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 02/11/2025

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PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigations 2590381/IL184513 2590509/IL184879	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal 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.

These requirements were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to follow resident care assessment and plan in providing adequate supervision and monitoring of residents with severe cognitive impairment for two (R3 and R4) of four residents reviewed for accidents and supervision. This deficiency resulted in R4 had a fall in the dining room and sustained a comminuted and mildly displaced fractures of the left medial acetabular wall and root of the superior pubic ramus (hip/pelvic area).

Findings include:

R4 is an 83-year-old, female, admitted in the facility on 11/02/2020 with diagnoses of

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Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; and History of Falling. MDS (Minimum Data Set) dated 12/02/24 recorded R4's BIMS (Brief Interview for Mental Status) score is 3 which means severe cognitive impairment.

R4's care plans documented the following:
1.At risk for increasing confusion secondary to dementia, initiated 11/02/20:
Interventions:
Provide cueing and prompting PRN (when necessary).
Involve in small group/low stress activities.
Reality orientation as needed.
Calm/quiet environment.
2.Self-Care Deficit, date initiated 11/12/202:
Interventions:
Provide assistance with all ADLs as required per the resident's need dependence: eating, transferring, bed mobility, bathing, dressing, personal hygiene, ambulation and personal hygiene.
R4's progress noted dated 01/30/25 documented R4 was found sitting up on the floor mat sitting up on buttocks with heel protectors in place wrapped in bed sheet. No apparent injury noted. No new orders received at this time. Bed in lowest position.

R4's care plan recorded the following:
1.At risk for falls related to resistive to care at times and history of fall, initiated 11/08/20:
Interventions:
Frequent room rounds when resident is in room.
Gather information on past falls and attempt to determine the root cause of the fall (s). Anticipate and intervene to prevent recurrence.

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Fall Risk Review dated 01/06/25 indicated R4 had been determined not to be a high risk for falls.

Fall incident report dated 01/22/25 documented that on 01/16/25 at approximately 2:04 PM, R4 had a fall in the 100-unit dining room. There were no open areas. The nurse assessed R4, noted to have facial grimaces when moving the left leg. R4 was sent out to the hospital as ordered for further treatment and evaluation.

R4's CT (computed tomography) scan and X-ray of left hip and pelvis dated 01/16/25 performed in the hospital revealed the following results:
CT pelvis without contrast: comminuted and minimally displaced anterior column fracture with incomplete nondisplaced posterior hemi transverse component.
X Ray hip 2 views left and pelvis: comminuted and mildly displaced fractures of the left medial acetabular wall and root of the superior pubic ramus.

On 02/03/25 at 11:31 AM, R4 was in the dining room, up in wheelchair. R4 is alert, oriented to self, confused. R4 was sitting at a table with other residents attending activities. R4 was asked regarding recent fall incident wherein she sustained fracture. R4 stated she does not know what happened and had no recollection of the fall incident.

On 02/04/25 at 10:55 AM, R4 was in the dining room; up in wheelchair; attending activities. She is alert to self but did not respond when surveyor asked on how she was doing.

On 02/04/25 at 11:24 AM, V15 (LPN) stated, "R4 is alert and confused. She is dependent on staff. She uses a wheelchair. I was the nurse assigned

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to her on 01/16/25. I was coming in from break, the aide called me and told me that she (R4) had a fall in the dining room while I was on break. V20 was the CNA assigned in the dining room. Usually there is one CNA assigned every hour in the dining room with the usual of no more than 20-25 residents in the dining room for 1 CNA. There were about 20 residents that time. I did the assessment on R4, there was no apparent injury. Vital signs were normal. When I found her, she was laying on the floor opening graham crackers. She appeared to be herself. She cannot recall what happened. The CNA told me that she was attending to another resident, when she turned around, she saw R4 fell. She was the only CNA in the dining room at the time. She (R4) was assisted back to her chair. I called physician and told me to get an X-ray and she (R4) was later sent out".

