| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145629 | A. Building<br>B. Wing | 04/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Prairie Manor Nrsg & Rehab Ctr | 345 Dixie Highway<br>Chicago Heights, IL 60411 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102<br><br>Based on interview and record review, the facility failed to develop and implement effective fall interventions related to the root cause of a resident with multiple falls. This affected one of three residents (R1) reviewed for falls. This failure resulted in R1 having six falls in six months with no change in fall interventions.<br><br>Findings Include:<br><br>R1 is an [AGE] year old with the following diagnosis: Parkinson's disease, functional quadriplegia, difficulty in walking, and orthostatic hypotension.<br><br>A Plan of Care note dated [DATE] documents the nurse was called to R1's room by another staff member. The nurse observed R1 on the floor sitting in front of the wheelchair. R1 was assisted back to the wheelchair.<br><br>The Care Plan dated [DATE] documents R1 is a high fall risk related to diagnosis of Parkinsonism, weakness, syncope, depression, and coronary artery disease. Interventions were added after each fall. The following interventions were documented on [DATE]: anticipate and meet R1's needs, follow facility fall protocol, and be sure R1's call light is within reach and encourage R1 to use it for assistance as needed. R1 needs prompt response to all requests for assistance.<br><br>The Fall Report dated [DATE] documents a staff member called the floor nurse to R1's room where R1 was observed sitting on the floor in front of R1's wheelchair. R1 reported R1 was trying to get into the wheelchair and slid onto the floor because R1 did not lock the wheelchair. R1 was alert to person, place, and time. There's no documentation of any additional interventions put in place after this fall.<br><br>A Nursing note dated [DATE] documents the nurse heard R1 calling up for help. Upon entering the room, R1 was on the floor with R1's back against the bed. R1 was in a sitting position. R1 told staff R1 was trying to self-transfer from the bed to the wheelchair when R1 slid to the floor from the bed.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Care Plan from [DATE] had interventions added from after the fall on [DATE]. The following interventions were documented on [DATE]: R1 needs a safe environment with even floors free from spills and/or clutter, adequate/glare-free light, working and reachable call light, bed in the low position, and personal items within reach; R1 needs activities that minimize the potential for falls providing diversion and distraction.<br><br>The Care Plan dated [DATE] documents R1 is high risk for falls. An intervention dated [DATE] documents physical therapy will evaluate and treat R1.<br><br>The Fall Report dated [DATE] documents R1 was calling out for help and upon entering the room, R1 was observed sitting on the floor with R1's back against the bed. R1 stated R1 was trying to self-transfer from the bed to the wheelchair and slid to the floor. The level of consciousness or mental status was not documented. There is no documentation of any additional interventions put in place after this fall.<br><br>A Nursing note dated [DATE] documents R1 was observed in R1's room in a sitting position. R1 stated the dresser fell on R1's right ankle as R1 is trying to open the dresser where the belongings were kept. R1 complained of right ankle pain. The nurse practitioner was informed and ordered an x-ray to the right leg, right ankle, and right upper back. The incident was immediately reported to maintenance and the dresser was replaced with a new dresser.<br><br>The Care Plan from [DATE] had interventions added from after the fall on [DATE]. The following intervention was documented on [DATE]: encourage R1 to use the call light for assistance with needs.<br><br>The Fall Report dated [DATE] documents R1 was observed in a sitting position in R1's room. R1 reported trying to reach for a belonging in R1's dresser when the dresser fell on R1's legs. R1 complained of the upper right back and right ankle hurting. The nurse practitioner was notified and ordered x-rays. Maintenance was notified and made immediate corrective action. The old dresser was replaced with a new one. There is no documentation on R1's mental status or level of consciousness. There is no documentation any additional interventions were put in place after this fall.<br><br>A Nursing note dated [DATE] documents R1 was found on the ground on the side of the bed during rounds. R1 stated R1 was trying to get into bed and slid out of the wheelchair. When asked why R1 didn't use the call light for help, R1 stated, I thought I could do it. The area was free from spills or objects. R1 had gym shoes on R1's feet. R1 denied all pain or discomfort.<br><br>The Care Plan from [DATE] had interventions added after the fall on [DATE]. The following interventions were documented on [DATE]: anticipate and meets R1's needs; follow facility fall protocol; and be sure R1's call light is within reach and encourage R1 to use it for assistance as needed. R1 needs prompt response to all requests for assistance. These are the exact same interventions that were documented after the fall on [DATE]. Other interventions for this care plan include ensure that R1 is wearing appropriate footwear when ambulating or mobilizing in a wheelchair and educate R1 and family about safety reminders and what to do if a fall occurs. It is documented R1 had on appropriate footwear during this fall.<br><br>The Care Plan from [DATE] had interventions added from after the fall on [DATE]. The following intervention was documented on [DATE]: physical therapy to evaluate and treat as ordered.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Fall Report dated [DATE] documents R1 was found sitting on the floor on the side of the bed. R1 reported trying to get R1 into bed from the wheelchair and slid. R1 thought R1 could do this unassisted so R1 did not call for help. The area remains free from spills and R1 had on gym shoes during the fall. R1 was alert to person, place, and situation. There's no documentation of any additional interventions were put in place after this fall.