

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 10/24/2024
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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066</p> <p>Based on interview and record review, the facility failed to notify responsible parties and perform comprehensive assessment for a resident with an injury of unknown origin for one (R84) of two reviewed for abuse in the sample of 42.</p> <p>Findings include:</p> <p>R84 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including but not limited to chronic kidney disease, stage 3; Cerebral Infarction; Unspecified Dementia; and Cognitive Communication Deficit.</p> <p>According to R84's MDS (Minimum Data Set) assessment dated [DATE], under section C, R84 has BIMS (Brief Minimum Data Set) score of 5 indicating severely impaired cognition.</p> <p>On 10/22/24 at 03:31 PM Surveyor interviewed V27 (Licensed Practical Nurse) who said in summary, I worked a day shift on 10/11/2024. V26 (CNA) reported to me that R84 has a black eye. I looked at R84, noticed the black eye (don't remember) which one. I checked her vital signs but didn't do any other assessment. I asked R84 what happened, but she wasn't able to tell me, R84 is confused. It looked like a fresh bruise. I didn't receive information about R84's injury in a hand off report and there was no progress note. I didn't notify the family or doctor. I created the progress note. Later on, V2 (DON) told me that, in similar case in the future, I should notify V2 (DON) and I received in-service. I did not receive any training upon hire pertaining to abuse or injuries.</p> <p>On 10/23/24 at 02:59 PM Surveyor interviewed V2 (Director of Nursing) who said in summary, the nurse should document the incident and notify responsible parties, such as doctor, family, and me (V2 DON). V27 (LPN), who put a note for R84, didn't do the follow through, meaning she didn't notify anyone of the incident. V27 (LPN) was in-serviced for that.</p> <p>On 10/23/24 at 03:46 PM Surveyor interviewed V1 (Administrator/Abuse Prevention Coordinator) who said in summary, during staff abuse training, we go over types of abuse, time frame to report, we point out the phone number staff should call, and emphasize that if staff doesn't report abuse it is a terminable offense. Staff abuse training should be done annually but I do it more frequently. Most recent training was in July of 2024.</p> <p>(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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress note dated 10/11/2024 11:08 AM written by V27 (LPN) reads in part, (R84) received at the dining room with bruise and swelling noted under the left eye. Writer tried to check the vitals but (R84) refused.</p> <p>V27's (LPN) Abuse Policy Employee Acknowledgment dated 06/06/2024 reviewed.</p> <p>The facility Abuse Prevention Program (no date) reads in part, Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor wo must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066</p> <p>Based on interview and record review, the facility failed to report alleged abuse to the state regulatory agency within timely manner for one (R84) of two residents reviewed for abuse in the sample of 42.</p> <p>Findings include:</p> <p>R84 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including but not limited to chronic kidney disease, stage 3; Cerebral Infarction; Unspecified Dementia; and Cognitive Communication Deficit.</p> <p>According to R84's MDS (Minimum Data Set) assessment dated [DATE], under section C, R84 has BIMS (Brief Minimum Data Set) score of 5 indicating severely impaired cognition.</p> <p>On 10/22/24 at 03:31 PM Surveyor interviewed V27 (Licensed Practical Nurse) who said in summary, I worked a day shift on 10/11/2024. V26 (CNA) reported to me that R84 has a black eye. I looked at R84, noticed the black eye (don't remember) which one. I checked her vital signs but didn't do any other assessment. I asked R84 what happened, but she wasn't able to tell me, R84 is confused. It looked like a fresh bruise. I didn't receive information about R84's injury in a hand off report and there was no progress note. I didn't notify the family or doctor. I created the progress note. Later on, V2 (DON) told me that, in similar case in the future, I should notify V2 (DON), and I received in-service. I did not receive any training upon hire pertaining to abuse or injuries.</p> <p>On 10/23/24 at 02:59 PM Surveyor interviewed V2 (Director of Nursing) who said in summary, the nurse should document the incident and notify responsible parties, such as doctor, family, and me (V2 DON). V27 (LPN), who put a note for R84, didn't do the follow through, meaning she didn't notify anyone of the incident. V27 (LPN) was in-serviced for that. Surveyor clarified what is the time frame to report alleged abuse or injury of unknow origin V2 (DON) said, initial abuse incident should be reported within a two hour window and final report should be submitted within 5 days. The initial report for R84 was submitted on 10/12/2024 (02:27 PM), and the final report for R84 was sent on 10/16/2024 (03:56 PM). R84's injury was initially documented on 10/11/2024 at 11:08 AM. The initial report was done over two hours from the time of the incident.