked resident over, she was fine and voiced no complaints of pain. Fall was unwitnessed. The facility Incident Audit Report, dated 9/14/2023, documents the root cause of R36's fall was resident rolled out of bed. Mattress changed to better fit foam positioning aids. R36's progress notes dated 10/19/23 at 4:11 AM, resident found on the floor beside her bed face down and on right side. Noted to have a large goose egg above her right eye and facial bruising noted. The floor mat was on the opposite side of the bed and the foam positioning aid was slid off the bed on the floor also. The facility Incident Audit Report, dated	S9999		

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10/19/2023, documents the root cause of R36's fall was that resident rolled out of bed. Intervention will be a bolstered mattress.

R36's fall risk assessment, dated 8/10/2023, documents R36 was high risk for falls with a score of 13. A score of 10 or more equals high risk.

On 11/13/2023 at 9:10 AM, R36 was observed to have light blue/green bruising to the right side of her face near the temporal region. V12 stated the bruising was from a previous fall.

On 11/14/2023 at 6:21 PM V10 (Licensed Practical Nurse) stated "she (R36) did not have her bed in low position and her mat was not on the floor when she fell on September 13, 2023."

On 11/15/2023 at 1:40 PM V2 (Director of Nursing) stated she would expect fall interventions to be in place according to the care plan.

The Facility's "Fall Prevention" Policy, dated 11/10/18, documents "To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. 1. Conduct Fall Assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. All staff must observe residents for safety. If residents with a high-risk code are observed up or getting up, help must be summoned, or assistance must be provided to the resident. 3. Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at

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S9999	Continued From page 9 high risk at the time of admission for up to 72 hours. 5. Immediately after any resident fall, the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new interventions on the CNA assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. "B"	S9999		