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
	IL6010078	A. BUILDING: ______ B. WING ______	C 02/04/2022

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: 2290536/IL142681	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) 300.1220b)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. 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not	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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limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 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.

d) Pursuant to subsection (a), general nursing

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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:

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.

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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 requirements were not met as evidenced by:

Based on interview and record review, the facility failed to notify other staff, and/or family immediately after a resident had a fall; neglected to follow their policy to notify physician of a residents fall; failed to conduct a comprehensive nursing assessment after a fall; and failed to develop an effective plan of care to include monitoring and supervision for a resident identified to have weakness and at high risk for falls for one (R1) resident out of three reviewed for falls in a total sample of six. This failure resulted in R1 not receiving medical treatment for approx. four days on the femur fracture R1 suffered during the fall; an approx. four-day delay of the physician being notified of R1's fall; R1 not being assessed for injury post fall for approx. four days where R1 sustained a fracture of the femur; and resulted in R1 sustaining an unwitnessed fall while attempting to transfer from the wheelchair to the toilet unassisted.

Findings Include:

R1 is an 86-year-old with the following diagnoses: congestive heart failure, difficulty in walking, and lack of coordination. R1 admitted to the facility on 5/9/15.

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A Nursing progress note dated 1/12/22 documents R1 was readmitted to the facility from the hospital with a diagnosis of rectal bleeding. Pitting edema that was painful to touch was noted to the bilateral lower extremities.

A Nursing note dated 1/13/22, documents the CNA (V3) notified the nurse (V4) post occurrence that R1 was self transferring from the toilet to the wheelchair. In an attempt to adjust herself (R1) onto the toilet, R1 began to slide off the toilet and required assistance from the CNA to be eased to the floor. R1 was assessed and transferred onto the bed. No injury was noted and R1 denied any pain at this time.

The Nursing note dated 1/16/22 at 7:58AM, documents R1 complained of left knee and lower leg pain. Moderate swelling was noted, warm to touch. An X-ray of the left leg was ordered. R1 declined pain management at this time. R1's family was made aware of status. (Survey note: this was 3 days after R1's 1/13/22 fall).

A Nursing note dated 1/16/22 at 10:48 PM, documents X-ray was done at 10:15 PM and showed a left femur fracture. The doctor was notified and ordered to send R1 to the hospital for evaluation. R1's family was notified. Pain medication was administered. (Survey note: this was 3 days after R1's 1/13/22 fall).

The Unusual Occurrence 24-hour Report Form dated 1/16/22, documents R1 complained of left leg pain during the 11p-7a shift last night. A portable X-ray showed a left femur fracture. When asked, R1 endorsed not reporting the fall to anyone because R1 thought V3 (CNA) reported it.

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The X-ray of the left femur dated 1/17/22, documents an oblique distal fracture of the left femur.

The Hospital records dated 1/17/22 documents R1 presented with pain in the left lower leg after falling. X-ray of the left femur shortly distal fracture of the femur and a possible proximal fracture as well. R1's left leg was deviated externally when R1 was seen by the paramedics. R1 does have a lot of pain. R1 does have muscle pain and joint pain upon assessment. Bilateral pedal edema is noted with more over the left lower extremity. Left lower extremity is deviated outward and is shorter than the right. R1's family decided to proceed with an open reduction internal fixation surgery to repair the left distal femur fracture.

On 01/29/22 at 2:32PM, V3 stated, "(R1) had no issues transferring before (R1) went to the hospital. (R1) can get herself into the bathroom in (R1's) wheelchair and transfer to the toilet and transfer back to (R1's) wheelchair. (R1) was in the hospital for seven days and (R1) came back to us weaker because they don't let you get out of the bed too much in the hospital. I was doing my rounds and I was coming down the hall and I heard (R1) yelling my name. I ran into the room and I didn't see (R1), so I went to the bathroom and (R1) is holding onto the side rail that's on the wall with (R1's) legs in between the toilet in the wall. (R1's) saying 'help me I'm going to fall.' I got in behind (R1) to try to sit (R1) down on the toilet but (R1) was slipping off the side, so I had to just lower (R1) down onto the floor. I did the best I could but (R1) did make a little thump when (R1) hit the floor. (R1's) legs kind of came up onto the toilet and (R1) landed on (R1's) left side. We got

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S9999	Continued From page 6 (R1) in the wheelchair and put (R1) back in the bed. (R1) didn't say (R1) was in any pain and it was a change of shift, so I left right after that. I don't remember telling anybody that (R1) fell. (R1) doesn't walk but (R1's) able to transfer herself. You just have to kind of watch (R1) do it. We told (R1) when (R1) got back to not do that by herself because (R1) wasn't as strong. (R1) can follow directions but (R1) does like to be independent with some of (R1's) care. (R1) likes washing herself up at the sink in the morning and going to the bathroom herself. We did tell (R1) to call for help because (R1) was weaker from being in the hospital but (R1) didn't call this time." On 01/29/22 at 2:49PM, V4 (Nurse) stated, "The CNA (V3) came and reported to me that V3 eased the resident (R1) down to the floor in the bathroom. I went in and assessed R1 and R1 said R1 was fine so we got R1 up to the wheelchair and back in bed. I asked R1 if R1 was any pain and R1 said no and I kind of looked to see if anything seemed off to R1 but it was ok. I didn't look at R1's leg once R1 got back in bed. I just asked R1 if she was in any pain. I assumed R1 wasn't hurting too bad because R1 was lower down to the ground. It happened towards the end of my shift so I only assessed R1 right then before I left. I didn't document it for a day or two later because I didn't consider it a fall. I let the DON know then too. After a fall you call the doctor in the family to let them know what happened. I think a fall is anytime resident ends up on the ground before it can be stopped. I don't remember if I told the next nurse or not and report that she had a fall. R1 never had a fall before and that's really what we base it on is R1's fall history. I don't think R1 had any fall interventions in place. R1 was able to transfer herself. I never got a report that R1 was weaker	S9999		

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after coming back from the hospital. I assumed everything was fine. R1 does have daily moments of confusion but R1 is able to follow directions."