</p> <p>On 10/23/24 at 03:46 PM Surveyor interviewed V1 (Administrator/Abuse Prevention Coordinator) who said in summary, The abuse reportable must be submitted within 2 hours from the occurrence of alleged abuse. When I looked in R84's electronic medical record, it a was documented that staff noticed R84 with a bruise on 10/11/2024. I'm not the only one who can submit the reportable, anybody can submit it. Surveyor asked why V27 (LPN) did not report R84's injury of unknow origin, V1 said, If the nurse didn't know that she can submit the report how could she submit it?.</p> <p>V27's (LPN) Abuse Policy Employee Acknowledgment dated 06/06/2024 reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Abuse Prevention Program (no date) reads in part, Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor wo must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066</p> <p>Based on interview and record review, the facility failed to thoroughly investigate alleged abuse for one (R84) of two residents reviewed for abuse in the sample of 42.</p> <p>Findings include:</p> <p>R84 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including but not limited to chronic kidney disease, stage 3; Cerebral Infarction; Unspecified Dementia; and Cognitive Communication Deficit.</p> <p>According to R84's MDS (Minimum Data Set) assessment dated [DATE], under section C, R84 has BIMS (Brief Minimum Data Set) score of 5 indicating severely impaired cognition.</p> <p>On 10/22/2024 between 11:40 AM and 11:42 AM in separate interviews, R32 and R48 denied being interviewed in relation to the incident involving R84 prior to the surveyor's interview. R32 resides in the room that was adjacent to R84 and R48 resides in the room that was immediately across from R84's room around the time of the incident.</p> <p>On 10/22/24 at 03:31 PM Surveyor interviewed V27 (Licensed Practical Nurse) who said in summary, I worked a day shift on 10/11/2024. V26 (CNA) reported to me that R84 has a black eye. I looked at R84, noticed the black eye (don't remember) which one. I checked her vital signs but didn't do any other assessment. I asked R84 what happened, but she wasn't able to tell me, R84 is confused. It looked like a fresh bruise. I didn't receive information about R84's injury in a hand off report and there was no progress note. I didn't notify the family or doctor. I created the progress note. Later on, V2 (DON) told me that, in similar case in the future, I should notify V2 (DON), and I received in-service. I did not receive any training upon hire pertaining to abuse or injuries.</p> <p>On 10/23/24 at 02:59 PM Surveyor interviewed V2 (Director of Nursing) who said in summary, on Saturday morning (10/12/2024) I received a call from the nurse on duty that V24 (Family Member) came in and was upset over the discoloration under R84's the left eye. V24 called the police in the meantime. I called V1 (Administrator), and she came into the facility to initiate the abuse investigate. R84's abuse investigation was prompted by an injury on unknown origin. V1 completed majority of the investigation, I did not come into the facility until I came in on Monday (10/14/2024) and continued the investigation. I spoke to R84's roommate who was cognitively intact, and she said she didn't hear or see anything, the roommate is no longer in the facility. I also completed the risk management form that wasn't done. I did not read the entire final report, but I know that V1 (Administrator) reviewed tape from the dining room and concluded that R84 bumped her face on the table.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 03:46 PM Surveyor interviewed V1 (Administrator/Abuse Prevention Coordinator) who said in summary, I was called and notified by V2 (DON) on the morning of 10/12/2024 that R84 has discoloration under her eye and the family was very upset. The police were already notified. I came in to initiate the reportable, tried to talk to R84 but she is confused and was not able to tell me what happened. I also interviewed the staff. I wrote the initial report and sent it. The abuse reportable must be submitted within 2 hours from the occurrence of alleged abuse. When I looked in R84's electronic medical record, it was documented that staff noticed R84 with a bruise on 10/11/2024. I sat in the dining room on Monday (10/14/2024) to see who else I should interview, and that's when I noticed R84 was constantly bending over to fix her shoes. I reviewed the recording from the dining room, but it was not clear if R84 hit her face on the table while doing that. I spoke to additional staff to continue my investigation.</p> <p>Progress note dated 10/11/2024 11:08 AM written by V27 (LPN) reads in part, (R84) received at the dining room with bruise and swelling noted under the left eye. Writer tried to check the vitals but (R84) refused.</p> <p>Absent upon request is any documentation related to the incident (10/11/2024) that shows R84's skin assessment or vital signs.