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	IL6010078	A. BUILDING: _____ B. WING _____	C 07/12/2022

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: 2294026/IL147200	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.1010h) 300.1210b) 300.1210d)3)6) 300.1810c)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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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 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 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.	S9999		

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S9999	Continued From page 2 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 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough physical assessment of a resident after finding the resident with his right leg contorted with his foot in his mouth and failed to prevent a resident with a diagnosis of Parkinson Disease, Dementia poor safety awareness and totally dependent on facility staff activities of daily living from sustaining an injury of unknown origin, a deformity of the right knee. This affected one of three (R4) residents reviewed for injury of unknown origin. This failure resulted in R4 being found with his leg contorted and was not assessed until 5 hours later with a right femur fracture.	S9999		

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S9999	Continued From page 3 Findings include: R4 face sheet and care plan shows R4 has diagnosis of dementia, abnormal gait and mobility, Parkinson's disease and failure to thrive. R4 physician progress note dated 4/7/2022 shows in-part, 78-year-old male seen today for newly admitted services. Resident was admitted from (nursing home name) resident presents with Parkinson disease, diabetes, CAD, COPD, GERD, and adult failure to thrive. On examination resident is seen in lying in bed, he is alert and oriented 1-2, agitated but verbally responsive with periods of confusion and forgetfulness. Nurse reports that resident was seen walking out of his room with no clothes on. He was immediately helped back into his room and redirected. Psychologic: clear and lucid, insight impaired, cognitive status: forgetfulness, confused, dementia. Dementia: monitor for behavior changes, redirect when necessary, supportive care. R4 MDS dated 4/10/22, shows section "G" for functional status for self-performance with bed mobility, R4 is extensive assist (resident involved in activity, staff provide weight bearing support). Transfer-R4 is extensive assist (resident involved in activity, staff provide weight bearing support). Walk in room- not assessed. Walk in corridor- not assessed. Dressing-R4 is extensive assist (resident involved in activity, staff provide weight bearing support). Eating- R4 requires limited assistance. Toilet use-R4 is total dependent (full staff performance every time). Section C for cognitive pattern shows R4 cognitive skills for daily decision making is moderately impaired. Review of R4 progress note dated 4/10/22,	S9999		

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completed by V19 (RN), shows in-part late entry: note text: Writer called to residents' room by CNA, who informed that the resident was putting his right foot in his mouth. Upon entering the room, resident is noted to have his foot to his face while still talking to CNA. Resident showed no S/S of pain or distress at this time, such as facial grimacing or guarding extremity. Writer asked if resident had pain and he (R4) stated "no". Assessment of area performed: he (R4) did not complain of tenderness or pain as he continued to talk clearly. Pain medication offered as a prophylaxis which he (R4) refused. Bed left in lowest position with call light in place. Writer then left resident room to continue work.

Review of V19 progress note shows there is no documentation noted if R4 leg was externally or internally rotated. No documentation noted if there are any scratches or abrasions to the great toe. There is no documentation if there was monitoring put in place for R4. There is no documentation that R4 was redirected from bending his leg and putting his foot to his face and chewing on his toe.

Facility incident report dated 4/10/22, completed by V18 (RN) at 11:03 a.m. shows in-part: writer called to room by CNA (certified nurse aide), upon entering room with co-nurse, resident (R4) noted in bed with head of bed elevated, complains of pain to right lower extremity, upon assessment, residents right knee noted to be swollen and externally rotated. Resident also noted with abrasion noted to right great toe area. Resident unable to explain nature of incident. Resident remains in bed. Physician notified of incident, T 97.5 P 72 R 18 B/P 134/74, new orders received to send to ER (emergency room), abrasion to right great toe cleansed with normal

