

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/17/2022
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NAME OF PROVIDER OR SUPPLIER PRAIRIE MANOR NRSG & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 345 DIXIE HIGHWAY CHICAGO HEIGHTS, IL 60411
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S 000	Initial Comments	S 000		
	Facility Reported Incident of 10/03/2022 #IL152302			
S9999	Final Observations	S9999		
	<p>Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6)</p> <p>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.</p> <p>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.</p> <p>Section 300.1210 General Requirements for</p>		<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to have effective fall interventions in place and failed to provide adequate supervision to ensure the safety of a resident assessed to be at risk for falls. This failure applied to one (R5) of one resident reviewed for accidents and supervision. This failure resulted in R5 having a fall with injury that resulted in a subdural hematoma and subsequently died.</p> <p>Findings include:</p> <p>R5 is a 75-year-old male admitted to the facility on 04/18/2022 with the diagnosis of but not limited to abnormalities of gait and mobility, restlessness and agitation, unsteadiness on feet, and Alzheimer's disease.</p> <p>On 09/25/2022 R5 had a fall in the facility during which R5 hit his head and sustained a laceration to the right brow.</p> <p>Record review of R5's death certificate documents cause of death for R5 as Subdural Hemorrhage (Due to or as a consequence of) Fall.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Death certificate also documents the following: Manner of death: "Accident" Date of Injury: September 25, 2022 Place of Injury: "Nursing Home" Description of How Injury Occurred: "Subdural Hemorrhage Due to Unwitnessed Fall"</p> <p>Further review of R5's medical record, includes note that R5 had a fall on 09/10/2022 at 6:30am where on-coming staff for the day shift noted R5 in room laying on his back with his legs in the air.</p> <p>Record review of R5's Progress Notes include multiple entries from different nurses on different days and shifts reporting that R5 walks at a fast pace with unsteady gait, with the need to be redirected.</p> <p>Record review of R5's Progress Notes on 09/28/2022 reads: R5 left the unit and was observed on the first floor.</p> <p>On 11/15/2022 V1 (Administrator) submitted a schedule of staff working on 9/25/2022 noted is two nurses and one CNA at the time of R5 fall in the floor dining room. Staff redirected R5 back to the second floor.</p> <p>On 11/16/2022 at 9:15am V1 administrator submitted a new schedule with V8 CNA handwritten into the second-floor schedule for the date of 09/25/2022.</p> <p>On 11/15/2022 at 10:20am Interview with V2 DON (Director of Nursing) said " R5 was very busy he would ambulate quickly up and down the hallways very impulsive no safety awareness and difficult to redirect at times. He had 4 falls in the facility the last fall he did go to the hospital they sent him back with all negative X-rays and CT</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>(Computerized tomography) scans. Vitals should be taken daily unless something is going on or there is a change in condition then they will be taken more often. Long term residents are charted on by exception if something is going on if not then monthly. On 10/01/2022 his behavior was as usual he was running in and out of resident's room, getting aggressive with staff. I believe the subdural hematomas was from the fall he had on 09/25/2022 I believe it was from that week because he has not had any more falls since that one. I don't recall him running into walls or any doors."</p> <p>On 11/15/2022 at 10:30am V2 DON said, "I need to correct myself R5 only had 3 falls in the facility not 4, I was mistaken."</p> <p>On 11/15/2022 at 1:06pm interview with V8 CNA (Certified Nursing Assistant) said, "I was working on 10/01/2022 but R5 was not my patient. He was seen coming and going in and out of residents room a little unsteady, but he didn't have any falls that day that I know of. He would walk really fast that's when he became unsteady then we will try to get him to sit down. The only thing they told us was to watch him and to make sure he was steady while walking. I know they got him a helmet but before that last fall I don't know what precautions they just said keep an eye on him. I only know of that one fall I'm not sure if they had him on 1:1 monitoring at that time. I know he would get like very anxious a lot I would redirect him to sit in the dining room or I will walk with him to the dining room he did not fall or hit his head this day."