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	02/11/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interviews and record reviews, the facility failed to protect a resident with severe cognitive impaired from physical abuse and failed to develop care plan interventions in preventing abuse for two (R1 and R2) of four residents reviewed for abuse. Findings include: R1 is a [AGE] year old, male, admitted in the facility on 04/15/24 with diagnoses of Alzheimer's Disease, Unspecified; Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood disturbance and Anxiety. MDS (Minimum Data Set) dated 01/06/25 documented R1's BIMS (Brief Interview for Mental Status) score of 5 which means severe cognitive impairment. According to incident report dated 01/13/25, around 1:45PM, R2 was sitting at his own lunch table by himself when he suddenly jumped up and reached for R1's face with his fork in his hand. R1 had been sitting eating his lunch at his own lunch table which was located on the right side of R2. R1 and R2 were immediately separated by staff. R2 was placed on a 1 to 1 while awaiting transfer to the hospital for a psychiatric evaluation. R1 was assessed and found to have superficial scratch on the lower left side of his cheek, which was cleansed by nurse. When interviewed both, R1 and R2 could not recall the incident. R1 and R2 both replied that everything is good, and they feel safe in the facility. R2 is an [AGE] year old, male, admitted in the facility on 06/19/24 with diagnoses of Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Anxiety Disorder, Unspecified; and Unspecified Psychosis not due to a Substance or Known Physiological Condition. Progress notes dated 01/13/25 documented R2 was petitioned out to hospital for psychiatric evaluation. Petition for Involuntary admitted d 01/13/25 recorded R2 needed immediate hospitalization for the prevention of such harm. On 02/03/25 at 12:05 PM, R2 was in his room; in bed, watching TV (television). R2 is alert to self, verbal and confused. R2 was asked if he knows R1, R2 stated, I don't know him (R1). R2 was asked if he remembers any incident of hitting R1 or any resident with a fork. R2 stated, I did not do that. I would never, ever do that. I dropped the fork on the floor, and somebody picked it up and took it. I don't know who picked it up. R2 repeated the same answer when asked about the incident. MDS dated [DATE] indicated R2's BIMS score of 5 which means severe cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/25 at 12:12 PM, R1 was in the dining room, sitting at the table. R1 is alert to self and verbal. R1 was asked regarding incident about R2 hitting him with a fork in the face. R1 stated, I don't remember nobody did that to me. I don't know (R2). I remember but he didn't do much. Yeah, but I don't have any scratches or anything in my head. He didn't jump at me. Everybody is doing their stuff. On 02/03/25 at 1:45 PM, V8 (Licensed Practical Nurse, LPN) was asked regarding incident on 01/13/25 on R1 and R2. V8 replied, I was on break, when I came back, I was told by 3 CNAs (Certified Nurse Assistant) and V2 (Director of Nursing) that R2 tried to stab R1's neck with a fork. I went to go to R1 and assessed him. By the time I got back, they were already separated. He just had a little scratch on his neck, left side, I cleansed it with normal saline, alcohol wipes. I called the family and physician. R2 was petitioned out for a psych evaluation. I have been taking care of these residents for a couple of months, they don't have any violent behaviors. That was the first time I heard that R2 tried to hit R1 with a fork. It happened in the dining room, right after mealtime. They were given utensils. R1 and R2 have cognitive impairments like Dementia. They don't have any unusual behaviors. V9 (CNA) was asked on 02/03/25 at 2:11 PM regarding R1 and R2 incident. V9 stated, It was during lunchtime, I was standing by the door, myself, V10 (CNA) and V11 (CNA). Some residents were finished, and some were eating. I saw R2 reaching something from his left sleeve, with his right hand while standing up. I called out his name (R2) and going towards him at the same time, but he just swung his right arm with the fork at R1 who was sitting at table close to him. R2 knew what he was doing. I have never seen him act like that before, that was the first time. V10 and I quickly separated them and started to separate other residents near them. V10 went out to get other staff and the nurse. R2 was eating meals, there was no argument, no talking, no commotion, it was like a regular mealtime. R1 and R2 were still eating lunch at the time. I had not collected their trays yet. R2 used the fork that he used while eating. I don't know how come he was able to keep it under his sleeve. I don't know how he got the fork. There was no second fork on the table at the time. V9 was asked regarding supervision and monitoring of residents during mealtime in the dining room. V9 stated, During mealtime, we are monitoring the dining room constantly to ensure nobody is choking and safety. I never been an incident that I witnessed R2 like that. When we monitor residents, we go around, looking around the dining room while residents are eating. Once residents per table are done eating, then we collect the tray. We wait until all the residents at that table are done eating before we collect the tray. R2 still had the food on his tray and still in front of him that is why we had not collected his tray yet. Usually if he's done, he will push the tray on the side or to the front. R2 is alert to self, confused most of the time. Not that I am aware of that he has delusions or hallucinations. R1 is alert to self and confused but no behavior at all, very redirectable, and had no incidents in the past. V10 stated, during interview on 02/03/25 at 2:44 PM, On 01/13/25, it was 3 of us in the dining room. I was standing by the table by the door. As I turned around, I saw him (R2) get up, and he tried to hit R1 in the face. There were no words. (R2) was quiet and all of a sudden, he stood up and tried to hit R1. I don't know R1 or R2, I was just monitoring residents in the dining room at the time. We just gave their trays, they were still eating - they got a spoon, fork and a butter knife. It happened so fast. We separated them We reported to V2 immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/25 at 2:56 PM, V11 verbalized, On 01/13/25, I was standing by the doorway in the dining room, there were two other CNAs, V9 and V10. The three of us were standing by the doorway. There were like 10 residents in the 300-dining room eating lunch. We just served the trays, and everybody were eating. I looked over and saw R2 moved towards R1, with the fork (utensil, not plastic). R1 was spaced out, didn't even look at him when he (R2) was scraping his neck with a fork. R1 didn't scream, no confrontation, no words. We all separated them