

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  09/12/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, interviews, and record reviews, this facility failed to ensure the call light cord was within reach for two residents (R59 and R63) out of three residents reviewed for call light accessibility in a sample of 104. Findings include: On 9/9/25 at 10:30 AM, R59's call light cord was observed dangling behind R59's bed. When questioned, R59 stated that R59 must lower the head of her bed to a flat position and stretch left arm above head and swing arm side to side until she can reach the call light cord. On 9/9/25 at 1:05 PM, R63 was heard yelling out for help. When this surveyor entered R63's room, R63 was observed sitting in wheelchair positioned in the middle of room. R63's call light cord was observed wrapped in circular patterns on R63's nightstand which was about three feet behind R63. R63's call light cord was not within reach. On 9/9/25 at 1:10 PM, V6 LPN (licensed practical nurse) was observed clipping R63's call light cord to R63's clothing at the right shoulder. On 9/9/25 at 1:20 PM, V2 DON (director of nursing) stated that R59's call light cord is not long enough. V2 stated that she will notify maintenance to fix R59's call light cord so it will be readily accessible to R59. The facility's call light policy, dated 04/2014, notes all residents shall have the nurses call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location.</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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interviews and record reviews, the facility failed to have an appropriate diagnosis for the use of antipsychotic medications and failed to identify a specific behavior for the use of an antipsychotic medication. This failure affected one resident (R10) out of four residents reviewed for chemical restraints in a sample of 104. Findings include: Findings include: On 9/12/25 at 9:30 AM, V15 ADON (assistant director of nursing) stated that R10 is receiving Seroquel for agitation. When questioned if a resident is receiving psychotropic medication should there be a diagnosis and reason why medication is needed, V15 responded R10 is on hospice care and V15 can call the outside hospice company to see if their physician would like to add a diagnosis. When questioned if diagnosis should be determined before initiating a psychotropic medication, V15 did not respond. On 9/12/25 at 10:00 AM, when questioned if a dementia diagnosis is an appropriate diagnosis for a resident to receive a psychotropic medication, V2 DON (director of nursing) responded that she does not have anything to do with psychotropic medications; V15 is responsible for this. R10 was admitted to this facility on 3/22/24, with diagnosis, including but not limited to, Alzheimer's disease and dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R10's POS (physician order sheet, dated 2/21/25, notes an order for quetiapine fumarate 25mg (milligrams) oral two times a day for monitoring related to dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R10's MAR (medication administration record), dated February 2025 - September 12, 2025, notes R10 has been receiving quetiapine fumarate 25mg (milligrams) oral two times a day. R10's psychotropic drug review and GDR (gradual dose reduction), dated 7/31/25, notes R10 does not have any psychiatric manifestations, never exhibits any behavioral conditions, and there have been no GDR attempted. R10's care plan, dated 7/16/24, notes R10 requires psychotropic medication. There is no diagnosis associated with this care plan. Per drugs.com, dated 8/22/23, notes quetiapine fumarate is an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depression. The facility's psychotropic drug therapy policy, dated 11/2014, notes residents with diagnosis of Alzheimer's or dementia must have supporting psychiatric diagnosis if on any anti-psychotic medication.