Illinois Department of Public Health

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 ______	09/20/2022

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

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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. Restorative measures shall include, at a minimum, the following procedures:

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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.

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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. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide supervision, investigate falls thoroughly to develop a root cause and analysis and implement progressive interventions to prevent falls for 2 residents (R1, R31) reviewed for falls. This failure resulted with R1 dislocating his shoulder multiple times, receiving 2 staples for a head laceration and hematomas.

Findings include:

1. R1's Admission Profile, undated, documents R1 was admitted on 2/10/22.

R1's September 2022 Physician Orders documents that R1 has diagnoses of Depression, Anxiety, and unspecified neuro cognitive disorder.

R1's Minimum Data Set (MDS), dated 2/17/22,

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S9999	Continued From page 3 documents that R1 has moderately impaired cognition and is totally dependent on one staff member for locomotion on the unit using a wheelchair. R1's Care Plan, with start date of 2/18/22 documents "Resident has risk factors that require monitoring and intervention to reduce potential for self-injury. (Consider medical conditions, sensory altercations, balance, gait, assistive devices, cognition, mood/behavior, safety awareness, compliance, medication, restrictions, restraints. Risk factors include poor safety awareness, dementia, agitation, anxiety, weakness as evidence by related diagnoses/ condition/history." R1's Goal for this problem documents "Resident will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors thru next 90 days." The following are R1's Care Plan Approaches/Interventions all dated 2/18/22: "Review quarterly and prn (as needed) resident's ADL (activities of daily living), mobility, cognitive, behavior and overall medical status. IDT (Interdisciplinary team) review of changes and needs with Resident and/or responsible party (when choose to attend) during care plan. Discuss fall related (information to review and revise plan as needed; Review quarterly and as needed during daily care and services of resident's plan for safety, giving verbal cues as needed to gain resident participation in minimizing risk factor and injury, encourage and assist placement of proper non-skin footwear; Attempt to anticipate needs-toileting, hydration, hunger and provide care before resident attempt to fulfill on own; observe for unsteady/unsafe transfer or ambulation and provide stand by or balance support as needed; Fall risk assessment quarterly and as needed with change in condition	S9999		

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or falls status; IDTG review of ADL status and fall potential changes in condition or fall status. Report significant finding to MD for follow up; Monitor for changes in condition such as appetite, sleep patterns, balance, ADL assist level, swelling, muscle weakness, less socialization. Report to nurse for follow up assessment and MD notification." An intervention, dated 2/11/22 documents "Low bed."

R1's Nurse's Note, dated 4/4/22 at 11:30 PM, documents, "Res (Resident) fell in living room with injuries noted to Lt (left) temporal area and shoulder deformity. Sent to ER (Emergency Room)."

R1's Nurse's Note, dated 4/4/22 at 12:45 PM, documents, "Res returned from ER (Emergency Room) with dx (diagnosis) of Anterior Dislocated of L shoulder, contusion to face, COVID 19, Broken collarbone."

R1's Emergency Room documentation, dated 4/4/22, documents, "Assessment/Plan: 1. Anterior dislocation of left shoulder. 2. Clavicle fracture. 3 Head contusion. 4. Neck Strain. Procedure: Attempted to reduce left shoulder dislocation multiple times without any success. Transfer to (regional) hospital."

On 9/15/22 at 1:48 PM, surveyors were unable to view the fall investigations independently. At that time, V2 Regional Nurse, reviewed the investigation from 4/4/22 with the surveyor and stated, "(R1) got up from his recliner. He had fallen asleep, and the aide went to clean the dining room. (R1's) alarm sounded and by the time the aide got to him he was on the floor. The Emergency Room could not do a closed reduction. He came back with both of his arms in

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a sling and a follow up appointment to the orthopedic doctor. (R1's) investigation showed that he woke up and was disorientated and tried to self-transfer and he fell. (R1's) new intervention was to not leave (R1) asleep in the lounge unattended."

R1's Care Plan was reviewed and there was no documentation that this intervention was implemented to prevent R1 from future falls.

R1's Nurse's Note, dated 4/5/22 at 1:30 PM, documents, "Res is alert with confusion noted. Res constantly trying to get up on his own."

R1's Nurse's Note, dated 4/5/22 at 7:30 PM, documents, "Res (resident) observed on floor in room 121. Res laying on abdomen with arms outstretched and legs outstretched. Res noted to have large s/t (skin tear) to lt (left) arm probably from ER (Emergency Room) visit from previous night. Res has laceration on Rt (right) brow with some slow to respond answers to questions. Res appears to be confused beyond his norm (normal). sent out to ER."

