STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Meadows	1000 Longmoor Savanna, IL 61074

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to conduct and document an assessment for a resident following an unwitnessed fall for 1 of 3 residents (R1) reviewed for quality of care in the sample of 3. The findings include:R1's admission record shows he was admitted to the facility on [DATE] and resided on the connection dementia unit. The same document lists his diagnoses including unspecified dementia.The facility's 10/27/25 incident report documents at approximately 7:40 PM R1 was found on the floor. He was lying on his right side in front of the TV. There was a pool of blood at his head, he was yelling and reaching up for help. He denied pain, stating he just wanted to get up. Cold compress to head and was assisted from the floor to a chair with the gait belt. At that time, he complained of right hip pain, unable to bear weight right hip. The Power of Attorney (POA) was notified, and he was sent to the emergency room for evaluation. The note includes vital signs but no range of motion (ROM) or neurological assessment (neuro check) with an obvious head injury.R1's emergency room documents show him to have pain with range of motion to the right hip due to a closed right hip fracture. On 10/30/25 at 9:19 AM, V7 (Licensed Practical Nurse/LPN) said when a resident has a fall, the nurse must make sure there is no injury before they are moved. By moving them it could cause further injury. If the resident is complaining of pain, they should be left in their position until the ambulance arrives. If the fall is unwitnessed, neuro checks are done to ensure they are within normal limits. All the assessments should be documented in the nurse's notes, including ROM and any neuro checks.On 10/30/25 at 12:10 PM, V5 (Certified Nursing Assistant/CNA) said V6 (CNA) had found R1 on the floor and V4 (Registered Nurse/RN) called me into the room. Upon arrival, V4 and V6 had R1 sitting up on the floor. V5 said he took R1's vital signs and helped to clean him up. A chair was moved behind R1 for him to sit in while waiting for the ambulance. He did complain of hip pain anytime we would touch him. He said V4 did check R1s range of motion to his arms and legs, and when his right hip was moved, he complained of pain, but then we still stood him up in the chair, trying to keep the weight off the right hip.On 10/30/25 at 12:30 PM, V4 (RN) said when she arrived to R1's room he had a pool of blood by his head, I assessed the area. He was screaming to get up, but he fell on the floor and no, he should not be moved. V4 said she tried to assess his pupils, but he was not cooperating. He had complaints of pain while he was still on the floor. He said his hip hurt. We were able to transfer him to the ambulance cot without bearing weight on the hip. She said attempts were made to check his ROM while on the floor. V4 said she did not document any of these attempted assessments; they should have been noted in the record. She knew he was being sent to the emergency room. If he was not being sent out, she would have documented more.On 10/30/25 at 11:35 AM, V2 (Director of Nursing/DON) said when a resident has a fall the nurse should complete an assessment. The assessment should include ROM, neuro checks, any indicators of pain, and vital signs. If there are any visible injuries those would also be noted in the assessment along with anything that would be abnormal. After reviewing the progress notes for R1, she said it does not appear the ROM was checked, there is no location of his head injury and no neuro assessment. The ROM would be important because if something is broken, you want the resident to stay in place until the ambulance arrives.On 10/30/25 at 2:15 PM, V1 (Administrator) stated the facility had no specific policy regarding resident assessments after a fall, but the nurse should have documented the ROM and neurologic assessment, or details why it could not be completed.