<br><br>A Nursing note dated [DATE] at 8:03 PM documents R1 fell and had no injury. R1 was attempting to go to the bathroom unassisted and fell . A new order was put in place to encourage fluids.<br><br>The Care Plan from [DATE] had interventions added from after the fall on [DATE]. The following interventions were documented on [DATE] and [DATE]: move R1 closer to the nurse's station and encourage R1 to participate in activities that promote exercise and physical activity for strengthening/improved mobility.<br><br>The Fall Report dated [DATE] documents R1 was observed on the floor on the side of the wheelchair and R1's room. R1 reported R1 attempted to go to the bathroom. R1 was alert to person, place, and situation. No injuries were noted at the time of the fall. There's no documentation of any additional interventions were put in place after the fall.<br><br>A Nursing note dated [DATE] documents the CNA notified the nurse R1 was found sitting on the floor mat. R1 stated R1 was going to the bathroom unassisted. R1 was educated on the importance of putting on the call that when needed. A full body assessment was completed, and no visible injuries were noted.<br><br>The Care Plan from [DATE] had interventions added from after the fall on [DATE]. The following intervention was documented on [DATE]: offer toileting assistance after meals and activities/before bedtime.<br><br>The Fall Report dated [DATE] documents R1 was found sitting on the floor on the floor mats beside the bed by the CNA. R1 reported R1 was going to the washroom. No visible injuries were noted. R1 was alert and oriented to place. There's no documentation of any additional interventions were put in place after this fall.<br><br>A Nursing note dated [DATE] documents this is post fall documentation. Bruising was noted to R1's mid forehead, right eyebrow, and around the right eye. The right side of the forehead had a closed scab near the upper head. The nurse practitioner was notified and assessed on face. No new orders at this time.<br><br>On [DATE] at 12:55PM, V1 (Nurse) stated V1 was the nurse during the [DATE] fall. V1 reported R1 used to be very independent before R1 started to decline around the beginning of 2025. V1 reported R1 has Parkinson's and kept declining and was getting weaker. V1 stated the fall in ,d+[DATE] was caused by R1 self-transferring to the wheelchair unassisted and the wheelchair was not locked. V1 reported R1 was alert and oriented times 2 to 3 at the time of the fall. V1 stated the restorative nurse put in all fall interventions and the staff nurses make sure the fall interventions are in place. V1 denied knowing how fall interventions are chosen.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 1:23PM, V2 (Restorative Aide/CNA) stated R1 was ambulatory when R1 arrived to the facility. V2 stated R1 was in the walking and transferring restorative program at this time. V2 reported as R1 was declining the restorative programs changed to bed mobility and dressing. V2 confirmed the changes in the program were made at the beginning of 2025. V2 reported R1 began getting weaker and more confused as the decline continued. V2 stated since R1 was ambulatory in the beginning, no physical interventions were put in place, but R1 was educated on using the call light and not getting up without help. V2 reported new interventions are put in place after each fall. V2 reported the interventions are documented in the care plans so staff can reference them when needed. V2 stated all of R1's falls were due to R1 trying to self transfer or walk alone. V2 could not recall any other interventions for falls.<br><br>On [DATE] at 3:18PM, V3 (Nurse) stated V3 was the nurse during the [DATE] fall. V3 reported R1 fell because R1 was reaching out for a personal belonging, and the dresser fell on top of R1's leg, knocking R1 out of the wheelchair. V3 reported R1 was found on the floor. V3 stated the staff nurse, or the restorative nurse can put in a new intervention after a fall. V3 denied remembering what intervention was put in place after this fall. V3 stated R1 was alert and oriented times three at the time of the fall. V3 was not able to recall R1's functional status or if R1 was a high fall risk.<br><br>On [DATE] at 3:32PM, V4 (Nurse) stated V4 was R1's nurse on [DATE]. V4 stated V4 last saw R1 during dinner time and a CNA called V4 about 30 minutes later to let V4 know R1 was found on the floor. V4 reported R1 told V4 that R1 was going to the washroom unassisted. V4 stated telling R1 that R1 had to use the call light before getting up. V4 denied R1 had any injuries. V4 stated R1 was confused, but still able to communicate R1's needs. V4 stated the floor nurse can put in fall interventions, but management can alter the fall interventions. V4 stated interventions are chosen based on what the cause of the fall is before reported, this is done to stop any other falls from happening in the same manner. V4 denied remembering what fall intervention was put in place after the fall on [DATE].<br><br>On [DATE] at 4:22PM, V5 (Nurse) stated while doing hourly rounds R1 was found on the floor near R1's wheelchair. V5 reported R1 was trying to self-transfer either to the bed or to the wheelchair unassisted on [DATE]. V5 denied R1 used the call light for assistance. V5 confirmed R1 had a habit of getting up without using the call and trying to take care of R1's needs alone. V5 stated R1 was alert and oriented times two at the time of the fall. V5 reported V5 reminding R1 to use the call light before transferring due to R1 being unsteady. V5 was unaware of R1's decline but was not able to answer any other questions due to only taking care of R1 two times. V5 denied knowing R1's transfer needs. V5 stated interventions were put in place for R1 after the fall. V5 couldn't remember what interventions were put in place in the care plan. V5 stated the restorative nurse will put in the fall interventions that best fit the resident to prevent any other falls from reoccurring in the same manner.