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 follow their smoking at risk program policy and develop an at risk plan of care. This affects one of three (R56) residents reviewed for safe smoking care plan interventions. During survey tour from on 9/9/25 between hour of 11:17am -11:39am, R56 was observed with a cigarette lighter. R56 said it was his lighter for his cigarettes.9/9/25 V2 (Director of Nursing) said residents should not have cigarette lighters in their possession, it's the facility policy. V2 made aware R56 was observed with a cigarette lighter.9/12/25 at 12:27pm V2 (Director of Nursing) stated her expectation is the staff conduct and complete an accurate assessment of the residents. V2 said care plan are individualized, and the assessments drives the plan of care is developed for the residents. V2 said R56 does smoke. V2 said R56 care should have been updated accurately; to reflect he is at risk smoker.9/12/25 at 1:26pm V6 (LPN) said she only have two residents on the unit smokes, she knows they smoke because she has observed them smoking. V6 said she not aware of other residents that smoke in the unit. V6 said R56 resided on the unit, and he is an identify as an at risk smoker.On 9/12/25 at 1:25pm V15 (ADON) said she cannot find the list of at-risk smokers on the unit where R56 resides. V15 said the list should be on every unit. V15 was asked how the staff can monitor the resident for smoking risk if they cannot identify who are at risk for smoking/ unsafe smoker. V15 response was, I know.R56 smoking risk review with effective date of 7/4/25 denotes R56 does not smoke. Facility presented an update version of the 7/4/25 smoke assessment with new sign date of 9/11/25, it is denoted R56 does smoke, 0 (indicates no problem) is marked for injury potential (potential for causing injury to self or others from smoking in unauthorized areas or careless use of smoking materials). 0 (indicates no problem) is marked for history of hazardous behavior. Total score is one. R56 plan of care dated 8/1/2025 denotes in-part, R56 is new to the facility &amp; expresses the desire to smoke. The resident will be monitored or placed in the supervised smoking program to fully assess compliance &amp; ability to smoke independently. Date initiated: 08/01/2025 Revision on: 09/09/2025. [NAME] will demonstrate compliance with safe smoking policies. Provide a copy of the facility safe-smoking policy &amp; explain the policy so the resident is fully aware of all obligations &amp; conduct a Smoking Safety Assessment as necessary. Review the important elements of the policy with the resident. This includes educating the resident regarding: where smoking may occur, times of smoking sessions, using ashtrays properly, not discarding ashes or butts on the floor, not lighting peers' cigarettes, not giving or trading cigarettes to peers, &amp; the health &amp; safety-related risks associated w/ smoking. Offer the resident smoking cessation information. Remind the resident staff will be observing &amp; supervising smoking-related behavior. Non-compliance is to be documented in medical record.R56 care plan does not denote/reflect R56 is a risk smoker.Facility policy titled smoking at risk program dated 5/2014, no last review date noted, policy denotes in-part the facility will have a smoking program in place is monitored by a smoking coordinator with assistance of all staff. Once at risk has been determined enter the residents name on a list of at-risk smokers. Post this list at each nursing station. Give each department head a copy. Write a care plan for all at risk smokers. Check appropriate area or Kardex. Nursing staff assigned to at risk will check bedside cabinets and the residents, for smoking materials. This check will be documented on the at-risk smokers list.</p>		

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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.  (continued on next page)		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on interview and record review, the facility failed to ensure that two-person assistance was utilized during resident care, as required by the resident's care plan, to maintain safety. This deficient practice affected one of three residents (Resident #13) reviewed for safety during care. As a result, Resident #13 fell from the bed during care, which led to the dislodgement of the resident's gastrostomy tube and required hospitalization for replacement. On 9/12/25 at 9:37 AM, R13 was observed able to nod head yes or no to questions asked. When questioned if able to raise arms off bed, R13 nodded head 'no'. On 9/9/25 at 4:00 PM, V2 DON (director of nursing) stated V2 wrote up V9 CNA (certified nurse aide) for improper care resulting in R13's fall out of bed. V2 stated R13 is a two-person assist with all care. On 9/11/25 at 12:08 PM, V10 RN (registered nurse) stated she worked night shift 11:00 PM 8/20/25 to 7:30 AM 8/21/25. V10 stated she had just changed R13 with the night shift CNA at 4:00 AM. V10 stated R13 is not able to assist with turning/repositioning. V10 stated R13 