STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CROSSING LVG & REHAB	409 WEST COMANCHE ROAD SHABBONA, IL 60550

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S 000	Initial Comments Facility Reported Incident of 12/2/23/IL167380	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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. 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. 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. 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. These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 2	S9999		

Based on observation, interview, and record review the facility failed to ensure a resident was transferred and ambulated in a safe manner for 1 of 3 residents (R1) reviewed for safety in the sample of 3. These failures resulted in R1 sustaining a fractured nasal bone, sutures to the forehead, and bruising.

The findings include:

R1's face sheet printed on 12/6/23 showed diagnoses including but not limited to Alzheimer's disease, dementia with agitation, anxiety disorder, wandering, impulsiveness, difficulty walking, muscle weakness, and abnormalities of gait and mobility. R1's facility assessment dated 11/20/23 showed severe cognitive impairment. The assessment showed substantial/maximal staff assistance needed for transferring from sitting to standing. The assessment showed partial/moderate staff assistance required for walking once standing.

R1's fall risk assessment dated 11/26/23 showed a high risk for falls.

R1's progress note dated 12/2/23 at 6:02 AM stated: "Called to resident room for witnessed fall. Resident found on floor with laceration to forehead above right eyebrow. Assessed resident and call 911 for ER transport. Resident made comfortable with C spine supported until EMS arrived. Pressure applied to laceration with woven sponge ..." The note documented R1 was found on the floor at 4:39 AM and was sent to the local emergency room at 5:00 AM. The note was written by V4 (Registered Nurse).

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S9999	Continued From page 3 R1's progress note dated 12/2/23 at 6:20 AM stated: "ED (emergency department) called with report, resident has fractured nasal bone, 3 stitches to laceration over right eyebrow-per report and will be returning to facility. MD notified, DON and administrator informed of fall, ED visit and pending return to the facility." On 12/6/23 at 9:00 AM, R1 was lying in bed dressed and covered with a light blanket. R1 had dark, purple crescent shaped bruises under both eyes and a 2x2 inch dressing on her forehead over the right eyebrow. R1's right arm was uncovered, and a quarter size dark purple bruise was on top of her right hand with scattered smaller bruises on her arm. R1 was awake but did not respond or react to any questions. R1's room was located on the dementia unit of the facility. On 12/6/23 at 11:15 AM, V8 (CNA-Certified Nurse Aide) assisted R1 out of bed and across the room to the bathroom. R1 was nonverbal and walked in a shuffling, unsteady manner. V8 used a gait belt to steady R1 and a walker during the transfer and while walking. At 2:10 PM, V8 stated the following: R1 needs help while getting out of bed and walking. R1 walks unsteady and cannot follow directions. R1 is confused and will walk away during care. R1 tries to walk while her pants are still at her ankles. R1 will just "give up" and plop herself down into the bed. R1 needs a walker and gait belt for safety. It provides R1 something to hold onto and she doesn't walk safely without both. On 12/6/23 at 10:40 AM, V3 (CNA) stated she was working the night shift on 12/2/23 and took R1 to the toilet at around 4:30 AM. V3 said she sat R1 at the side of the bed and directed R1 to	S9999		

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S9999	Continued From page 4 grasp her around the waist, like a bear hug. V3 said she stood R1 up by holding her hands and placed the wheeled walker in front of R1. V3 said she walked R1 to the bathroom and changed her into day clothes while toileting R1. V3 said she had to close the bathroom door during care to prevent R1 from walking away from her. V3 said she directed R1 back across the room and to the bed side. V3 said she stood in front of the walker and pulled on it to guide R1 toward the bed. V3 stated she turned away from R1 to adjust the bed linens and R1 walked away from her, toward the closet door. V3 said R1 was walking by herself and out of grasp. R1 suddenly fell forward and pushed the walker to the side during the fall. V3 said R1 did not reach out with her hands and fell face first to the floor. V3 said she hit the floor "full impact". V3 said R1 began bleeding and she immediately yelled for V4 (Registered Nurse). V3 was questioned if R1 was wearing a gait belt and if V3 holding onto it. V3 said, no. The thought never crossed V3's mind and V3 didn't have a gait belt with her at the time. V3 said R1 needs a gait belt and walker to be moved safely. V3 said she has cared for R1 in the past and was familiar with her mental confusion and unsteady walking. On 12/6/23 at 1:26 PM, V4 (Registered Nurse) stated she was working the night shift on 12/2/23 and heard V3 (CNA) yelling out for help around 4:40 AM. V4 said she went to R1's room and found R1 on the floor bleeding from the nose. V4 said she immediately called the physician and orders were received to send R1 to the emergency room. V4 said R1 was dressed in day clothes and her walker was near her. R1 was wearing anti-skid socks but not a gait belt. V4 said R1 is confused and has a weak gait. R1 needs staff help to stabilize her during transfers and walking to prevent her from falling. V4 said	S9999		

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S9999	Continued From page 5 R1 returned to the facility the same morning and was diagnosed with a fractured nasal bone. R1 required stitches to her forehead and had bruising to her right arm and face. On 12/6/23 at 12:50 PM, V5 (Registered Nurse) stated R1's ambulation skills have been decreasing due to her disease progression. R1 is confused and will walk by herself if staff do not guide her. V5 said R1 needs more and more help to walk safely. V5 said R1 is becoming weaker and more unsteady and needs a wheelchair on her extremely weak days. V5 said R1 should always have a gait belt and walker with her to maintain balance. It is an extra way for CNAs to hold and stabilize R1. On 12/6/23 at 2:38 PM, V9 (Physical Therapist) stated he has worked with R1 in the past and was familiar with her needs. V9 said R1 needs a lot of help transferring and walking safely. Staff should be using a gait belt and standing at her side to guide her. Pulling the front of a walker to direct a resident is not appropriate. V9 said gait belts are required for any resident who is a high fall risk. On 12/6/23 at 11:35 AM, V2 (Director of Nurses/Fall Coordinator) stated prior to R1's 12/2/23 fall she was under standard fall interventions. V2 said R1 did not have gait belt use cared planned but they are required for any resident who is unsteady. V2 said, gait belts are used to have something to hold onto and staff can gently lower a resident to the floor if need be. At 12:11 PM, V2 was asked for the facility policy related to gait belt use. At 2:43 PM, V2 was asked for the facility policies related to resident transfers and resident ambulation. V2 stated the facility did not have any policies regarding the topics requested.	S9999		

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S9999	Continued From page 6 R1's emergency room after visit summary dated 12/2/23 showed the reason for the visit was fall related. R1's resulting diagnoses showed a cut on forehead and a nose fracture. The facility's Fall Prevention and Management policy last review dated 9/29/23 states under the fall prevention section: "7. 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. Staff will be educated on the fall reduction and prevention program." (B)	S9999		