</p> <p>V27's (LPN) Abuse Policy Employee Acknowledgment dated 06/06/2024 reviewed.</p> <p>The facility Abuse Prevention Program (no date) reads in part, Investigation Procedure. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statement that has been submitted will be reviewed, along with any pertinent medical records or other documents.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40987</p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders and failed to follow their policy for restorative programs by failing to obtain a physician order for a restorative device for 1 (R16) resident and failed to apply a splint/brace, or restorative device to prevent further contracture formation for 2 residents (R16 and R80) out of 3 residents reviewed for limited range of motion and rehabilitation.</p> <p>Findings include:</p> <p>1. R80 is [AGE] years of age. Current diagnoses include but are not limited to Hemiplegia and hemiparesis following Cerebrovascular Disease Affecting Right Dominant Side.</p> <p>R80's MDS Minimum Data Set (Comprehensive Assessment) Section C Cognitive Status dated 10/09/2024 indicates a brief interview for mental status score of 13 out of 15. A score of 13-15 indicates no cognitive impairment.</p> <p>On 10/21/24 at 10:44 AM, R80 was alert and oriented and seated in her wheelchair in her room. R80 has limited range of motion to the right arm. R80 wasn't wearing a splint or brace. R80 said, I had a stroke so I can't use my right arm.</p> <p>On 10/22/24 at 09:51 AM, R80 was sitting on the side of the bed. She was not wearing her splint.</p> <p>On 10/23/24 at 1:32 PM, R80 was inquired of using her splint. R80 said, I have one, but I don't know where it is. I think I had it 2 weeks ago. My CNA Certified Nurse Assistant usually puts it on me. R80 began to look on and through her chest of drawers but did not find the splint.</p> <p>On 10/23/24 at 1:34 PM, V8 LPN Licensed Practical Nurse was inquired of R80's splint use. V8 said, I don't know her order for sure. She has a splint that she doesn't like to wear. Usually during the week, the restorative aides make rounds and put the resident's splints on. I noticed she wasn't wearing it for the last week. I don't know if the restorative nurse knows where it is.</p> <p>On 10/23/24 at 2:02 PM, V21 Rehab Assistant was inquired of R80's splint use. V21 said, R80 has a hand splint for her right hand to help keep the hand straight. She wears it as tolerated. I think she went home last weekend, and she had it. She doesn't know if she left it. She knows how to put it on and take it off by herself. Sometimes she needs help. I saw it last week. We were looking for it. I reported to the nurse it was missing. I don't remember which nurse. She was going to call the husband to see if it was at home. I don't recall mentioning it to my supervisor. When I document the splint I put in the minutes. Not applicable means she didn't have it. I only chart on her if I have restorative that day.</p> <p>On 10/23/24 at 2:30 PM, V22 Restorative Nurse was inquired of R80's splint use. V22 said, R80 has the splint for contracture management as tolerated. I wasn't aware her splint wasn't here. I do walk around and try to see them. I saw it last week.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V22 was inquired of restorative charting not applicable. V22 said, Not applicable would only be if the resident didn't have that program, that's being charted wrong.</p> <p>R80's current physician orders indicate an order written on 05/23/2024 a right resting hand splint to be worn daily or as tolerated.</p> <p>R80's MDS Minimum Data Set (Comprehensive Assessment) Section GG Functional Abilities and Goals dated 10/10/2024 states in part functional limitation in range of motion upper extremity A. 1- impairment on one side.</p> <p>Section O Special Treatments, Procedures, and Programs Restorative Nursing Programs Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days. C. Splint or brace assistance- 7 (number of days).</p> <p>R80's care plan states in part: Resident requires (Right resting hand splint to be worn daily or as tolerated by resident) related to: Contracture. Interventions: Educate on the importance of wearing splint/brace. Provide education on how to independently apply splint/brace. Right resting hand splint to be worn daily as ordered.</p> <p>R80's POC Point of Care charting completed by the restorative department staff indicates on 10/21/24 - no documentation for the 7AM to 3PM shift for the amount of minutes spent providing splint or brace assistance. At 16:38 (4:38 PM) during 3PM to 11 PM shift and 23:46 (11:46 PM) during 11PM to 7AM shift there is documentation of 15 minutes spent providing splint or brace assistance. On 10/22/24 at 12:56 PM there is documentation of 15 minutes spent providing splint or brace assistance. On 10/23/24 at 14:18 (2:18 PM) R80's documentation for the 7AM to 3PM shift for the amount of minutes spent providing splint or brace assistance states not applicable. Restorative staff continued documenting R80 was receiving assistance with her splint when the splint was unable to be found.