</p> <p>On 11/15/2022 at 1:42pm Interview with V6 CNA said "Yes I worked 10/01/2022 second shift, I'm familiar with R5 he did a lot of moving running,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>stumbling, moving extra fast he was hard to redirect. I know they gave him a helmet and floor mats. He can walk but he would get extra hyper then we would try to redirect him. It was hard trying to take care of him. The nurse would sometimes assign one CNA to him when we had the staff to walk with him and monitor him. It's supposed to be 4 CNAs it may have been 2 or 3 that day. Yes, we would ask for him to be put on 1:1 if we have the staff if not everybody had to help out with him."</p> <p>On 11/15/2022 at 2:08pm Interview with V7 LPN said "Yes I worked 10/01/2022 day shift. He was normal nothing abnormal. That morning he was difficult to redirect earlier but I was able to redirect him. No, he did not have any falls as far as I know of. I kept him by my side a lot to monitor him Yes more like a 1:1. No, the facility didn't put it in place I did as being his nurse. Well, he would ambulate at a fast pace so I would try to be with him because he has an unsteady gait he would just take of at a fast rate of speed. No, he didn't have any falls on my shift. No, I never requested extra help because we had 3-4 CNAs and activities was there. I think at the beginning R5 was easy to redirect but as it got towards the end no, I don't think he was a fit for the facility."</p> <p>On 11/15/2022 at 2:34pm Interview with V4 CNA said "Yes I remember R5 yes I worked 09/25/2022 on day shift, yes, I was the only CNA working on that day. It doesn't happen often maybe once every three or four weeks. The most they try to have are 2-3 CNAs. I am supposed to be in restorative, but I have been working as a CNA on the floor for months. It's no one in restorative we all been working the floor. Well, we don't know how many CNAs working until we get here sometimes people call off and they will try to</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>replace them, but you just never know. I can't recall off hand but if he is up walking, he would walk really fast most of the time I believe he was steady. They told us to monitor his shoes or nonskid socks we needed to remind him to slow down. I was not aware of him falling because I was doing my rounds at that time. I was doing rounds toileting people. Yes, sometimes I believe he was on 1:1, that day I had 30 something residents and its hard trying to watch everybody. Sometimes it's only two CNAs and that will give us like 21 residents. Yes, we would let the nurse know and if they not busy, they will help us, or we would try to keep him in activities, but he was very impulsive and just jump up and start running."</p> <p>On 11/15/2022 at 2:58pm Interview with V5 LPN said "Yes I was the nurse for R5 the day he fell. He was being his usual self, walking around I kept him in activities that day. As long as he in activities he was doing okay. After lunch he came out the dining room walking really fast, and I couldn't get to him, and he lost his balance and fell. I believe he did need more monitoring. It was discussed I can't remember when that we can use more help for him. Since he's been here, I had to put him on 1:1 that day after he fell. I can't remember off top I just use to try to keep him next to me for his safety. I did everything I could that day to keep him safe."</p> <p>On 11/16/2022 at 10:12am interview with V3 ADON said Yes, I knew R5 I didn't know his medical history as far as dealing with his medication regimen or his care. I didn't deal with him as much. I think it was a weekend the nurse on second floor called to ask me for help with R5. They needed help monitoring him he was restless he was grabbing other residents food I went to</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>provide extra help. I know he was a pacer at times I went to help he was trying to open doors he would be redirected. On his floor the doors are lock because of the unit so he would just twist the knobs. We had people that would walk with him to try to keep him safe it was very difficult, and it was hard to have 1:1 or people for extra monitoring we would discuss in morning meetings about his medication regimen, ask if anyone has time to go to the floor and walk with him. I do recall when he would fall, we would send him out to the hospital, and they would send him back. I guess we didn't fill out the paperwork correctly so they had to send him back here because they could find placement. We were looking for placement for him. He needed the extra monitoring that's why we would ask if anyone had extra time to come walk with him. We talked to the Psych Nurse Practitioner, and she gave an as needed order it was liquid and that help get him to bed, I sat in the room with him until he fell asleep. Everyone in the building knew he was all hands-on deck with him. I think we was doing the best we could with the resources we had. We would even ask the family if they could come in and help with mealtimes or just monitoring. Usually, the second floor get priority because of the level of acuity of care they need. They should have 3-4 CNAs we don't do 1:1 but they would get an extra CNA when he needed extra monitoring. Yes, if I was working, he would have been safe with one or Two CNAs because I would have isolated him with me."