STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145927	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Oasis	16000 South Wabash South Holland, IL 60473

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to follow their policy by failing to provide an individualized plan of care with effective interventions to prevent falls; the facility failed to provide supervision while walking in corridors per resident assessment. These failures applied to one (R1) of five residents reviewed for falls and resulted in R1 having three falls in the last three months and requiring hospital transfer for medical treatment of a laceration and hematoma after the last two falls. Findings include: R1 is [AGE] years old and has resided at the facility since 2022, past medical history includes Altered mental status unspecified, anxiety disorder, hallucinations, malignant neoplasm of unspecified site of female breast, metabolic encephalopathy, unspecified dementia, unspecified fall, unspecified protein calorie malnutrition, etc. 11/12/2024 2:15PM, R1 was observed in her room sleeping, bed not low and no floor mats on either side of the bed. Resident's walker was noted in the room but not close to the resident, no call lights noted and bedside table with an empty plastic cup was observed in front of resident's bed. Review of resident's health record showed R1 had 5 unwitnessed falls since 1/11/2024 (4 in the hallway and 1 in resident's room) and was sent to the hospital 4 times for medical management after the falls. Minimum Data Set (MDS) assessment dated [DATE] section C (cognition) scored R1 as a 4 for brief interview for mental status (BIMS). Section GG (Functional abilities and goals) coded R1 as requiring partial to moderate assistance for most activities of daily living (ADL). R1 was also assessed as requiring supervision or touching assistance for walking in the room or corridors. Fall risk assessment dated [DATE], 10/7/2024 and 10/13/2024 all documented R1 is a high risk for fall. Care plan initiated 9/3/2022, revised 7/23/2024 stated R1 is at risk for falls related to history of falls. Interventions include encourage resident to take frequent breaks from ambulating on the unit, redirect resident when up and ambulating with walker, gather information on past falls and attempt to determine the root cause of the fall, anticipate, and intervene to prevent recurrence, etc. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 8/3/2024 states R1 had a fall in the 100-unit exit door while ambulating with her walker, no visible injury noted. Another note dated 8/5/2024 documented R1 was observed walking around the facility without walker, staff redirecting resident to use her walker. Facility reported incident dated 9/4/2024 stated R1 was ambulating with her walker down the hallway when another resident swung the dining room door open, hitting R1 who fell and sustained a laceration to the left side of her forehead. R1 was sent to a local hospital where her laceration was treated with derma glue. A reportable incident dated 10/13/2024 documented 2 staff nurses were called to the 200 unit for a fall, R1 was found in a sitting position with her walker in front of her, a large hematoma was noted to her left forehead, the incident was unwitnessed. R1 stated her head hurts and was sent to emergency room for further evaluation. 11/13/2024 at 12:43PM, V7 (Restorative Nurse) said R1 has a walker and ambulates by herself but still requires staff supervision. 11/13/2024 at 1:00PM, V4 (LPN) said the day R1 had a fall, V4 was paged to the front lobby. R1 was walking in the hallway by the main dining room, another resident was coming out of the dining room, opened the door and hit R1 accidentally. V4 added R1 was on the floor when she got to the scene, she noted some blood coming from a laceration above her right eye was about 2 centimeters in length. R1 was asked what happened and she stated she fell . V4 said no one witnessed the fall. V4 said R1 falls all the time. R1 walks with her walker but will discard the walker sometimes. Staff tries to redirect her. R1 is hard to monitor because she walks all the time and can be aggressive, and one time she tried to throw her walker to a staff. 11/13/2024 at 1:48PM, V8 (C.N.A) said she was assigned to R1 the day she had a fall. R1 likes to walk by herself with her walker and she is confused. V8 said she did not witness the fall; she was charting at the nursing station and was notified by another C.N.A R1 was on the floor. When V8 got there, R1 was sitting on her bottom with her walker in front of her. There was no staff at the nursing station where resident fell . 11/13/2024 at 2:50PM, V2 (DON) said R1 is alert with confusion, walks around with a rolling walker and will sometimes leave her purse and staff will bring it to her. V2 stated R1 requires supervision and her last 3 falls were unwitnessed. V2 said after the last 2 falls the only changes to resident's intervention is sending resident to the hospital, fall care plan should be individualized. R1 may need more supervision to avoid further falls with injury. 11/4/2024 at 3:53PM, V9 (C.N.A) said she was charting at the nursing station when R1 walked past her then she heard a thump and went to check it out. V9 saw R1 on the floor, and R1 said her head hurt. There were no visible injuries or bleeding noted. V9 said, R1 walks around all the time with her walker, staff tries to redirect her, but she does not listen. There was no body in the hallway when R1 fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall policy dated 2/28/2014 presented by V1 (Administrator), stated in part it is the policy of the 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 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. Under safety precautions for residents at risk, the policy states in addition to standard fall precautions, the following interventions will be implemented for resident identified at risk: 1. The resident will be checked approximately every two hours, or according to the care plan, to assure they are in a safe position. The frequency of the checks will be determined by the resident's risk factors and plan of care. 2. In the event safety mentoring is initiated for 15-30 minute periods, a documentation record will be used to validate observations. Assigned nursing personnel are responsible for completing the safety checks ad documenting.