</p> <p>2. R16 is [AGE] years of age. Current diagnoses include but are not limited to Cerebral Palsy.</p> <p>R16's MDS Minimum Data Set (Comprehensive Assessment) Section C Cognitive Status dated 09/05/2024 indicates a brief interview for mental status score of 4 out of 15. A score of 0-7 indicates severe cognitive impairment.</p> <p>On 10/21/24 at 10:46 AM, R16 was in bed. Her bilateral hands and wrists have contractures. There are no splints in place at this time.</p> <p>On 10/22/24 at 08:51 AM, R16 was in the dining room being fed breakfast by a CNA Certified Nurse Assistant. She appears to be clean and is appropriately dressed. She was not wearing her bilateral palm protectors for her wrist contractures.</p> <p>On 10/23/24 at 1:36 PM, R16 was seated in the dining room in her Geri chair, and she was not wearing the palm protectors. V20 CNA Certified Nurse Assistant was inquired of R16's palm protectors. V20 said, She just had them on. V20 pulled R16's blanket back and found the palm protectors down in the sides of the Geri chair. V20 said, She gets them off.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 1:40 PM, V8 LPN Licensed Practical Nurse was inquired of R16's splint use. V8 said, I don't know her order off hand, but I do refer to the orders. I rely on restorative to put them on her. We have a nurse resource binder with a splint list.</p> <p>On 10/23/24 at 1:54 PM, V21 Rehab Assistant was inquired of R16's splint use. V21 said, R16 has splint and range of motion. She needs total care for everything. I put the palm protectors on every day. Her hands are contracted, and nails are folded in. It keeps it from further contracture. I was here Monday and Tuesday. I worked on the floor and had a group of residents Monday, so I didn't do restorative. I didn't have her, so her CNA Certified Nurse Assistant is responsible for putting them on. I did restorative on Tuesday and put them on her. We have to check on them every few hours because she takes them off.</p> <p>On 10/23/24 at 2:21 PM, V22 Restorative Nurse was inquired of R16's splint use. V22 said, It's for contractures recommended by therapy for both hands daily as tolerated. The restorative aides are responsible to make sure PROM (passive range of motion), hand hygiene, making sure splints and braces are clean, and they're put on. All CNAs are responsible to put in the minutes for POC (point of care) charting for any program. The time on the POC is when they charted it.</p> <p>On 10/24/24 at 12:11 PM, review of R16's physician orders does not indicate an active order for the palm protectors as stated in the facility policy for a restorative device.</p> <p>R16's MDS Minimum Data Set (Comprehensive Assessment) Section GG Functional Abilities and Goals dated 09/08/2024 states in part functional limitation in range of motion upper extremity A. 2- impairment on both sides.</p> <p>R16's Section O Special Treatments, Procedures, and Programs Restorative Nursing Programs Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days. C. Splint or brace assistance- 7 (number of days).</p> <p>R16's care plan states in part: Resident requires (Bilateral palm protectors to be worn daily as tolerated) related to: Contracture.</p> <p>Interventions: Apply Bilateral palm protectors to be worn daily as tolerated.</p> <p>POS states in part: PROM to BUE/Neck and BLE all planes/joints 6-7 times a week.</p> <p>R16's POC Point of Care charting completed by the restorative department staff indicates on 10/21/24 - no documentation for the 7AM to 3PM shift for the amount of minutes spent providing splint or brace assistance.</p> <p>The undated Splints/Braces/Devices policy states in part 1. A physician's order is necessary to apply a splint/brace or restorative device. The order should include the application location and time to be worn. ie, 24 hours a day, daytime or nighttime only, apply at bedtime and remove in the morning. As tolerated should also be included in the order.</p> <p>5. Nursing/Restorative will document the application of the splint/brace/device on the appropriate facility ADL (activities of daily living) form.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The undated Application of Splints policy states in part:</p> <p>Purpose: To properly apply a splint for support, comfort, or aid in contracture prevention.</p> <p>Equipment: Physician's order, specific splint for the resident.</p> <p>Procedure for Application: 5. Note time the splint was applied, and time splint is to be removed according to the plan of care. 6. Document initials and total minutes for the appropriate shift. Document any difficulties or unusual situations on the reverse of the form or in the nursing notes and contact nursing supervisor.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066</p> <p>Based on interview and record review, the facility failed to monitor and prevent a cognitively impaired resident from sustaining an injury for one (R84) of two residents reviewed for accidents in the sample of 42.