

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510572	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
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NAME OF PROVIDER OR SUPPLIER PRAIRIE POINTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 58 W PARK AVENUE SUGAR GROVE, IL 60554
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A 000	Initial Comment Complaint Investigation: IL#182882/24710344- Substantiated. Refer to IL172624 (7/24/24) Entity Reported Incident Investigation IL#180901- Substantiated, 295.4010 is cited. IL#178458- Substantiated, 295.4010 is cited. IL#177559- Substantiated, 295.4010 is cited.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and	A4010		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A4010	<p>Continued From page 1</p> <p>dated by all individuals involved in its development.</p> <p>d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)</p> <p>e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).</p> <p>g) Service plans shall address:</p> <p>1) The level of service the resident is receiving, including:</p> <p>A) assistance with activities of daily living;</p> <p>C) special accommodations for the resident;</p> <p>2) The amount, type, and frequency of health-related services needed by the resident;</p> <p>3) Staff responsible for the provisions of the service plan;</p> <p>h) The service plan shall include all support services provided or arranged for by the establishment.</p> <p>i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on</p>	A4010		

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A4010	<p>Continued From page 2</p> <p>the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the establishment failed to revise and implement an individualized fall interventions for three (R1, R2, R3) of three residents reviewed for multiple falls.</p> <p>Findings include:</p> <p>According to R1's Electronic Health Record (EHR), R1 is 93 years old. R1 moved to the Memory Care unit on 7/24/24. R1's diagnoses include but not limited to Unspecified Dementia, and Type 2 Diabetes Mellitus.</p> <p>R1's notes were reviewed. R1 had several fall incidents:</p> <p>-10/24/24 1922: This RN was called to resident's room. CNA reports unwitnessed fall. Resident found sitting on a chair ...complained of pain to right shoulder and right hip.</p> <p>-10/29/24 States she had a fall. Abrasion noted to nose, small bump on left forehead. Left eye noted to be mildly swollen. Redness noted to under eye skin. Resident c/o left knee pain ...skin tear or abrasion note to knee. Small skin tear on right forearm." R1 was sent to the hospital.</p> <p>-11/19/24 1655 ...observed her lying on her floor near the bathroom on her left side, propped up on her left elbow with upper body raised off of floor, with her walker nearby. When inquired about fall, she stated " I don't know. I was over there picking up off of the floor when I fell."</p>	A4010		

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A4010	<p>Continued From page 3</p> <p>-2/19/25 1356: ...unwitnessed fall ...found her on the floor beside the bed. The resident's walker was found to be positioned backward.</p> <p>On 2/25/25 at 11:34am, E4 (Registered Nurse) said R1 is encouraged to be out of the room to prevent fall.</p> <p>R1's Service Plans were reviewed. Fall Service Plan dated 9/23/24 stated in part; Problem: Resident is at risk for falls (d/t) due to impaired cognition, poor safety awareness. Approach (all these interventions were checked): -Adapt environment with (grab bars, raised toilet seat, etc as needed) to meet resident's safety needs. -Clear pathways in resident's normal route -Encourage use of night and lights -Instruct resident in proper/safe transfer techniques -Keep environment consistent and alert resident to any changes -Monitor for fatigue or unsteadiness -Monitor resident for fall related side effects for medications -Remove unnecessary furniture or equipment -Encourage resident to wear non- slip footwear -Discourage bending/stopping postures -Notify family and MD of any falls -PT/OT evaluations PRN -Call light within reach -Answer call lights promptly 10/29/24 Fall service plan has the same approach. No changes on interventions implemented despite repeated falls.</p> <p>According to R2's EHR, R2 is 90 years old. R2 moved to the Assisted Living on 3/22/23. After rehab stay post fall with fracture, R2 moved into the Memory Care unit on 2/7/25. R2's diagnoses</p>	A4010		

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A4010	<p>Continued From page 4</p> <p>include but not limited to Unspecified Dementia and Essential Hypertension.</p> <p>On 2/25/25 at 11:31am, R2 was observed in the dining area seated on a wheelchair.</p> <p>R2 had a fall on 1/21/25. Per document R2 missed the chair and fall. R2 went to the hospital and diagnosed with Shoulder Contusion, Pubic Ramus and Sacral Fracture.</p> <p>R2's Fall History Service Plan dated 8/26/24 stated in part;</p> <p>Problem: Resident has history of falls d/t cognitive decline.</p> <p>Approach (These interventions were checked):</p> <ul style="list-style-type: none"> -Adapt environment with (grab bars, raised toilet seat, etc as needed) to meet resident's safety needs. -Clear pathways in resident's normal route -Encourage use of night and lights -Instruct resident in proper/safe transfer techniques -Keep environment consistent and alert resident to any changes -Monitor for fatigue or unsteadiness -Monitor resident for fall related side effects for medications -Remove unnecessary furniture or equipment -Encourage resident to wear non- slip footwear -Discourage bending/stopping postures -Notify family and MD of any falls -PT/OT evaluations PRN -Call light within reach -Answer call lights promptly <p>R2's notes dated 1/22/25 10:59: this writer was called in resident room. found resident found in the bathroom floor, on her back with legs extended.911 called and resident sent to ...hospital.</p>	A4010		