</p> <p>Review of R5's care plan did not show that the facility modified the resident's plan of care based on the increase needs of the resident in regard to falls and safety. Interventions were not individualized to meet the resident's needs.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Care plan has a problem start date of 8/17/22: (R5) has a behavior of running in hallway which may be r/t his DX of dementia. Interventions dated 8/17/22 are to ensure proper footwear, redirect as needed, and review medications (adjust as needed). Evaluation Notes dated 9/19/22 documents Quarterly reviewed care plan. Continue with goal and approaches. No additional interventions added after 9/19/22.</p> <p>Care plan with problem start date 4/26/22: (R5) is at risk for falling Dx/Hx of dementia, Alzheimer Disease, constipation, Weakness and Anemia. Interventions added 9/12/22 do not address resident ambulation while in hall until after fall occurred on 9/25/22, although resident has a history of unsteady gait and difficulty ambulating per staff interviews and medical record review. On 9/26/22 interventions were added: walk scheduled with one person assist in the afternoons and safety helmet ordered.</p> <p>R5's MDS (Minimum Data Set) dated 6/20/22 documents that R5 required extensive assistance, two + persons physical assist with bed mobility, transfers, walking in room, and walking in corridor.</p> <p>MDS dated 9/20/22 documents that R5 required extensive assistance, two + persons physical assist with bed mobility and transfers; required limited assistance, one-person physical assist when walking in room and walking in corridor. Facility did not provide documentation of improvement in resident condition to explain decrease from two + to one staff assist.</p> <p>On 11/16/2022 at 11:23am interview with V9 Medical Director said "Yes I seen R5 two to three times since he was here. If his facility can't get a doctor to follow a patient by default, I see them.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>When the resident first come to the facility they do interviews and assessments to see if they are a fit for the facility. When he first came, I believe he just needed to get settled in because this was a new place for him. When I saw him one time he was in his room, one time he was at the nursing station and one time he was pacing up and down the hallway. If he fell, they should do an assessment and put precautions in place based on what they decide that patient need it could be 1:1. But dementia patient can't always be on 1:1 it's on a day-to-day basis. I can't make that decision it's up to the staff and nurses to decide on what monitoring a patient may need. It's their decision amongst themselves. Of course, extra monitoring is always better. (Reviewing R5 progress notes) He was aggressive, unsafe judgment, walking quickly unsteady they should have had someone with him gait unsteady. Yes, if they would have reported this behavior to me, I would have told them to get more supervision for him. They have a Nurse Practitioner that was working with him so they would report behaviors and things like that to them. When he had a fall or change in condition, they would call me. A subdural hematoma can take one to several days to show up. It depends on if it is a slow bleed or huge trauma, a huge trauma will show bleeding right away a slow bleed can take two -three days to show. One possibility is that he fell again but they say he didn't fall again so the other possibility is that it was a slow bleed from the last fall he had. So, possibility that it was a slow bleed that progress and got worst or new fall that no one seen."</p> <p>Record review of document submitted by the facility Titled Falls-Clinical Protocol with the revised date of August 2008 on page FA-2 next to monitoring and follow up states: 1. The staff, with</p>	S9999		

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S9999	Continued From page 9 the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have bleed ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. (A)	S9999		