</p> <p>Findings include:</p> <p>R84 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including but not limited to chronic kidney disease, stage 3; Cerebral Infarction; Unspecified Dementia; and Cognitive Communication Deficit.</p> <p>According to R84's MDS (Minimum Data Set) assessment dated [DATE], under section C, R84 has BIMS (Brief Minimum Data Set) score of 5 indicating severely impaired cognition.</p> <p>Absent are any care plans prior the incident (10/11/2024) to show R84 has a history of behavior related to bending over to take off shoes that would put her at risk to hit her face on the surface of the table.</p> <p>On 10/21/24 at 10:59 AM R84 observed with hematoma under left eye. Assigned nurse and CNA not aware how R84 obtained the injury.</p> <p>On 10/21/24 at 01:11 PM Surveyor interviewed V3 (Assistant Director of Nursing) who said in summary, R84's injury was documented as an incident from 10/11/2024 and V2 (Director of Nursing) will know more about it.</p> <p>On 10/22/24 at 09:47 AM Surveyor interviewed V24 (Faily Member) who said in summary, My daughter and father visited R84 on 10/12/2024 and they noticed that R84 had a black eye. My daughter called me to tell me, and I drove immediately to the facility. When I arrived, I asked to talk to someone who knows what happened. I was told V2 (DON) will call me. In the meantime, I called the local police. Nobody could give us answers as to what happened. Nothing like this has happened before. It looked like R84 was punched in the eye. V2 (DON) called me when I was talking to the police. V2 (DON) was telling me that R84 probably hit her face when she fell in her room and hit her face on the air-condition unit. R84 had an aggressive roommate (R51) at the time. We have been asking to transfer her to another room but there was no response form the facility. Once, I saw R84 with the black eye, I insisted on moving her to another room. There was always only one nurse and one nurse aid on the unit 300, I felt like that's not enough staff to monitor all the residents. Often times, I would stay with R84 in the dining room, and seen no staff around.</p> <p>On 10/22/24 at 11:47 AM Surveyor interviewed (R7) who said in summary, R84 and R51 would be arguing all the time. I tried not to get into their business though. R51 can be nice when she wants to be. I don't know if R84 and R51 got into a fight.</p> <p>(continued on next page)</p>		

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Prairie Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE 16000 South Wabash South Holland, IL 60473	
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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>On 10/22/24 at 11:50 AM Surveyor interviewed V25 (Certified Nurse Assistant) who said in summary, I have been a CNA here for 5 years. R84 was moved to this unit from another room just recently. R47 and R84 don't get along. R84 goes into other residents' rooms. Every time R47 saw R84, he would get upset. We tried to keep them separated, but it is difficult because R84 moves around in her wheelchair. We try to redirect R84 but it's too hard, I feel like we don't have enough staff to monitor residents adequately. I questioned why was R84 moved to another room, but I don't know the reason. When I asked about R84's bruise, I was told that the cameras from the dining room showed that R84 hit her face on the table.</p> <p>On 10/22/24 at 12:46 PM Surveyor interviewed V17 (Licensed Practical Nurse) who said in summary, I have been working here for a few months, always on the unit 300. R84 is quiet, has dementia, and usually sits in the dining room. R84 is wandering, mostly on the afternoon shift and occasionally at night. Staff redirects R84 when she attempts to go to other residents' rooms. R51 tends to be verbally aggressive behavior but I haven't seen her being physically aggressive. R84 didn't have a problem with anybody. When I started my shift on (10/12/2024, day shift) R84 had a discoloration underneath her left eye. I don't think anybody punched her; R84 tends to put her head down on the table. I didn't hear about R84 injury in the hand off report, I was told by the family who arrived that morning, before I was able to look back in the notes. I hear some of the residents argue sometimes but never physically fight. I feel like our assignments are too heavy, some of my tasks are not complete. V17 (LPN) unable to name tasks that she is not able to finish due to lack of staff.</p> <p>On 10/22/24 at 03:07 PM Surveyor interviewed V26 (Certified Nurse Assistant) who said in summary, When I got to work on 10/11/2024 (day shift), I noticed that R84 has a black eye. I notified both, night shift nurse who was still giving hand off report and day shift nurse (V27 LPN) who was receiving report. V27 (LPN) looked at R84 who was sitting in the dining room at the time. I do not know what happened to R84 and I did not receive any information from a previous shift that day or any time after.