both, redirected them and alerted V2 immediately. We also notified V8. R2 is alert to self, confused. He does not answer to his name often, not immediately. There were no violent behaviors of R2, that was the first time. R1 is alert to self and confused all the time, no behaviors. V1 (Administrator) was asked on 02/03/25 at 3:19 PM regarding R1 and R2 incident on 01/13/25. V1 stated, V9 notified me that R2 had jumped up with his fork and hit R1 with it. I went to the dining room; they had been separated. I asked R1 but R1 has no awareness of the incident; unable to recall anything what had happened. He started telling me about his grandmother and among other things. R2, the same way, cannot recall that happened. They were roommates and no prior violent incidents. Now we care planned R2 to use spoon only. Both of them can't tell me anything. There were no prior arguments between the two of them, but it did happen. R1 sustained a superficial scratch on the lower left side of the cheek made by the fork. There was no premeditation, no malicious intent. It was not abuse but behaviors. We do monitoring, sent R2 out for psych evaluation, and separate rooms. V1 was asked regarding supervision and monitoring in the dining room. V1 stated, During lunch in the dining room, staff are monitoring and assisting residents, cutting the foods, if they want additional drinks. Staff should be scattered in the dining room, monitoring residents from time to time, visually. One staff should be rounding in the hallway anticipating needs. Nurses should also be doing rounds in the dining room. Whenever the 300 unit nurse goes on break, V2 is notified so that she (V2) could be there in the dining room and monitor the residents for needs and assistance. On 02/03/25 at 3:40 PM, V2 was interviewed regarding R1 and R2. V2 verbalized, On 01/13/25, I was in the dining room, I was serving trays, I stepped out of the dining room. The 3 CNAs were there, they notified me at the time. I was in the office. They told me R2 jumped and nicked R1 around the left cheek. I went there in the dining room, we separated them. We petitioned R2 out and notify the family. CNAs do the monitoring. During lunch, they watch and go from resident to resident and ask them what they need, serve them cut up foods, open milk cartons.; monitor residents by walk around, talk to them, assist them, some residents may want to go to the bathroom; staff may interact with residents during eating. R1's care plans were reviewed. There was no abuse care plan on file. R2's care plans were reviewed. There was no abuse care plan in R2s medical records. There was no care plan noted regarding the use of spoon only during mealtime. According to V1, all residents are care planned for abuse upon admission and reevaluated in case there are any incidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's abuse policy titled Abuse Prevention Program Facility Policy dated 2011 documented in part but not limited to the following: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ individuals who have been convicted of abusing, neglecting, or mistreating individuals. Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Procedures for Prevention IV. Establishing a Resident Sensitive Environment Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect or mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis.

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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** 34071 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: 1. R3 is an [AGE] year old, female, admitted to the facility on [DATE] with diagnoses of Parkinson's Disease without Dyskinesia, without Mention of Fluctuations; Depression, Unspecified; Schizoaffective Disorder, Unspecified; Dementia in other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Mood Disturbance and Anxiety; and History of Falling. MDS (Minimum Data Set) dated 12/10/24 recorded R3 has BIMS (Brief Interview for Mental Status) score of 7 which means severe cognitive impairment. MDS dated [DATE] indicated R3 needs substantial/maximal assistance during chair/bed to chair transfer. R3's care plans documented the following: 1.Self-care deficit, initiated 04/10/23: Interventions: Provide assistance with all ADLs (activities of daily living) as required per resident's need dependence: eating, transferring, bed mobility, bathing, dressing, personal hygiene, ambulation and personal hygiene. 2. ADL self-care performance deficit related to disease process Parkinson, initiated 10/06/23: Interventions: Transfer (01/27/25): R3 requires the assistance of 1 staff member when transferring. On 02/04/25 at 10:35 AM, observed R3 was coming out from the dining room, in her wheelchair to hallway. There was an ongoing activity in the dining room and R3 was attending. R3 was using both feet in propelling her wheelchair. R3 went to her room and made several attempts to transfer self from wheelchair to a chair. Finally, R3 was able to transfer self to the chair without any supervision from staff. R3 was able to leave the dining room unnoticed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/04/25 at 11:00 AM, V21 (Licensed Practical Nurse, LPN) was interviewed regarding R3 supervision, monitoring and transfer. V21 replied, She is alert, oriented to self and place, with periods of confusion. Sometimes when you speak to her, she will answer you but will start with something else. She is on a wheelchair and dragged her wheelchair using her feet to move around. She cannot transfer herself. We all have eyes on her. She will try to get up on her own. Monitor her every hour while in room. During activities, she is monitored. She tried to leave the dining room; staff usually call the nurse. We cannot leave her unsupervised. Fall risk review dated 01/31/25 recorded R3 is high risk for falls. R3's progress notes documented the following: 01/14/25: R3 was observed laying on the floor next to bed during rounds. 01/30/25: R3 was observed in the hallway sitting on the floor in front of her wheelchair. 01/31/25: R3 was found lying on floor with wheelchair on top of legs. On 02/04/25 at 2:13 PM, V2 (Director of Nursing/Fall Coordinator) stated, She (R3) is provided with supervision and monitoring by placing her at the nurses' station or in activities. We keep an eye on her. Since she came back from the hospital, she needs assistance during transfers, she needs help. 2. R4 is an [AGE] year-old, female, admitted in the facility on 11/02/2020 with diagnoses of 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 [DATE] 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 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: (continued on next page)

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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	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 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.