requires two-person assistance with all ADL care. V10 stated R13 fell out of bed and was on the floor on the side of bed furthest from the door; fell on left side of bed. V10 stated upon arrival to room, V10 observed R13's gastrostomy tube dislodged with balloon inflated resting on R13's stomach. V10 stated R13 was sent to the hospital morning for G-tube replacement because nursing staff cannot re-insert the tubing. V10 stated the day shift, V9 CNA (certified nurse aide,) was performing care without another staff member to assist. On 9/11/25 at 12:15 PM, V5 (restorative nurse) stated R13 is able to move hands. V5 stated R13 receives AAROM (active assisted range of motion) to both legs. V5 stated R13 can move legs side to side with staff holding leg off bed. V5 stated R13 can move her arms with AAROM. V5 stated R13 needs a lot of encouragement to participate in restorative therapy. V5 stated R13 is not able to turn self or hold self on side while staff provide care. V5 stated resident requires two-person assistance with all turning/repositioning and transfers. On 9/12/25 at 11:00 AM, V9 CNA (certified nurse aide) stated on 8/21, V9 was providing morning care to R13 by herself. V9 stated R13 is totally dependent on staff; not able to assist with turning. V9 stated typically V9 provides care for R13 by herself due to not enough staff present in facility to assist V9. V9 stated R13 is a two-person assist with all ADLs. V9 stated sometimes R13 will throw herself onto back when positioned on side during care. V9 stated this is not a new behavior for R13. V9 stated R13 was positioned on her left side facing window. V9 stated V9 was positioned on the right side of bed placing new linen on bed behind R13 when R13 fell off bed. R13's fall incident report, dated 8/21/25, notes V10 RN found R13 on floor near bed lying on her right side. V10 noted R13's gastrostomy tube dislodged. The conclusion: R13 slid to the floor during morning care. R13's ADL care plan, dated 9/3/23, notes R13 has performance deficit related to stroke with hemiparesis affecting left non-dominant side. Intervention, dated 2/28/25, notes R13 is totally dependent on staff for turning and repositioning in bed. R13's diet care plan, dated 7/18/23, notes R13 has a nothing by mouth diet and receives gastrostomy tube feeding of Glucerna 1.2 at 75ml (milliliters)/hour x 20 hours and 450ml water flush per shift. R13's MDS (minimum data set), dated 8/5/25, notes, in part, R13 is dependent on staff for bed mobility, toileting, hygiene, and bathing. Per section GG, dependent is defined as helper does all of the effort. R13 does none of the effort to complete the activity. Or the assistance of two or more helpers is required for R13 to complete the activity. R13's transfer and bed mobility review, dated 8/5/25, notes R13's mobility and balance - ability to turn side to side is poor. R13 requires two person physical assistance from staff for bed mobility. R13's side rail assessment, dated 8/5/25, notes R13 has moderately impaired cognitive skills for decision making. R13 has alterations in safety awareness due to cognitive decline. R13 will not use side rails at this time. The facility's fall prevention program policy, dated 2/28/2014, notes safety interventions will be implemented for each resident identified at risk using a standard protocol. All nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained.</p>		

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F 0692  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide enough food/fluids to maintain a resident's health.  (continued on next page)

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to successfully implement interventions to prevent resident (R17) from losing weight. This failure resulted in the resident experiencing a significant weight loss of 6 percent in one month and a significant weight loss of 11.3 percent within six months for one of seven reviewed for nutrition. Findings include: R17 was admitted to the facility on [DATE] with a diagnosis of type II diabetes, hypertension, anemia, severe protein caloric malnutrition, blindness category four to left and right eye. R17's weights documents: 9/5/25 65.2 pounds; 8/27/25 65 pounds; 8/20/25 66.6 pounds; 8/5/25 62.8 pounds; 7/3/25 66.8 pounds, 6/4/25 66.8 pounds, 5/28/25 66.8; 5/6/25 65 pounds, 3/5/25 70.2 pounds; 2/7/25 70.8 pounds; 1/7/25 69 pounds and 12/6/24 71.4 pounds. R17's plan of care dated 6/7/24 documents: R17 receives a regular diet with thin liquids which I consume