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	IL6010078	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation 2591365/IL186625 Facility Reported Incident of February 15, 2025/IL186902	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999		

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a post fall assessment of a resident immediately following a fall; failed to	S9999		

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ensure a resident's physician was notified after a fall; failed to ensure residents received medications as ordered by the physician; and failed to ensure the physician was notified of abnormal lab results. These failures applied to three of four residents (R3, R4, R5) reviewed for quality of care and resulted in R3 having a delay in care of approximately two days after a fall in which R3 was found to have a hip fracture that required surgical intervention.

Findings include:

1. R3 is a 73-year-old male with a diagnoses history of COPD, Heart Failure, Unspecified Convulsions, and Alcohol Abuse who was admitted to the facility 08/14/2024.

R3's Current Care Plan documents he is at risk for falls related to requiring assistance with activities of daily living and for transfers and mobility related tasks with interventions implemented 08/15/2024 including be sure call light is within reach and encourage the resident to use it for assistance as needed, staff to respond promptly to all requests for assistance, and complete the Fall Risk Review per the facility protocol.

R3's progress note created by V18 (Licensed Practical Nurse) dated 2/15/2025 at 2:17 PM documents resident appears to be more confused in a.m. and not verbally understood by writer, refused to eat breakfast/lunch even with encouragement/setup, resident is also losing control of bowel/bladder, refuses to get out of bed to toilet self as he normally does or sit up to eat; Orders received to send resident out for altered mental status and failure to thrive; at 4:52 PM writer received call from the hospital charge nurse

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stated that resident is being admitted for left hip fracture, that left leg is inverted, rotated and shorten, she also stated that fracture appears to be 48 hours old. Resident is scheduled for surgery in a.m.

R3's Fall Incident report dated 02/15/2025 documents he was sent to the hospital for evaluation and treatment due to change in condition and was informed by the hospital via phone on 02/15/2025 at approximately 4:52 PM that he had a left hip fracture.

Unusual Occurrence Final Investigative Report dated 02/19/2025 documents on 02/15/2025 at approximately 2:17 PM, R3 was sent to the hospital for evaluation due to refusal of meals, incontinence of bowel and bladder, and refusal to get out of the bed which were acute change of condition per nursing assessment. The nurse was informed by the hospital nurse at 4:30 PM that R3 had a left hip fracture and will be admitted to the hospital. Undated witness statement from V7 (Licensed Practical Nurse) documents on 02/14/2025 at 3:45 PM she was off duty and returned to the facility because she forgot her phone and observed aides running to a room to assist R3 off the floor, she assisted the aides at this time to remove R3 off the floor, observed him, and no pain was observed. Witness statement from R12 dated 02/15/2025 documents he reported R3 had a fall trying to pick up a resident that fell in their room and aides assisted R3 from the floor; Witness statements from R13 dated 02/15/2025 documents he reported R3 fell. It was daylight at the time and aides assisted him from off the floor; Witness statement from V18 (Licensed Practical Nurse) dated 02/15/2025 documents she reported his roommates informed that he fell two days ago in their room and aides

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picked him up off the floor; Witness statement from V9 (Certified Nursing Assistant) dated 02/17/2025 documents she reported she worked from 3-11 PM on Friday and approximately between 3:30 - 4PM she observed R3 on the floor, the nurse checked him and helped place R3 on his bed. R3's roommates reported R3 was trying to help R9 up and fell.

R3's hospital report dated 02/15/2025 documents he was admitted from the nursing home for lethargy but noted at baseline while at the emergency department and instead found to have a left thigh fracture and is unable to explain how he fell. R3 was assessed to have an acute fracture of the left hip and the circumstances of the fall are unclear; patient with a high level of risk based on: acute or chronic illnesses or injury which poses a threat to life or bodily function; he is a 73 year old male presenting with a fall at the nursing home and left thigh fracture and underwent surgical treatment for fracture on 02/16/2025; the etiology of the fall is unclear, suspect mechanical.

On 02/25/2025 at 12:27 PM V2 (Director of Nursing) stated she completed the investigation on 02/19/2025 for R3's fall that occurred 02/15/2025. V2 stated there was confusion about his fall and they were trying to determine when R3 had a fall. V2 stated she concluded after the investigation that R3 had a fracture. V2 stated she wanted to go back to 02/14/2025 because someone said he fell two days ago but he was up and walking on 02/15/2025 so she said that couldn't be correct.

On 02/25/2025 at 2:07 PM V2 (Director of Nursing) stated V7 (Licensed Practical Nurse) was suspended for three days because she did

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not complete an incident report for R3's fall because she said she was off the clock when R3 fell. V2 stated V7 assisted the aides with getting R3 up after he fell on 02/14/2025 and then left the facility immediately after. V2 stated V7 should have let someone know R3 had a fall. V2 stated V7 will be terminated because she failed to inform anyone about a fall that resulted in an injury. V2 stated an injury could occur due to failure to report a fall or failure to properly assess a resident after a fall. V2 stated if you continue to put pressure on an injury after a fall that could result in harm.