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 6:03PM, V6 (Nurse) stated V6 was the nurse during the fall on [DATE]. V6 reported R1 kept getting up unassisted, but R1's health was declining. V6 stated R1 was getting weaker. V6 reported R1 was found on the floor in R1s room. V6 stated R1 was trying to use the bathroom alone. V6 reported all nurses have to put in a new intervention after a fall. V6 denied remembering what was put in place for R1 and denied remembering any other fall interventions. V6 did report that R1's room was moved closer to the nurse's station. V6 reported R1's was a high fall risk due to being weaker. V6 stated restorative sees the resident after a fall to see if any other interventions can be put in place to prevent further falls. V6 reported all interventions are documented on the care plan. V6 denied being aware if fall interventions were assessed after being implemented for residents. When asked how the facility determines if a fall intervention is appropriate for a resident, V6 said, I don't know.<br><br>On [DATE] at 12:53PM, V7 (Nurse) stated V7 was the nurse for R1 during the fall on [DATE]. V7 reported R1 was found sitting on the floor next to R1's bed. V7 stated R1 was alert oriented times three at the time the fall. V7 stated R1 was attempting to transfer from the bed to the wheelchair unassisted and couldn't make it to the wheelchair. V7 reported R1 slid onto the floor. V7 reported R1 normally transferred to the chair without assistance and then self-propelled around the facility. V7 stated R1 just missed the chair that time. V7 reported after this fall is when R1 began to get weak. V7 reported R1 knew how to put on the call light and ask for help but R1 refused to call for assistance. V7 stated staff were encouraged to increase monitoring for R1 for three days. V7 denied remembering what other interventions were put in place after this fall. V7 reported restorative will update the care plan with new interventions and floor staff are told in report or can also access the care cards for more information. V7 stated residents are assessed by restorative to see if they have the appropriate fall interventions in place. V7 was not able to answer how often residents are assessed for appropriate fall interventions. V7 reported fall interventions should mirror the type of fall and no intervention should be repeated if the same fall has happened more than once because this indicates it is not an intervention that is working for this resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 2:47PM, V9 (Restorative/Fall Nurse) stated R1 had multiple falls (V9 was unable to remember the exact number) due to R1 attempting to get up unassisted. V9 reported R1 was alert and oriented up until the last couple falls but could not say when R1's mental status decline happened. V9 stated R1 needed partial/moderate assistance with transfers. V9 reported R1 had Parkinson's disease which was the cause of R1's decline over the past couple months before R1 expired. V9 stated after a resident fall, a new intervention needs to be put in place to prevent the fall from happening again. V9 reported a new intervention has to be put in after each fall and match the cause of the fall so the fall will be less likely to occur again. V9 reported V9 will interview the resident and talk with staff to see if a cause of the fall can be determined. V9 stated each intervention is assessed after it is put in place for about one to two days after implementation. V9 stated V9 will talk with staff to see if the interventions that are in place are effective. V9 was unable to access the care plan, but stated physical therapy evaluations, education on call light use, keeping items within reach, and moving R1 closer to the nurse's station were some of the interventions put in place after the fall. V9 was not able to give dates of what interventions were placed when. V9 stated the floor nurse or V9 can put in an intervention after a fall. V9 denied staff ever bringing any concerns to V9 about R1's interventions not being effective. V9 stated that if staff makes V9 aware that a current intervention is ineffective than a new intervention will be put in place. V9 reported if the resident has had the same fall occur in the same manner, then a different intervention should be used for each fall. V9 stated interventions should never be repeated. When asked why R1 had multiple of the same fall interventions and if R1's fall interventions were effective, V9 reported the interventions were put in place but R1 refused to use the call light and staff were trying to manage R1's decline as best as possible.<br><br>The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status as ten (moderate cognitive impairment). Section GG of the MDS documents R1 is dependent with all ADL care except eating, needs partial/moderate assistance with bed mobility and transfers and substantial/maximal assistance with walking. Section J of the MDS documents R1 has had falls since the previous assessments but the falls did not have any injury.<br><br>The policy titled, Falls and Fall Risk, Managing, dated ,d+[DATE] documents, Policy Statement: Based on previous evaluation and current data, the staff will identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of fall. If a systematic evaluation of a resident's fall risk, identify several possible interventions, the staff may choose to prioritize interventions .4. If falling recurs, despite initial interventions, staff implement additional or different interventions, or indicate why the current approach regimen remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the fall is identified as unavoidable. 6. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident response to interventions intended to reduce falling or the risks of falling .3. If the resident continues to fall, staff will reevaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusion that specific irreversible factors exist that continue to present a risk factor for falling or injury due to falls. |