usually with a poor appetite. The resident may be at risk for weight loss related to: adjustment to new surroundings. Interventions include: Administer medication as ordered Date Initiated: 10/18/2024; Prepare/serve the resident's nutritional diet as ordered. Prescribed diet is: Date Initiated: 06/14/2024; Determine food preferences through one-to-one interview &amp;/or family interview. Date Initiated: 06/14/2024; Weigh the resident monthly or per facility protocol. Date Initiated: 06/14/2024; Provide one-to-one staff intervention to promote proper nutritional intake. Date Initiated: 06/14/2024; Provide dietary supplements, as ordered. Date Initiated: 06/14/2024; Encourage &amp; praise the resident's attempts to follow the prescribed diet. Date Initiated: 06/14/2024; Offer between meal snacks &amp; meal substitutions, as appropriate. Date Initiated: 06/14/2024; Offer the resident a bedtime snack. Date Initiated: 06/14/2024; Review the resident's daily exercise &amp; caloric expenditures. Keep physical activity at a moderate level. Date Initiated: 06/14/2024. There were no new interventions documented. On 9/12/25 at 10:44AM, V12 (medical doctor) said he is familiar with R17 but unclear of any issues related to weight concerns. V12 was unclear of any medical diagnosis contributing to weight loss and low body mass index. R17's progress notes by V12 on 12/11/24 documents: Severe protein-calorie malnutrition ([NAME]: less than 60% of standard weight): Weight continues to fluctuate but remains severely underweight with BMI &lt;14 percent will add Megestrol Acetate Suspension 40 MG/ML -10ml daily. Encourage Nutritional supplements in between meals. Encourage high calorie diet. R17's dietary progress note dated 8/14/25 documents: Weight loss. Height 59 BMI 12.7 - underweight. Weight: 8/5 62.8, 7/3 66.8, 6/4 66.8, 5/6 65, 4/7 66.8, 3/5 70.2, 2/7 70.8 Significant weight loss x 1 6 percent, 6 months 11.3%. BMI indicates underweight. History of significant weight gain and loss. Upper Body weight high 60's to low 70's. Estimated needs: 1034-1182 (35-40kcal/ml fl/kg), 38-47 (1.3-1.6g pro/kg) Diet: NAS, Regular texture, thin liquids ~2200kcal/110g pro/2L fl (dietary/nursing - meeting estimated needs if consumed Recorded intake varies 26-100% - appetite mostly fair, 51-75%. May benefit from adding nutritional supplement to increase energy intake and improve weight/nutritional status. Resident appears elderly, thin, frail. Diet appropriate and meeting estimated needs if consumed with current appetite. Unintended weight loss related to energy intake as evidence by significant weight loss x 1 and 6 months. PLAN. Recommend health shakes with meals ~600kcal/18g protein. R17's dietary progress note dated 5/8/25 documents: Weight loss. Height 59 BMI 13.1 underweight. Weight: 5/6 65, 4/7 66.8, 3/5 70.2, 2/7 70.8, 1/7 69, 12/6 71.4, 11/5 71.3 Significant weight loss x 3 months 8.2 percent BMI indicates underweight. History of significant weight gain and loss. Upper Body weight high 60's to low 70's. Est needs: 1034-1182 (35-40kcal/ml fl/kg), 38-47 (1.3-1.6g pro/kg) Diet: NAS, Regular texture, thin liquids ~2200kcal/110g pro/2L fl (dietary/nursing - meeting estimated needs if consumed. Previously received Megestrol 10/18/24. Recorded intake varies 0-100% - appetite mostly fair, 51-75%. May benefit from adding nutritional supplement to increase energy intake and improve weight/nutritional status. Diet appropriate and meeting estimated needs if consumed with current appetite. Unintended weight loss related to energy intake as evidence by significant weight loss x 1 month. PLAN. Recommend ready care three times a day. R17 was admitted to the facility on [DATE] with a diagnosis of type II diabetes, hypertension, anemia, severe protein caloric malnutrition, blindness category four to left and right eye. R17's weights documents: 9/5/25 65.2 pounds; 8/27/25 65 pounds; 8/20/25 66.6 pounds; 8/5/25 62.8 pounds; 7/3/25 66.8 pounds, 6/4/25 66.8 pounds, 5/28/25 66.8; 5/6/25 65 pounds, 3/5/25 70.2 pounds; 2/7/25 70.8 pounds; 1/7/25 69 pounds and 12/6/24 71.4 pounds. R17's plan of care dated 6/7/24 documents: R17 receives a regular diet with thin liquids which I consume usually with a poor appetite. The resident may be at risk for weight loss related to: adjustment to new surroundings. Interventions include: Administer medication as ordered Date</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide sufficient RN (registered nurse) coverage for the second quarter of 2025. Per PBJ (payroll based journal) requirements there should be an RN working 8 consecutive hours 7 days a week. This failure has the potential to affect all residents residing in the facility. Findings include: On 9/9/25 at 9:30 AM, there was signage posted at the main receptionist desk, dated 8/19/25, noting 'this facility did not meet the minimum staffing ratios required by law for the quarter ending March 31st, 2025. On 9/12/25 at 9:00 AM, V2 DON (director of nursing) stated that for 21 days during the second quarter PBJ report there wasn't an RN present for 8 consecutive hours 7 days a week. The facility's staffing sheets for January, February, and March were reviewed. Per V18 RN (registered nurse), V19 RN, V20 RN, V21 RN, and V22 RN time punches, the facility did not routinely have an RN present for 8 consecutive hours on New Year's Day, Saturdays, and Sundays: 1/1/25 - RN time punch requested during survey but not made available for review. 1/4 - RN time punch requested during survey but not made available for review. 1/5 - V19 RN worked 7.9 hours 1/11 - V20 RN worked 7.25 hours 1/12 - V20 worked 7.25 hours 1/18 - V19 worked 7.5 hours 1/19 - V19 worked 7.8 hours 1/25 - V18 RN worked 7.7 hours, V18 worked 7.8 hours, and V20 worked 6.5 hours 1/26 - V18 worked 7.6 hours and V18 worked 7.7 hours, and V20 worked 7 hours 2/1 - 7.75 hours and 6.5 hours 2/2 - V21 RN worked 7.1 hours 2/8 - V18 worked 7.25 hours 2/9 - V18 worked 7.5 hours 2/15 - RN time punch requested during survey but not made available for review. 2/16 - V19 worked 5.9 hours 3/1 - V19 worked 6.25 hours and V22 RN worked 7.75 hours 3/2 - V19 worked 6.25 hours 3/9 - V18 worked 7.5 hours 3/16 - V22 worked 7 hours 3/22 - V18 worked 7.25 hours 3/23 - V22 worked 7.5 hours</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interviews and record reviews, the facility failed to have an appropriate diagnosis for the use of antipsychotic medications, failed to identify a specific behavior for the use of an antipsychotic medication. This failure affected one resident (R10) out of four reviewed for unnecessary medications in a sample of 104. Findings include: On 9/12/25 at 9:30 AM, V15 ADON (assistant director of nursing) stated that R10 is receiving Seroquel for agitation. When questioned if a resident is receiving psychotropic medication should there be a diagnosis and reason why medication is needed, V15 responded R10 is on hospice care and V15 can call the outside hospice company to see if their physician would like to add a diagnosis. When questioned if diagnosis should be determined before initiating a psychotropic medication, V15 did not respond. On 9/12/25 at 10:00 AM, when questioned if a dementia diagnosis is an appropriate diagnosis for a resident to receive a psychotropic medication, V2 DON (director of nursing) responded that she does not have anything to do with psychotropic medications; V15 is responsible for this. R10 was admitted to this facility on 3/22/24, with diagnosis, including but not limited to, Alzheimer's disease and dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R10's POS (physician order sheet, dated 2/21/25, notes an order for quetiapine fumarate 25mg (milligrams) oral two times a day for monitoring related to dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R10's MAR (medication administration record), dated February 2025 - September 12, 2025, notes R10 has been receiving quetiapine fumarate 25mg (milligrams) oral two times a day. R10's psychotropic drug review and GDR (gradual dose reduction), dated 7/31/25, notes R10 does not have any psychiatric manifestations, never exhibits any behavioral conditions, and there have been no GDR attempted. R10's care plan, dated 7/16/24, notes R10 requires psychotropic medication. There is no diagnosis associated with this care plan. Per drugs.com, dated 8/22/23, notes quetiapine fumarate is an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depression. The facility's psychotropic drug therapy policy, dated 11/2014, notes residents with diagnosis of Alzheimer's or dementia must have supporting psychiatric diagnosis if on any anti-psychotic medication.