On 01/29/22 at 3:26PM, V6 (Nurse) stated, " I know the CNA went in to do AM care and that's when R1 told us R1 had pain. R1 didn't even want to move R1's leg R1 was in so much pain. I went and I told the doctor and there was an order for an x-ray put in. I never got any report that R1 had fallen. After every fall you should assess the residents and make sure there is no injuries, notify the doctor and the family, notify the supervisor or DON, and chart everything you did. You chart what happened during the fall, who you talk to notify the fall happened, what the residence pain level was and if there were any injuries, and what the plan will be after the fall."

On 01/29/22 at 3:37PM, V7 (Nurse) stated, "R1 started complaining of pain on the night shift on the morning of January 16th. The nurse (V6) who had R1 before me on day shift said R1 was doing fine with an X-ray was ordered of R1's left leg. They came around the x-ray at about 10:15PM. The technician came and showed me the x-ray and said that there was a femur fracture and he wanted to let me know now but it was going to take him about another hour or two to get back to the place where he had to go to upload it. I called the doctor right away and let him know and he said to send R1 out to the emergency room."

On 01/29/22 at 3:51PM, V2 (Acting DON) stated, "They (nurses) notify the doctor, the family, and the DON. No one was notified with this fall. A fall is considered when you go from a higher plane to a lower plane. Yes, this should have been brought to the doctor's attention. When we asked R1, R1 didn't tell anyone because R1 thought V3 the

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CNA would tell someone what happened. R1 is able to make transfers alone and R1 is able to follow directions. R1 recently went into the hospital for rectal bleeding and when R1 came back to us R1 was weaker due to not getting up in the hospital. A couple days later R1 complained of pain to the left leg and when the x-ray was taken and showed a fracture to the left femur. Fall Risk Assessment is done when a resident comes back from the hospital. It should tell use if there's anything different from before they went out, so we know if they is anything to be monitoring."

On 01/29/22 at 4:23PM, V9 (Primary Physician) stated, " I wasn't told they had any concerns with R1 when R1 got back. R1 does have chronic lymphedema (swelling) so if R1 was not walking and just lying in bed in a hospital it could've gotten worse and decreased R1's mobility. The extra fluid in R1's legs could have made it harder to walk for R1. I would just say follow your policy for monitoring after they come back from the hospital to help prevent things like this. When someone falls they are supposed to examine them and report it to me. The nurse wouldn't have known this was a hip fracture without getting an x-ray. There could be classic signs like having one leg shorter than the other or the leg rotated out. A whole assessment of the body should be performed after a fall to see if there is something abnormal. There's no reason I shouldn't be updated about a fall. It should be reported to me immediately."

The Care Plan dated 1/25/19 documents R1 displays behavioral symptoms related to poor and/or ineffective coping skills and a history of non-compliance with recommendations from health care professionals - transferring self without support. There are no interventions

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S9999	Continued From page 9 related to R1 transferring without support. The Care Plan dated 2/7/20 documents R1 is monitored due to being at risk for falls related to injury due to assistance required for movements and transfers. The following interventions are documented: encourage R1 to call and ask for assistance with transfers and monitor R1 hourly and offer toileting assistance during hourly rounding. The Fall Risk Review dated 10/8/21 documents R1 is a high fall risk due to loss of balance while standing, use of an assistive device, and has a predisposing disease of circulatory/heart conditions. The MDS Section G dated 10/8/21 documents R1 needs a one person limited physical assist with transfers and a one-person physical assist with supervision for toilet use. When moving from a seated to a standing position R1 is not steady and only able to stabilize with staff assistance. The Fall Risk Review dated 1/12/22 documents R1 is not a high fall risk after returning from the hospital. The Management Incident Form dated 1/16/22 documents R1 is not identified as a fall risk, does display poor coordination/unsteady gait, and does have decreased strength. The policy titled, "Fall Prevention Program," dated 02/28/14 documents, "A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. Residents who require assistance will not be left alone after being assisted to bathe, shower, or toilet.	S9999		

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S9999	Continued From page 10 Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified on the care plan." The policy titled, "Fall Policy," dated 6/2014 documents " ... 2. Assess for respiratory difficulties, bleeding and fractures, wear gloves in the presence of blood, open wounds or other body fluids. 3. Place (resident) in a position which is comfortable and will maintain an open airway. If head, neck, or back injury suspected, do not move unless it is necessary to maintain an open airway. Immediately call for an email to notify the physician... additional measures: document all assessment findings and observations, physician and family notification in the residence clinical record in accordance with the assessment guidelines. Document all assessment findings and observations, physician and family notifications in the resident's clinical record in accordance with the assessment guidelines." The policy titled, "Change in Condition Physician Notification Overview Guidelines," dated 4/2014 documents "These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed in physician notification is based on assessment findings and is to be documented in the medical record. 2. Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and through manner (generally within 24 hours or sooner). The nurse should not hesitate to contact the attending physician at any time for a problem which is in his or her judgment requires immediate medical intervention."	S9999		

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S9999	Continued From page 11 The policy titled, "Abuse Prevention Program Facility Policy," dated 2011 documents "the facility affirmed the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment ... Neglect means the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident." (A)	S9999		