

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2026
NAME OF PROVIDER OR SUPPLIER  Prairie Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE  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 - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to implement fall preventive measures for a resident who is a high fall risk. This deficiency affects one (R3) of three residents reviewed for Falls prevention program. Findings include:R3 is an [AGE] year-old admitted to facility on 7/3/19 with the following diagnosis: cerebral infarction, aphasia, dysphagia, essential hypertension, hyperlipidemia, secondary hypertension, anemia, age related osteoporosis without current pathological fracture, insomnia, presence of right artificial hip joint, dementia, depression, history of falling, low back pain, personal history of urinary tract infections.Facility reported incident indicates on 2/28/26 R3, upon rounds staff note resident sitting on her left side of the bed between the dresser and bed. The incident occurred during self-transfer from bed without assistance. She (R3) denies any pain no discomfort noted. She is able to move all extremities, and all limbs are in good alignment. She denies any pain no discomfort noted. The resident was assisted back to bed with assistance, and she has gait imbalance and unsteady call light within reach. The resident has a small hematoma to the right side of face and bruising. MD notified new orders given and carried out.On 3/21/26 at 12:50PM, R3 observed sitting in wheelchair with no shoes and regular socks on, room observed with bed next to furniture (nightstand dresser) to left side of bed.On 3/21/26 at 12:53PM, V3 (Licensed Practical Nurse) said R3 should have non-skid socks as her fall intervention, V3 said she is not sure about the bed next to furniture said she is unsure if that is R3 fall intervention.On 3/21/26 at 12:55PM, V5 (Certified Nurse Aide) said she dressed R3 and did not put on her non-skid socks on. V5 said she just did not put them on for no apparent reason.On 3/21/26 at 1:24PM, V2 (Director of Nursing) said her expectations for staff is to follow all fall interventions for all high fall risk residents, V2 said she was not in facility when R3 had a fall on 2/28/26, said she is not sure of the specific interventions, but staff should know where to locate interventions for high risk fall residents.On 3/21/26 at 2:59PM, V1 (Administrator) said her expectations for all staff is to implement fall interventions and make sure they are in place. Fall interventions are located in the residents point of care chart and also are communicated by the restorative staff.R3 Fall risk review dated 9/25/25 Admission/Readmission-indicated R3 high risk for falls.R3 Fall risk review dated 2/28/26- indicated R3 high risk for falls. R3 Risk for Falls related to Confusion, unaware of safety needs, unsteady gait, impulsiveness, history of fall- care plan interventions dated 1/1/24 intervention- Ensure the resident is wearing appropriate footwear (Specify and describe correct client footwear in example brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in wheelchair.R3 Risk for Falls related to Confusion, unaware of safety needs, unsteady gait, impulsiveness history of fall- care plan interventions dated 2/28/26 intervention- X-ray to rule out any fractures and Move furniture over from the bed. Facility Policy on Fall Prevention Program-revised 2/10/26Policy: 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 assistive devices are utilized as necessary. Quality (continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assurance programs will monitor the program to assure ongoing effectiveness. This fall prevention plan is a site specific plan to eliminate or reduce the risk of falls. Responsibility: all facility staff. Teamwork between all staff is essential for fall prevention program contents: The fall prevention program includes the following components: Methods to identify risk factors. Methods to identify residents at risk. Assessment time frames. Use an implementation of professional standards of practice. Changes in interventions that were unsuccessful. Notification of physician family legal representative. Communication with direct care staff members. Documentation requirements. Adherence to manufacturers recommendation in use of alarm and medical devices and special care equipment. Care plan incorporates: identification of risk /issue. Interventions are reviewed and or changed with each file as appropriate. Preventative measures. Monthly risk management meeting agenda will include a discussion of: fall prevention surveillance activities. Recommendation for changes in the plan of care to minimize reoccurrence. Protocol compliance. Standards: A fall risk assessment will be performed by a licensed nurse at the time of admission the assessment tool will incorporate current clinical practice guidelines. A fall risk assessment will be performed at least quarterly with each significant change in condition and after any fall incident. Safety interventions will be implemented for each resident identify at risk using a standard protocol. The admitting nurse and assign CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Standard fall safety precautions for all residents all staff will be oriented and trained in the fall prevention program. 7. Residents will be observed approximately every two hours to ensure the resident is safely positioned in bed or a chair and provide care as signed in accordance with the plan of care. Rounds may be more frequent if deemed necessary. 15. All nursing personnel will be informed of residents who are at risk of falling. The fall risk classification will be identified on the care plan. 17. Footwear will be monitored to ensure the resident has proper fitting shoes or footwear is non-skid.</p>		