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S9999	Continued From page 5 saline and left open to air. 911 called. Resident transported to hospital in stable condition. Orientated to person, confused/ disoriented, abrasion- right knee. Predisposing physiological factors- confused, incontinent, impulsive, resistant care, impaired memory, decreased safety awareness and agitated /anxious. At approximately 5:00 am the 11-7 shift staff reported observing resident in bed with his right great toe in his mouth, chewing on it. Resident is very thin and appears to be flexible. No obvious injury to RLE (right lower extremity) was noted at that time. The 7-3 staff observed resident lying in bed with his right knee externally rotated. Resident admitted to hospital with a right femur fracture. No falls were noted or reported by staff. Staff reports the resident had been up and walking and was exit seeking during both the 3-11 and 11-7 shift. He was difficult to redirect. He is confused. On 7/6/22 at 11:06a.m. V3 (CNA) said he was working with R4 on 4/9/22 on the 11:00 pm to 7:00 am shift. V3 said around 4:00 a.m., he observed R4 standing in the doorway of his room, and he escorted R4 back to his bed, V3 said around 5:30 a.m., he observed R4 in his bed and R4 had his foot to his face and R4 was chewing on his right great toe. V3 said he was shocked to see R4 so flexible and limber, V3 said he summonsed V19 (nurse) to come and observe R4. V3 said V19 came to R4's room and that V3 walked away shortly after because he had to finish working. V3 said he did not redirect R4 to remove his foot from his face and his toe from his mouth. V3 said the way R4's leg was bent toward his face, it looked like something in a circus act. V3 said R4's leg looked flimsy now that he thought about it. V3 said he mentioned that R4 was limber	S9999		

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and V19 said to him that older people can be flexible like that. V3 said he did not report R4's behavior to the oncoming CNA, nurse, or the Director of Nursing. V3 said he does not know why R4 was chewing on his toe. On 7/8/22 at 9:20 a.m., V3 said the first time he changed R4's brief, R4 was lying in bed, and he turned R4 from side to side, V3 said around 4:00-4:30 a.m. he changed R4 again, V3 said he assisted R4 to a standing position at the bedside so that he could provide incontinent care to R4. V3 said R4 put R4's left arm on his (V3) shoulder for support. V3 said he had to bend down to put the brief through R4's legs and then fasten the brief. V3 said he did not get a report on how much assistance R4 needs for ADL (activity of daily living) care.

On 7/6/22 at 11:16 a.m. V19 (Nurse) said around 5:30 a.m. on 4/10/22 she was summons to the room to observe R4 with his foot in his mouth. V19 said she observed R4 with his right great toe in his mouth. V19 said R4 continued to talk while he had his toe in his mouth and foot to his face. V19 said while R4 remained in that position she completed her assessment of R4. V19 said she touched R4 legs from his hip to his ankles. V19 said R4 denied pain and discomfort and she did not observe any deformities to R4 extremities. V19 said she could not tell if R4 leg was bent at the knee or above the knee. V19 said she did not check to see if R4's leg was internally or externally rotated. V19 said she did not look at R4 legs for asymmetries. V19 said after she assessed (touched R4 right leg from hip to ankle) R4 she left R4 in the room in the bed with his foot folded over his lap (V19 describe Indian style position). V19 said she did not redirect R4 from the observed behavior. V19 said she went to finish working because she had to work two halls (200 and 300 wing). V19 said she asked R4 was

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S9999	Continued From page 7 he okay and offered R4 something for pain. V19 said she saw R4 again at 6:30 a.m. and R4 was sleeping in the bed. V19 said that was the last she saw R4. V19 said she doesn't know what time she left the facility. V19 said she gave report on R4 behavior to a nurse, but she doesn't know who the nurse was. On 7/8/22 at 12:19 p.m., V19 said she did not document R4's behavior because she was not sure of the facility policy on documentation. V19 said she documented on 4/11/22 when she was asked to put a note in the electronic record. V19 said her handwritten statement is dated for 4/10/22 because that was the date of the occurrence, and she wrote the statement on 4/11/22. V19 said she assessed R4 and R4 did not have an abrasion or scratches to his right great toe. V19 said she does not know why R4 was chewing on his right great toe, she did not ask R4. V19 omitted initiating behavior monitoring for R4. On 7/6/22 at 11:32a.m V21 (CNA) said she was the assigned CNA for R4 on 4/10/22 for the morning shift. V21 said she got to work late that morning around 8-8:30 a.m. V21 said during her first rounds she passed a breakfast tray to R4. R4 was resting in bed with no complaints. V21 said she told R4 she will get him up during her second rounds. V21 said she did not provide any care to R4 at that time. V21 said she did not touch R4 at that time. V21 said at 10:30 a.m. when she went to get R4 up for the day, she asked R4 if he was ready to get up and R4 replied "yea but I can't lift my leg". V21 said she thought that was odd because R4 was able to stand with assistance before. V21 said that when she pulled the sheet back and observed R4's knee, it did not look right. V21 said R4's right knee was rotated to the side. V21 said that's when she went and got the nurse. V21 said when she returned to the room	S9999		