</p> <p>On 10/22/24 at 03:31 PM Surveyor interviewed V27 (Licensed Practical Nurse) who said in summary, I worked a day shift on 10/11/2024. V26 (CNA) reported to me that R84 has a black eye. I looked at R84, noticed the black eye (don't remember) which one. I checked her vital signs but didn't do any other assessment. I asked R84 what happened, but she wasn't able to tell me, R84 is confused. It looked like a fresh bruise. I didn't receive information about R84's injury in a hand off report and there was no progress note. I didn't notify the family or doctor. I created the progress note. Later on, V2 (DON) told me that, in similar case in the future, I should notify V2 (DON), and I received in-service. I did not receive any training upon hire pertaining to abuse or injuries.</p> <p>On 10/22/24 at 03:43 PM, on 10/23/2024 at 10:12 AM, and on 10/24/2024 at 8:48 AM surveyor attempted to interview V15 (Certified Nurse Assistant), no answer, voicemail left.</p> <p>(continued on next page)</p>		

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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>On 10/23/24 at 02:59 PM Surveyor interviewed V2 (Director of Nursing) who said in summary, On Saturday morning (10/12/2024) I received a call from the nurse on duty that V24 (Family Member) came in and was upset over the discoloration under R84's the left eye. V24 called the police in the meantime. I called V1 (Administrator), and she came into the facility to initiate the abuse investigate. R84's abuse investigation was prompted by an injury on unknown origin. V1 completed majority of the investigation, I did not come into the facility until I came in on Monday (10/14/2024) and continued the investigation. I spoke to R84's roommate who was cognitively intact, and she said she didn't hear or see anything, the roommate is no longer in the facility. I also completed the risk management form that wasn't done. I did not read the entire final report, but I know that V1 (Administrator) reviewed tape from the dining room and concluded that R84 bumped her face on the table. R84 displayed behavior consistent with reaching down for her shoes before the incident.</p> <p>On 10/23/24 at 03:46 PM Surveyor interviewed V1 (Administrator/Abuse Prevention Coordinator) who said in summary, I was called and notified by V2 (DON) on the morning of 10/12/2024 that R84 has discoloration under her eye and the family was very upset. The police were already notified. I came in to initiate the reportable, tried to talk to R84 but she is confused and was not able to tell me what happened. I also interviewed the staff. I wrote the initial report and sent it. I sat in the dining room on Monday (10/14/2024) to see who else I should interview, and that's when I noticed R84 was constantly bending over to fix her shoes. I reviewed the recording from the dining room, but it was not clear if R84 hit her face on the table while doing that. I spoke to additional staff to continue my investigation. R84 displayed behavior consistent with reaching down for her shoes before the incident. Surveyor asked if there were any interventions based on history of behavior preventing R84 from obtaining injury before the incident on 10/11/2024, V1 said, I have to check if there were any interventions prior to the incident. If there weren't any interventions that means staff failed to communicate their monitoring and observations of R84 behaviors.</p> <p>Progress note dated 10/11/2024 11:08 AM written by V27 (LPN) reads in part, (R84) received at the dining room with bruise and swelling noted under the left eye. Writer tried to check the vitals but (R84) refused.</p> <p>Absent upon request is any documentation related to the incident (10/11/2024) that shows R84's skin assessment or vital signs.</p> <p>Facility Reported Incident dated 10/12/2024 02:47 PM reads in part, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Per (R84) interview, (R84) was not able or recall any incident or occurrence with any staff or other resident. Staff interviews also stated that they had not witnessed or heard of any unusual occurrence with (R84). (R84) has been reported to, while sitting in the dining room table, or persistent donning and doffing of her shoes which she consistently bends down by the table's edge on her left side. Abuse is unsubstantiated due to no witness to any type of possible occurrence the allegation could not be substantiated.</p> <p>The local police incident report dated 10/12/2024 10:43 AM reads in part, On 10/12/2024 (the local police officer) responded to (the facility) for an elder abuse call. Upon (the officer) arrival, (they) met with (V24 Family Member). (V24 Family Member) stated she observed purple/black bruising underneath the left eye on (R84's) face. (V2 DON) stated to (V24) that (R84) fell off her bed and hit her bed and hit air conditioner, causing bruising, and swelling. (V24) stated she last seen (R84) on 10/10/2024 and did not see any bruises.</p> <p>(continued on next page)</p>		