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to set up a dental referral/appointment for one resident (R62) who required a tooth extraction for one of one reviewed for dental services. Findings include: R62 was admitted to the facility on [DATE] with a diagnosis of type II diabetes, dementia, hypertension, epilepsy, anxiety and weakness. On 9/9/25 at 10:59AM, R62 who was alert and oriented said he was having tooth pain for about week due to cracked tooth. R62 said he was supposed to see a dentist for removal but still not sure what is happening. Referral dated 9/5/25 documents: patient wants extraction of upper right premolar. On 9/12/25 at 9:48AM, V2(DON) said she was not aware of referral until she received the email on 9/11/25. V2 said she made the appointment on 9/11/25 for next week.</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  09/12/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation and record review, the facility failed to follow their recipe by not utilizing the appropriate serving size for zucchini, lettuce and cheese during lunch service. This has the potential to affect all 58 resident receiving regular diet. In addition, the facility, failed to provide pureed tortilla during lunch service for 20 of 20 residents receiving pureed diets. Findings include: On 9/9/25 at 11:49AM kitchen tray line observed with V13 (Cook). Lunch being served was beef taco on a tortilla with lettuce, cheese, onion and tomato with zucchini and refried beans. V13 said the mechanical soft diet is the same as regular but without lettuce. V13 observed using a tongs to serve the zucchini. No measurement or tools used for cheese, lettuce and tomatoes. V13 using gloved hand to place on cheese, lettuce and tomatoes the plates. Facility recipe for shredded lettuce with diced tomatoes and cheese documents to portion as garnish 1/2 cup of lettuce and tomato with tablespoon of shredded cheese. Facility recipe for seasoned zucchini documents to serve with #8 scoop to provide 1/2 cup vegetables per serving. Facility diet list dated 9/9/25 documents: 58 residents on regular diets. On 9/9/25 at 11:49AM kitchen tray line observed with V13 (Cook). Pureed food was identified as refried beans, beef and zucchini. Pureed food trays were given zucchini, beef and refried beans no other food was on the plate. No pureed tortilla was observed. Facility recipe for pureed tortilla document portion with #16 scoop. Facility diet list dated 9/9/25 documents: 20 residents on pureed diets.</p>		

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NAME OF PROVIDER OR SUPPLIER  Prairie Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE  16000 South Wabash South Holland, IL 60473	
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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 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.  (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER  Prairie Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE  16000 South Wabash South Holland, IL 60473	
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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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 ensure the dishwasher was working to provide the correct sanitation solution during washing and utilized the dishes for the next meal service. In addition, the facility failed to follow their thawing policy by leaving raw pork on the stove top (that was off) and reaching a danger zone temperature of 60 degrees after being left out for over four hours. This has the potential to affect all 99 residents receiving meals. Findings include: On 9/9/25 at 11:49Am, tray line observation conducted and facility using regular plates, silverware and cups for meal service. On 9/9/25 at 1:46PM, V14 (dietary aide) low temp/sanitizer dish washer checked. Chlorine test strip did not turn. V14 said it didn't work this morning when he checked and showed surveyor logbook. V14 said he informed another staff, but they continued to use dishwasher after breakfast and lunch service. On 9/12/25 at 11:04Am, V17 (dishwasher repairman) said he serviced facility dishwasher on 9/10/25 due to tubing connecting the sanitation liquid to the dishwasher was leaking. V17 said the dish machine was not receiving enough sanitation solution and that is why the testing strips were not activating when testing. The machine should not be used until serviced because the dishes are not receiving the required sanitation liquid during the wash. Facility September dishwasher log documents on 9/9/25 no entry for the morning or lunch service under comments documents: test stripes not showing results. Facility dishwasher invoice dated 9/10/25 documents: replaced tubing from pump to soap on the machine. Cracked and leaking. Facility dishwashing machine operation undated documents: Test kits with the appropriate strips are used to determine