On 02/25/2025 at 2:52 PM V8 (Certified Nursing Assistant) stated at approximately 3:15 PM on 02/14/2025 as she was entering the unit where R3 's room was located V9 (Certified Nursing Assistant) observed R9 crawling on the floor. V8 stated V9 informed her of this as well as V7 (Licensed Practical Nurse). The nurse walked with her (V8) and V9 towards R9. V8 stated she found R9 crawling on all fours directly outside of R3 's room. V8 stated once they made it to the doorway of R3's room on the other side of the threshold, R3 was laid out parallel to the wall. V8 stated V7 stated R3's was on the floor too. V8 stated V7 then asked R3 if he was ok, what was he doing, asked him if he hit his head then answered for him no you didn't hit your head then instructed her (V7) and V9 to get him up. V8 stated V9 and V7 then assisted R3 off the floor, then she (V8) and V9 helped R9 up into her wheelchair and placed R9 at the nurses station. V8 stated V7 said she's not reporting it, she was ready to go, they didn't hit their head and they're alright. V8 stated V7 then sat at the nurses station until approximately 3:30 then left the facility. V8 stated V7 did not perform an assessment of R3 when he fell. V8 stated neither

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she nor V9 reported this to anyone else. V8 stated she was trained to report falls to the nurse and the nurse was present and aware of R3 's fall.

On 02/25/2025 3:21 PM V9 (Certified Nurse Assistant) stated on 02/14/2025 at approximately 3:15 PM she was coming in from getting a linen bag then approached the nurses station and could see R9 sitting on the floor. V9 stated she informed V7 (Licensed Practical Nurse) that R9 was on the floor. V9 stated then she, V7 and V8 (Certified Nursing Assistant) approached the threshold of R3 's room and observed R3 was on the floor. V9 stated V7 said R3 is on the floor too and then immediately went to assess R3. V9 stated V7 assessed R3's body by patting him on his head, arms, legs, and back and then asked her (V9) and V8 to help R3 into bed. V9 stated she's unsure of R3's response while V7 was assessing him. V9 stated during this time she was observing R9 who was just sitting on the floor. V9 stated she remained standing in R3's doorway in between R9 and R3 while V7 assessed R3. V9 stated V7 asked R3 if he was ok and if anything hurt but she doesn't recall his response. V9 stated R3 looked like he was in pain and grunted when she, V7, and V8 picked him up and placed him in his bed. V9 stated after they placed R9 in the wheelchair, V7 stated she was getting ready to leave then went and got her bags and things and left. V9 stated R9 didn't have any injuries and didn't show any signs of pain other than grunting while being picked up. V9 stated she believes R3 stayed in his bed the remainder of the shift.

On 02/25/2025 at 3:48 PM V2 (Director of Nursing) stated V7 (Licensed Practical Nurse) would have had a nurses note in R3 's medical

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records if an assessment was performed after he fell. V3 (Assistant Director of Nursing) stated a fall assessment, nurses note, incident report, and vital signs should all be documented in R3 's medical record along with notation of whether there was a loss of consciousness, complaints of pain, or changes in range of motion after a resident's fall.

R3's medical records did not include documentation of a fall assessment, nurses note, or incident report that included his vital sign measurements, level of consciousness, pain status, or assessment of his range of motion, or physician notification after his fall on 02/14/2025.

The facility's Fall Risk and Post Fall Assessment Policy and Procedures received 02/26/2025 states:
The purpose of the policy is "To conduct appropriate assessments after falls."
Post Fall Assessment Procedures include:
"conduct physical and mental status assessment, assess resident's airway breathing and circulation, note level of consciousness and perform neuro checks whenever there is potential for actual head injury, assess limb strength and motion by asking the resident if he has pain and the location of said pain; ask if he can do active range of motion."

The facility's Fall Policy and received 02/27/2025 states:
"Observed and reported by staff member. Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible causative factors."
"Assess for respiratory difficulties, bleeding and fractures."

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S9999	Continued From page 8 "Additional Measures include: Notify Physician." "Document all assessment findings and observations, physician and family notifications in the resident's clinical record in accordance with the assessment guidelines." The facility's Physician Orders Policy received 02/26/2025 states: "These guidelines are to ensure that: Changes in resident status/condition are assessed and physician notification is based on assessment findings; Any orders given by Physician are carried out." "Any calls to physician will be documented in the nurse's notes indicating information conveyed and received." (A)	S9999		