On 02/04/25 at 1:01 PM, V20 verbalized, "On 01/16/25, I was in my dining room time. She (R4) does ambulate. I was keeping eye on another resident. On the other side. R4 was standing, it was fine because she ambulates, and she can walk. When I turned towards my left, I saw her (R4) going to the floor and fell. I was the only one in the dining room at the time. I believe it was after lunch. Usually, after lunch, there's only one CNA who rotates every hour for dining room supervision. There were 15 or slightly more residents at the time. Majority of residents were in wheelchairs. She (R4) was in the chair not in wheelchair because she can still walk. When I saw her fell to the floor, I called the nurse." V20 was asked what interventions should be implemented to prevent R4's fall. V20 mentioned, "Close supervision, make sure she doesn't stand or ambulate."

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On 02/05/25 at 10:15 AM, V15 was asked regarding staff assignment for dining room supervision. V15 stated, "We, nurses on the floor are the ones responsible for assigning a CNA to monitor the dining area. I'm on 100 unit. Only one CNA is assigned regardless of the number of residents in the dining room. The rotation is every hour. At 10AM to 11 AM and 2 PM to 3 PM, it is our activity time. Activity aides are assigned to conduct activities and there's no CNA assigned around this time. Between the hours of 3 PM to 4 PM, an activity aide and an assigned CNA should be in the dining room monitoring residents. This is the typical schedule for the day. R4 is in the 100 unit. I am her regular nurse."

Per R4's incident report, she had a fall at approximately 2:04 PM. V15 stated that between 2 PM to 3 PM, it is scheduled activity time and activity aides should be conducting activities on resident.

Facility was asked to provide schedule sheets for dining room supervision. V1 (Administrator) stated they don't document staff schedules.

On 02/04/25 at 2:13 PM, V2 was asked regarding R4 and fall supervision and monitoring. V2 replied, "Every hour, there could be one CNA assigned in the dining room. During monitoring of residents in the dining room, there should be one CNA assigned regardless of the number of residents present. Staff monitor residents, attend to their needs. For R4, we make sure she is clean, dry, fed, assisted with feeding, when she is up, she is in the dining. She can participate in activities, keeping her busy. She was not a fall risk before, she used to ambulate and still walking. I investigated her (R4) fall on 01/16/25. She had a fall in the dining room. She got up and

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she took some steps and lost her balance. She was sitting in the chair, stood up and fell on her left side. The nurse assessed her, and she was sent out. She sustained pelvic fracture. She was admitted for a few days and came back for readmission. She can get agitated, she can get impulsive, we try to approach her in a calm manner. She is confused. She likes to get up and move We have to bring her out to activities. We don't know exactly why she (R4) stood up but she had that fall. R4 is able to walk around, we just monitor her. We don't need to supervise her when walking, because she is able to walk around, prior to fall."

R4's MDS dated 01/04/25 also recorded: Section GG - sit to stand: supervision or touching assistance; walk 10 feet: supervision or touching assistance. Supervision or touching assistance is coded as helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

On 02/04/25 at 1:14 PM, V22 (Physician) stated, "I am her physician and been seeing her. I was notified that she had a recent fall. She is confused, walked around, and fell down, she had fracture in the pelvis. She just fell. For high risk residents for falls, I expect staff to constantly watch them. In the dining room, there should be close supervision. For a staff to be watching more than 15 residents in the dining room, and majority are in their wheelchairs, it is almost impossible to provide close supervision. If you are constantly looking into another resident and one resident may stand up, walk and fell, it's almost impossible. I expect staff to provide close supervision; eyes on them at all times and follow

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the facility fall protocol."

Facility's policy titled "Fall Prevention Program" dated 2/28/14 documented in part but not limited to the following:
Policy:
It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.
Program contents:
The Fall Prevention Program includes the following components:
4.Use and implementation of professional standards of practice.
5. Changes in interventions that were unsuccessful.
10.Care plan incorporates:
b. Interventions are changed with each fall, as appropriate.
c. Preventative measures.
11. Periodic quality assurance audit activities of records relating to falls that exhibit adherence to facility policies and implementation of the plan of care.
Standards:
3. Safety interventions will be implemented for each resident identified at risk using a standard protocol.
Safety Precautions for residents at risk:
In addition to the use of Standard Fall Precautions, the following interventions will be

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S9999	Continued From page 8 implemented for resident identified at risk. 1.The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care. (A)	S9999		