R1's ED (Emergency Department) Physician note, dated 4/5/22, documents, "History of Present Illness: 80-year-old man with a history of dementia brought to the emergency department after a fall in which he injured his head and his left shoulder per EMS (Emergency Medical Services). Witnessed fall from a standing position. No loss of consciousness. Patient was seen yesterday for a similar presentation and found to have a right clavicle fracture, left anterior shoulder dislocation and scalp contusions. Transferred to (regional) hospital for shoulder dislocation after several unsuccessful attempts were made here. There were abrasions and

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contusions on his face and forehead on the right last night. There are 2 new contusions today."

R1's Nurses Note, dated 4/6/22 at 2:30 AM, documents, "Res returned to via transport. Orders to see ortho r/t dislocation of lt. (left) shoulder from fall on 4/4/22."

On 9/19/22 at 11:00 AM, V2, stated that she was unaware of this fall. There was no fall investigation for the fall on 4/5/22 for review.

R1's Care Plan was not revised after this fall on 4/5/22, with progressive interventions to prevent him from future falls.

R1's Nurse's Note, dated 4/27/22 at 8:00 PM, documents, "Res fell in LR (living room) with gash to Rt side of head. Unable to assess fully r/t (related to) sending res out with head trauma."

R1's Nurses Note, dated 4/27/22 at 10:00 PM, documents, "ER called and sending res back res has 2 staples to Rt (right) side of head no other injuries."

R1's ED (Emergency Department), dated 4/27/22, documents, "Procedure: Scalp laceration right forehead 2 cm (centimeter) x (by) 0.5 cm no active bleeding local lidocaine 1% 5 cc (cubic centimeters) stapled with 2 closed the wound."

On 9/15/22 at 2:15 PM, V2, reviewed the investigation and stated that R1 was resting in the recliner. V2 stated R1 tried to stand, and he fell. V2 stated that the new fall intervention is to always wear shoes because he only had on gripper socks.

R1's Care Plan was not revised after this fall to

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prevent R1 from future falls.

R1's Nurse's Note, dated 4/29/22 at 2330, documents, "Resident was in low bed, alarm on alarm was sounding, resident on floor by bed. hematoma above L eye noted."

On 9/19/22 at 11:55 AM, V2, Regional Nurse, stated, "(R1) got out of bed and bumped head on foreign object. (R1's) intervention is to ensure to continue use of low bed."

R1's Nurse's Note, dated 5/2/22 at 12:25 PM, "Resident in w/c (wheelchair) in dining area. Resident attempted to stand out of w/c and fell to floor on L side. Hitting left side of head on floor 3 x 2 cm (centimeter) s/t noted to LFA (left forearm). Cleansed with (wound cleanser) dry dressing applied scant amount of serosanguinous drainage noted to L forehead."

On 9/15/22 at 2:35 PM, V2, stated, "(R1's) root cause for the fall on 5/2/22 was he attempted to self-transfer and 15-minute checks were initiated."

R1's Care Plan was not revised after his fall on 5/2/22 with progressive interventions to prevent him from future falls.

R1's MDS, dated 7/19/22, documents, R1 is moderately cognitively impaired and requires supervision of 1 staff member for ambulation and transfers.

R1's Nurse's Note, dated 8/12/22 at 12:35 AM, documents, "Writer called to resident room. Res is sitting in floor 1 cm skin tear noted to R elbow unable to reapproximate. area cleansed with (wound cleanser) steri-strips applied, thumb

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swollen and purple in color. Res c/o (complaint of) pain to Left finger and LFA, unable to perform pronation / supination to L arm. no other injuries apparent. Res sitting in chair at this time."

R1's Nurses Note, dated 8/12/22 at 11:45 AM, "Res returned to facility per facility van. L shoulder back in place. L thumb severely fractured and L pinky fx. (fracture) Splint in place to L hand and arm and ace wrap."

R1's Hospital Emergency Department Discharge Instruction, dated 8/12/22, documents, "Diagnosis: 1. Anterior dislocation of left shoulder. 2. Fracture of fifth metacarpal bone of left hand."

On 9/15/22 at 2:36 PM, V2, stated, " On 8/12/22 (R1) was found on the floor at 12:35 AM, just prior to this he was walking in the hallway to go back to his room. He stated that he got his foot caught on an extra cover and he fell. The new intervention for this fall is to ensure that blankets are not touching the ground and extra blankets are taken off the bed."

On 9/19/22 at 12:15 PM, V20, Medical Director, was questioned about all R1's falls. V20 stated, "It is obvious (R1) should be on one to ones (supervision). The facility made me aware of all of the fractures, but I was never made aware of the big picture that he had fallen that many times."

On 9/19/22 at 3:10 PM, V8, Licensed Practical Nurse, stated, "I am not sure what was going on with (R1) when he kept falling. They were using a wheelchair for him, and he just kept standing up and trying to walk. He then went out to (Behavioral Health) and when he came back, they just let him walk and he has been doing better."