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A4010	<p>Continued From page 5</p> <p>From the hospital, R2 was discharged to a rehab facility and was admitted to the Memory care unit upon return to the establishment on 2/7/25.</p> <p>Review of R2's Fall Service plan dated 1/22/25; Problem: Resident at risk for falls Ambulation with walker. New diagnosis: Pelvic Ramus Fracture and Sacral Fracture. Use of wheelchair. The Approach (Interventions) remains the same, despite R2 moving to the Memory care unit.</p> <p>According to R3's documents, R3 moved into the establishment on 4/30/24. R3 expired on 11/29/24. R3's diagnoses include but not limited to Peripheral Vascular Disease and Left Bundle Branch Block. R3's notes were reviewed. R3 had several fall incidents; -9/13/24 at 0928: Resident found on the floor near recliner. Reports pushing wrong button on her power recliner. No injury observed. Spouse near resident trying to assist resident off the floor. On 9/14/24 at 0810 R3 was brought to the hospital by the daughter and was diagnosed with elevated Troponin and Fracture of Pelvis.</p> <p>R3's "Individual Service Plan" effective date of 5/1/24, under the section "Falls" document stated 9/13/24 fall noted at 0928, not taken to ER, family declined, later took her to ER, on 9/14 with a fracture of pelvis, AMS (Altered Mental Status). 9/18/24 - Family has hired Home instead to assist couple during the day Monday, Tuesday, Thursday and Friday from 10am-2pm. They will provide activities, assist with minor ADL's and assist to the bathroom. Comments/Action: "(R3) is reminded of proper and safe transfer techniques and ambulation and use of her cane and wheelchair. She is encouraged to wear nonslip footwear and utilize</p>	A4010		

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A4010	<p>Continued From page 6</p> <p>her pendant for any assistance and keep it within her reach at all times. Her husband whom she shares a room with will try to assist with her transfers, husband has been reminded repeatedly not to move his wife, family is trying to remind husband and wife for proper safety techniques and waiting for assistance from staff."</p> <p>R3 stayed in the hospital and returned to the community on 9/17/24.</p> <p>R3's notes indicated further fall incidents;</p> <ul style="list-style-type: none"> - 9/19/24 1830: Resident was observe lying on the floor (L)side next to her recliner. This writer asked what happened and the resident stated she Slipped off her recliner. - 9/22/24 1630: ...observed the resident lying on the floor (R)side next to the dresser in the bedroom ... stated "I wanted to grab a jacket from the closet and I fell". - 10/13/24 1511: ...noted resident in a sitting position on floor next to toilet ...stated she went to sit but wasn't close enough to toilet and sat on floor ... Resident did have on proper nonskid shoes. - 11/4/24 1021: resident noted to be on the floor with legs extended, near her recliner. resident alert and verbally responsive, some confusion. resident slid out of the recliner per staff and husband. <p>Fall Risk Service Plan dated 9/30/24 stated; Problem: Resident is at risk for fall due to (d/t) poor safety awareness, impulsivity, commands spouse to assist with transfers unassisted by staff. Approach: (These interventions were checked): -Adapt environment with (grab bars, raised toilet seat, etc as needed) to meet resident's safety needs.</p>	A4010		

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A4010	<p>Continued From page 7</p> <ul style="list-style-type: none"> -Clear pathways in resident's normal route -Encourage use of night and lights -Instruct resident in proper/safe transfer techniques -Keep environment consistent and alert resident to any changes -Monitor for fatigue or unsteadiness -Monitor resident for fall related side effects for medications -Remove unnecessary furniture or equipment -Encourage resident to wear non- slip footwear -Discourage bending/stopping postures -Notify family and MD of any falls -PT/OT evaluations PRN -Call light within reach -Answer call lights promptly <p>She is instructed not to have her spouse assist her with transfer and instead call for assistance. Assisitive devices kept within reach. Instructed to keep her pendant with her and within reach at all times Spouse also informed to activate his pendant for staff assistance for her. Fall risk monitoring is ongoing.</p> <p>These interventions were repetitive and have not been successful in preventing previous fall incidents. The fall incidents also occurred outside the times the private caregiver hired by the family. E2 Director of Nursing) was asked if there were other fall interventions in place once private caregiver was off the clock.</p> <p>On 2/25/5 at 12:48pm, E2 said one CNA was assigned there. "so I am sure they rounded on her. The CNA rounds every couple of hours. The family brought in caregiver to help assist us but I do not recall any other intervention. We discussed 24 hour caregiver but due to cost it did not go through."</p> <p>Despite repeated falls, there were no changes</p>	A4010		

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A4010	Continued From page 8 made on the service plan Establishment document titled "Falls and Fall Risk, Managing" Policy Interpretation and Implementation 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.	A4010		