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S9999	Continued From page 8 with V18 (Manager on duty) she observed that R4 had scratches on his right great toe. On 7/7/22 at 1:30 p.m. V13 (CNA-Certified Nursing Assistance) said on 4/10/22 V21 got her attention when V21 said something was wrong with R4's knee. V13 said she went and looked at R4's knee and it looked bad. V13 said R4's right knee was rotated to the side and R4's right toe had scratches on it. V13 said no one reported to her that R4 was having behaviors of putting his foot in his mouth. On 7/7/22 at 11:40am V22 (Nurse) said she was working the other half of the 200 unit when V21 came and got her to look at R4 leg. V22 said when she looked at R4 leg, she had never seen anything like that in all her years of working as a nurse. (V22 would not describe what she saw) V22 said she told the aide to get the supervisor immediately. V22 said the night nurse (V19) did not give her report that R4 was having any behaviors of putting his foot in his mouth. On 7/6/22 at 12:26p.m V18 (Manager on Duty) said she was the manager on duty when the CNA came and got her to look at R4's leg. V18 said when she got to the room, she pulled the covers back and observed R4 knee looked dislocated and rotated, and R4 had an abrasion on his right great toe. V18 said she cleansed R4's toe and left it open to air, V18 said she notified the physician and orders were given to send R4 out to the hospital for further evaluation. V18 said she do not know who the assigned nurse was for R4. V18 said V19 did not report that R4 was having behavior early that morning and chewing on his right great toe. On 7/6/22 at 1:33p.m V2 (DON) said she	S9999		

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conducted the investigation of R4's injury of unknown origin. V2 said she was not aware of R4 unusual behavior of putting his toe in his mouth initially. V2 said she was not made aware until V18 (manager on Duty/Nurse) informed her of the observation of R4's knee looking dislocated. V2 said that's when she called V19, and V19 informed her of R4 behavior that early morning. V2 said she wished V19 would have informed her of R4's behavior initially. V2 said she would have put monitoring in place for R4 and she would ensure the occurrence was documented. V2 said she would have notified the physician; informed the aides of the behavior so that they can observed for continued behavior and redirect the resident: the care plan would have been updated, and the guardian notified. V2 said she can't say what the frequency would be because again the behaviors were so unusual. V2 said a head-to-toe assessment should be conducted, making observation of all extremities. V2 said R4 is cognitively impaired, has poor safety aware and he does not understand that he could injury himself doing such behavior. V2 said no staff reported to her that R4 had a fall. V2 said if R4 had a fall from the bed that morning, there is no way that R4 would have been able to get himself off the floor independently with the extent of R4's injury. V2 said R4 would have needed some assistance to get off the floor. V2 said she and V1 (Administrator) viewed the facility video recording and verified V3's and V19's statements only. V2 was asked if she viewed the video to determine if any staff went into that room to pick R4 up off the floor. V2 continued to say the video was reviewed to verify what V3 and V19 had said only. V2 said she does not know if any staff went into R4's room between the time R4 was last observed in the bed and the time R4 was observed with the scratches to the great toe and the distorted knee.