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S9999	Continued From page 9 2. R31's Admission Sheet documented R31 was admitted to the facility on 6/2/22. R31's Nurse's Note documented "Res (Resident) arrived @ (at) facility per facility van into room (Room #)-see assessment." R31's Nursing Admission Assessment, dated 6/2/22, documented R31's admitting diagnosis was brain hemorrhage. R31's Fall risk assessment, dated 06/02/2022, documented that she was a high risk for falls. R31's Baseline Care Plan, dated 06/02/2022, documented, "High Risk Fall Assessment, Poor Safety awareness, Fall history and 15 (minute check)." R31's 15 Minute Observation checklist, dated 06/02/2022 from 5:30 PM until 7:30 PM, documented that R31 was in her room, sitting in a chair and was anxious. No interventions for R31's anxiousness was documented. There was nothing in R31's Nurse's Notes regarding R31s anxious behaviors and what staff were doing to address her anxious behaviors while she was alone in her room. R31's Nurse's Note, dated 06/02/2022 at 7:30 PM, documented, "(Resident) attempted to get up (without) assistance (and) was alerted to staff per call light. Staff found her on the floor (at) foot of bed, sitting on bottom. Top of head was rested up against the foot board, blood all over head (and) hands. (Small) pool of blood on the floor (and) (resident) states "I fell headfirst." Able to answer all nurses questions correctly but due to recent bleeding in brain (resident) will be sent to (local	S9999		

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hospital Emergency Room) for (evaluation) (and) (treatment). Administrator and (V18, Care Plan and MDS) aware. (Power of Attorney) (phone number) is not in chart. (Regional Hospital) was called (and) they would not give nurse any (information). (Administration) notified."

R31's Investigation Report for falls, dated 06/02/2022, documented that she was seen at 7:25 PM and that she had a tab alarm in place.

On 09/15/2022 at 02:10 PM, V2, Regional Nurse stated that R31's tab alarm was not sounding because it was in her hand when she fell.

Report sent to the Illinois Department of Public Health, dated 06/09/2022, documented, "...Tabs monitor was in resident's right hand."

R31's Minimum Data Set (MDS), dated 06/13/2022, documented that R31 required extensive assistance with transferring, frequently incontinent of bladder and occasionally incontinent of her bowels.

R31's History of Present Illness from Trauma Center, dated 06/03/2022, documented, " (R31) is a 88 year old female brought in by (Emergency Medical Service), ground transfer from outlying facility and was in cervical collar and boarded on presentation. The patient was involved in a fall from standing. Per report, (R31) was discharged earlier today after being admitted from 2/18 to 6/2/2022, patient was discharged to a nursing home. Patient was admitted for an intracranial hemorrhage, (Urinary Tract Infection) Hypertensive emergency, metabolic encephalopathy, and A-fib who was on coumadin which was stopped at time of discharge. Upon being discharged and admitted to the nursing

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S9999	Continued From page 11 home, patient was reported to be found lying on the floor on her back after an unwitnessed fall." It continues, "At the (Outside Service Hospital), patient was reported confused and moaning. Imaging reported at the (Outside Service Hospital) found a C1-C2 fracture. Upon arrival to the trauma center, there was no (Outside Service Hospital) records to review. Patient is noted to have a small scalp laceration and surrounding hematoma." R31's Trauma CT Cervical Spine report, dated 06/03/2022, documented, "Findings: Acute, mildly displaced type 3 fracture of the odontoid process. Mild dorsal subluxation of the lateral masses of C1 relative to C2. Moderate multilevel cervical spondylosis..." It continues, "Impression: Acute type 3 fracture of the odontoid process." On 09/14/2022 at 1:30 PM, V17, Assistant Director of Nurses (ADON), stated that when a resident falls, the nurses fill out the form and then the Interdisciplinary team (IDT) will meet and discuss the fall and then they will fill out the rest of Quality Care Reporting Form, the investigation. On 09/14/2022 at 2:00 PM V18, Minimum Data Set/Care Plan Coordinator, stated that R31 had a baseline care plan and it addressed her being a high risk for falls and that she should have been on 15-minute checks. On 09/15/2022 at 2:10PM, V2, Regional Nurse stated that she would expect the nurses and CNAs to do the 15-minute checks if it was on the care plan. She continued to state that the Investigation Report for Falls was an internal document, and that the facility would not give a copy to the state surveyor but was able to review the document.	S9999		

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S9999	Continued From page 12 The Fall Prevention Policy, dated 11/10/18, documents, "Policy: 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. Procedure: 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." It continues, "Report all falls during 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		