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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>V27's (LPN) Abuse Policy Employee Acknowledgment dated 06/06/2024 reviewed.</p> <p>Per record review, R84's room changed on 10/16/2024.</p> <p>The facility Nursing Assistant Job Description (no date) reads in part, Duties/Responsibilities: Visually monitor residents minimally every 2 hours; promptly report all incident, accidents and changes in condition to charge nurse immediately; report abuse and neglect immediately to abuse coordinator (Administrator).</p> <p>The facility Licensed Practical Nurse Job Description (no date) reads in part, Essential duties and responsibilities: Completes incidents/accident reports as necessary and document. Notify Physician and Family; take and record vital signs as required.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46066</p> <p>Based on observations, interviews, and record review, the facility failed to always have sufficient staff available to provide nursing services to meet the residents' needs in the facility. This has a potential to affect 105 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On 10/21/2024 at 10:00 AM Surveyor was provided census showing 105 residents residing in the facility at this time.</p> <p>On 10/22/2024 at 10:28 AM Surveyor met with residents during resident council meeting where R7 said, There is long response time to call lights on the second and night shift. They (staff) come when they want to come.</p> <p>On 10/22/2024 at 11:40 AM Surveyor inspected unit 300, no staff was present in the nursing station or in the hallways. Surveyor noticed ongoing call light at 11:40 AM without response. Surveyor prompted V25 (Certified Nurse Assistant) at 12:00 PM to answer the call light.</p> <p>On 10/22/2024 at 11:50 AM Surveyor interviewed V25 (Certified Nurse Assistant) who said in summary, I feel like we don't have enough staff to monitor residents adequately. My assignments usually contain 27 residents. It's hard to complete my tasks but I do my best. There are times when I don't have time to complete document.</p> <p>10/22/2024 12:46 PM Surveyor interviewed V17 (Licensed Practical Nurse) who said in summary, I feel like our assignments is too heavy, some of my tasks are not complete. V17 (LPN) unable to name tasks that she is not able to finish due to lack of staff.</p> <p>On 10/23/2024 at 11:59 AM Surveyor interviewed V28 (Staffing Coordinator) who said in summary, There three units in the facility. All, 100 unit, 200 unit, and 300 unit are mix of long and short term residents with variety of needs. I make schedule for nurses and nurses' aides. I prioritize continuity of care and I look at the census on each unit. The union guidelines for nurses' aides is 15:1. Nurses usually have between 20-24 residents in their assignment. Unit 100 has 41 residents; we have 4 aids and 1.75 nurses. One of the nurses from Unit 100 has 3 rooms accommodating 8 residents on Unit 200. Unit 200 has 31 residents and there is 1 nurse and 4 aids. Unit 300 has about 27 residents and there 3 aids and 1 nurse for morning and afternoon shifts. For night shifts, Unit 100, 200, and 300 have 3 aids and 1 nurse. The schedule stays the same throughout the year. When there are call offs, I cover them if they come in before 4:00 PM, I can cover for nurse and nurse's aide. If a call off comes in after 4:00 PM I find a replacement. After I leave at 4.30pm, it is V2's (DON) and V3's (ADON) responsibility to cover or find staff replacement. We get one to two call offs a day. There are days when it's challenging to find coverage.</p> <p>Schedules for August, September, and October 2024 reviewed with identified concern of multiple call offs.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility assessment tool dated 08/12/2024 reads in part, Individual staff assignment will be based on the individual resident needs, preferences and acuity of care provided, and will be re-evaluated and adjusted accordingly to meet these needs.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40987</p> <p>Based on interview and record review, the facility failed to provide an arbitration agreement to a resident/representative that provided 30 days after signing to rescind the agreement. This failure applies to 1 (R23) resident of 1 reviewed for arbitration agreements.</p> <p>Findings include:</p> <p>R23 is [AGE] years of age. Current diagnoses include but are not limited to Cerebral Infarction.</p> <p>R23 has a POA Power of Attorney in place due to her current cognition to make decisions on her behalf.</p> <p>Findings include:</p> <p>On 10/22/24 at 01:30 PM, R23's arbitration agreement dated 11/11/2022 was reviewed which indicates: This agreement may be cancelled by any signatory within seven (7) days of its execution. Said cancellation must be delivered to the facility in writing.</p> <p>On 10/22/24 at 01:34 PM, interview with V11 Family Member regarding R23's arbitration agreement cancellation within seven (7) days of its execution signed on 11/11/2022. V11 said, I can't say I'm familiar with what it said.