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V2 said she believes the facility video recording records up to 24 hours. V2 continued to say no one reported to her that R4 had a fall. V2 also said no one reported to her, R4's behavior early that morning either, V2 said she had to call her staff and ask them what happened. V2 said her staff also did not document until she requested them to document their observation of R4. V2 said the staff should document on the resident behavior right away. V2 said R4's injury must have happened after the initial observation of R4 with his toe in his mouth. V2 said if V19 was not familiar with the facility policy and practice, V19 should have contacted her or the physician for directives.

On 7/6/22 at 2:38 p.m. V20 (Therapy Director) said R4 was screened and evaluated by therapy. R4 has an unsteady gait, weakness. R4 is a fall risk. R4 could come to a sitting position and sit up for about 30 seconds. V20 said R4 should not be in a position where he has his right foot to his face and his great toe in his mouth. V20 said that position is not safe and R4 could roll out of the bed and cause an injury to himself.

On 7/8/22 at 10:04a.m V24 (Physician) said she cannot say if the injury was a result of trauma because the facility does not have evidence that there was a fall or trauma. V24 said she has seen in her practice a few situations where a resident suffered a fracture without having trauma. V24 said R4 had to do some twisting because it's not easy to put the toe in the mouth without twisting of the extremities. V24 said twisting can cause spiral fractures. V24 said it's possible that R4 had a hairline fracture and suffered a comminuted fracture due to the twisting. V24 said she cannot say because she does not have the

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S9999	Continued From page 11 supporting evidence to say this fracture came from trauma or fall. On 7/8/22 at 3:05p.m. V9 (MDS coordinator) said R4 required weight bearing support from staff for bed mobility, transfers, toilet use, V9 said R4 was able to feed his self. V9 said she did not assess R4 for walking ability. On 7/08/22 the surveyor observed a photo of R4 lying in bed, with his right knee grossly deformed and twisted 90 degrees out of its normal position. R4 progress notes dated 4/10/22 at 6:20 p.m. shows resident was admitted to hospital with a diagnosis of right femur fracture. R4 hospital records dated 4/10/22, shows primary complaint: general medical complaint specific right knee deformity, pain unable to assess AMS (altered mental status), associated symptoms leg swelling, risk factors diabetes. 78 y/o male with past medical history of DM (diabetes mellitus) presents to the ED (emergency department) via EMS form NH (nursing home) c/o (complain of) right knee deformity. Per NH, no witness fall, it is unclear when it happened. NH also states that patient has been walking as of last night. HPI limited d/t AMS (altered mental status). Diagnostic impression-other distal femur fracture. ER Xray shows this is a severely comminuted displaced fracture involving the metadiaphysis of the distal right femur. Facility policy titled, "Behavioral management for new or worsening behavior symptoms", dated 4/14 shows in-part: the purpose is to determine the cause of the behavior, to prevent the resident from harming self or others, to establish guidelines for reducing or preventing behaviors	S9999		

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S9999	Continued From page 12 when possible. It is the policy of the nursing department to determine the cause of behaviors when possible and initiate interventions to reduce, control, or prevent identified behaviors. In the event the behavior cannot be managed, staff will implement protocols to prevent the resident from harming self or others which may take precedents over the procedure as written. Procedures measure vital signs, review drug regime, review clinical record, observe body position and ROM(range of motion): (rational-protecting or guarding, neurological deficits, new asymmetries or swelling, pain or tenderness, fractures) , assess skin condition, assess body system, evaluate environmental changes, notify social services as soon as possible, perform depression assessment, initiate behavioral monitoring and intervention record, develop behavior management plan with interdisciplinary team members. Facility policy titled, "Incident/accident reports", dated 9/14 shows in-part that an incident is defined as any happening, not consistent with the routine operation of the facility, event out of the ordinary that does not result in bodily or property damage. An accident is defined as any happening, unexpected, unintended event not consistent with the routine operation of the facility that can result in bodily injury other than abuse. Incidents of unknown origin are to be investigated thoroughly in an effort to rule out abuse. These are to be reported to Illinois Department of Public health. (B)	S9999		