the correct parts per million (PPM) of the sanitizers final rinse. In the event that the test strip does not show the correct PPM's, the dish aid will notify the person in charge who takes the following steps: notify maintenance director, maintenance determines source of malfunction and repairs the equipment if possible; if unable maintenance contact the customer service company; appropriate service is rendered to restore proper operation of the dishwasher machine. No reusable small wares including plates, flatware, glasses, cups and trays will be used for meal service if dishwashing machine does not meet PPM requirements as indicated by the test strips. Facility policy Equipment and utensil cleanliness and sanitation dated 5/14 documents: the dishwashing machine will be maintained and run according to the manufactures instructions. Any service/repair dietary is to contact rental provider for service, if machine is facility owned maintenance to repair /inspect, if not able to repair contact appropriate service/repair provider. Facility diet list dated 9/9/25 documents 99 residents receiving by mouth diets. Meat temperature observation: On 9/9/25 at 11:49AM kitchen tray line observed with V13 (Cook). Large package of meat in plastic wrapping observed on top of griddle stovetop that was off. The meat was not in a pan. On 9/9/25 at 1:04PM, Stovetop was warm but not on. V13(cook) said the meat was pork that was delivered this morning around 8:00AM. V13 said the meat was frozen when delivered and was thawing out to be prepared for dinner tomorrow. There was no other marking on the meat. Meat was warm to touch. V13 said they usually thaw the meat on the other counter. On 9/9/25 at 2:16PM, thermometer calibrated with ice. Pork meat that packaged in clear plastic was checked at 60 degrees Fahrenheit and placed in pan. V13 (cook) said she was still planning to cook the pork for dinner tomorrow. On 9/9/25 at 3:15pm, pork observed in pan on counter in the kitchen. On 9/9/25 at 4:13pm, V13 said the pork that we checked earlier was in the oven. Kitchen delivery invoice dated 9/9/25 documents under refrigerated one 8.5 pound pork butt. Facility policy thawing food undated documents: Food that is time/temperature control for safety is only thawed by one the following procedures. [NAME] refrigerator that maintains food temperature of 41degrees or less. As drip-proof pan is placed under the thawing meat that may drip liquids during the thawing process. Under potable running water at a temperature of 70 or below with sufficient water velocity to agitate and float off loose articles. In a microwave oven and is immediately transferred to conventional cooking equipment as part of a continuous cooking process. Food that is found thawing improperly on the counter is discarded. Facility diet list dated 9/9/25 documents 99 residents receiving by mouth diets. According to the centers for disease control under four steps for food safety documents: Chill: refrigerate promptly. Bacteria can multiply rapidly if left at room temperature or in the Danger Zone between 40 F and 140 F. Never leave perishable food out for more than 2 hours (or 1 hour if exposed to temperatures above 90 F). Keep your refrigerator at 40 F or below and your freezer at 0 F or below, and know when to throw food out before it spoils. Never thaw food on the counter because bacteria multiply quickly in the parts of the food that reach room temperature</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, V8 (nurse) failed to sanitize or wash her hand during medication administration. This affected two of three (R3, R32) residents reviewed for hand washing during medication administration. Findings Include: On 9/10/25 at 9:00am, during medication pass, V8 (nurse) administered R3's morning medications, return to the medication cart and proceed to prepare R32's morning medications without washing her hands or using hand sanitizer. V8 said she was supposed to clean her hands after she gave R3 her medication and before she prepared R32's medication. V8 said she forgot to clean her hands in between residents. V8 said she will clean her hands now. On 9/12/25 at 12:30pm, V2 (DON) said hand hygiene should be performed in between resident during medication administration to prevent the spread of infections. V2 said hand sanitizer or soap and water should be used for hand hygiene. Hand Hygiene Policy no date documents: Hand hygiene shall be performed: before contact with a resident or resident's environment.</p>		