</p> <p>On 10/24/24 at 09:17 AM, V1 was inquired of the admission policy's arbitration agreement. V1 said, We were supposed to have a meeting about the agreements. V23 Admissions Director and V13 Assistant Administrator are more familiar with it. I get the CMS updates, but I may have not read it, it's more for the attorneys. V1 provided a copy of the admission packet at the beginning of the survey, and it includes the same arbitration agreement signed by R23.</p> <p>On 10/24/24 at 09:31 AM, V23 Admissions Director was inquired of the admission policy's arbitration agreement. V23 was provided a copy of R23's signed agreement from 11/2022 for review. V23 said, I do let them (residents) know and I let the families know they have 30 days to look it over. I started last year, and this was the copy of the agreement sent to me for the admission. V23 affirmed the copy indicating the arbitration agreement cancellation is within seven (7) days of its execution as the copy she received.</p> <p>On 10/24/24 at 09:49 AM, V23 Admissions Director provided the updated 2021 arbitration agreement. V23 said, This is the updated copy and it's in the admission packet.</p> <p>On 10/24/24 at 09:55 AM, V13 Assistant Administrator was inquired of signing R23's arbitration agreement from 11/2022 which states in part the arbitration agreement cancellation is within seven (7) days of its execution. V13 was provided R23's signed arbitration agreement for review. V13 said, I use to be in admissions, this copy was prefilled. The corporate usually send us the revised copies. I'm not sure why this copy was used.</p> <p>(continued on next page)</p>		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 10:00 AM, V1 said, I just got the new copy of the arbitration agreement from V23 Admissions Agreement.		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>46066</p> <p>Based on interview and record review, the facility failed to ensure staff was provided adequate abuse prevention education. This failure has a potential to affect 63 residents in the facility.</p> <p>Findings include:</p> <p>On 10/21/2024 at 10:00 AM Surveyor was provided census showing 36 residents residing in the unit 200 and 27 residents residing in the unit 300. Total residents for unit 200 and unit 300 is 63.</p> <p>10/22/24 03:31 PM Surveyor interviewed V27 (Licensed Practical Nurse) who said in summary, I worked a day shift on 10/11/2024. V26 (CNA) reported to me that R84 has a black eye. I looked at R84, noticed the black eye (don't remember) which one. I checked her vital signs but didn't do any other assessment. I asked R84 what happened, but she wasn't able to tell me, R84 is confused. It looked like a fresh bruise. I didn't receive information about R84's injury in a hand off report and there was no progress note. I didn't notify the family or doctor. I created the progress note. Later on, V2 (DON) told me that, in similar case in the future, I should notify V2 (DON) and I received in-service. I did not receive any training upon hire pertaining to abuse or injuries.</p> <p>10/23/2024 at 12:50 PM Surveyor interviewed V28 (Staffing Coordinator) who said in summary, V27 (LPN) is regularly scheduled to work in the unit 200 and picks up additional shift in the unit 300.</p> <p>On 10/23/24 at 02:59 PM Surveyor interviewed V2 (Director of Nursing) who said in summary, The nurse should document the incident and notify responsible parties, such as doctor, family, and me (V2 DON). V27 (LPN), who put a note for R84, didn't do the follow through, meaning she didn't notify anyone of the incident. V27 (LPN) was in-serviced for that.</p> <p>On 10/23/24 at 03:46 PM Surveyor interviewed V1 (Administrator/Abuse Prevention Coordinator) who said in summary, During staff abuse training, we go over types of abuse, time frame to report, we point out the phone number staff should call, and emphasize that if staff doesn't report abuse it is a terminable offense. Staff abuse training should be done annually but I do it more frequently. Most recent training was in July of 2024.</p> <p>Progress note dated 10/11/2024 11:08 AM written by V27 (LPN) reads in part, (R84) received at the dining room with bruise and swelling noted under the left eye. Writer tried to check the vitals but (R84) refused.</p> <p>V27's (LPN) Abuse Policy Employee Acknowledgment dated 06/06/2024 reviewed.</p> <p>(continued on next page)</p>		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Abuse Prevention Program (no date) reads in part, During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and resident needs; What constitutes abuse, neglect, exploitation, and misappropriation of resident property; The prohibition against taking, using, keeping, or distributing photographs or recordings of residents or a resident's personal space, as described in Section IV below; Procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property; Dementia management and resident abuse prevention; How to assess, prevent, and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff; En employee's obligation under the law for reporting a suspected crime to the facility, the state survey agency and local law enforcement; the time frames; and management's obligation to prohibit retaliation against anyone who makes a report.		