

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054833		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2026	
NAME OF PROVIDER OR SUPPLIER PRAIRIE OASIS				STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH , SOUTH HOLLAND, Illinois, 60473			
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S0000	Initial Comments Complaint Investigations 2691855/2741734, 2691510/2734861 Facility Reported Incident of 11/22/25/2686223		S0000			02/27/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3210t) 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 300.1210 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		S9999			02/27/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a hazard free environment for two (R1, R5) of 4 (R1, R2, R4 and R5) residents reviewed for hazards/supervision. This failure resulted in R1 getting out of bed and falling on an uncovered radiator heater resulting in R1 suffering second degree burns to the right shoulder and right hip and admitted to the hospital's burn intensive care unit for evaluation and treatment of severe burns. This failure also resulted in R5 suffering a laceration to the left eye that required sutures, subdural hematomas that required R5 to be admitted to the hospital's intensive care unit and ultimately resulted in admission to hospice due to the subdural hematoma. Findings include: 1. R1's face sheet documents diagnoses that include but are not limited to Alzheimer's Disease, dementia,		S9999				

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S9999	Continued from page 2 insomnia, palliative care, restlessness and agitation, and fall. R1's BIMS (brief interview for mental status) score, dated 11/11/25, is 7 which indicates R1's cognition is severely impaired. R1's FRI (facility reported incident), date and time of Occurrence: 2/7/26 at 5:15am, documents, in part, "Describe Occurrence: Observe on the floor upon rounds (R1). Blistering to the right shoulder and right hip. Resident (R1) was transferred to hospital for evaluation of blistered right shoulder and right hip. First aid was rendered per nurse and medicated for pain as ordered per MD (medical doctor). Resident (R1) was admitted to the hospital." Record review of facility document titled, "Attorney/Client Privilege," dated February 7, 2026, per V30 (Regional Nurse Consultant), documents, in part, "Received call this morning from V2 (Director of Nursing/DON) that a resident (R1) was observed lying on radiator and subsequently has burns on right shoulder and hip. Met with and spoke with assigned CNA (certified nursing assistant/V8). According to V8, she (V8) made rounds on resident (R1) initially when she (V8) arrived for work but did not make another round on her (R1) til "almost 5am". When asked why, she (V8) stated she (V8) was assisting "V9 (certified nursing assistant/CNA" with her (V9) residents in a certain room. Per punch time, CNA (V8) arrived to work at 10:55pm. CNA (V8) was very apologetic verbally and stated, "I hate that happened to her (R1). Unaware how resident ended up on floor. According to 11-7 (11:00pm to 7:00am) Charge Nurse (V3/Licensed Practical Nurse/LPN), she (V3) observed Resident (R1) lying on floor on right side of bed near the head of bed on her right side after being alerted by V8. Stated (and demonstrated position and location) the floor heat radiator cover was off, and Resident (R1) was right side lying directly on the radiator wedged between the bed and the wall. Unsure of how long Resident (R1) had been there. Stated the V8 came to get her (V3) for help. States Resident (R1) tends to favor right side and therefore, had rolled bath blankets to form a wedge on Resident's (R1) right side of bed to prevent rolling off on that side. Unaware how resident ended up on floor. Noticed (V30) intact dressings to right shoulder and right hip (R1) areas with moderate amount of break-thru serous drainage to shoulder area and small amount to hip area. After examining sites, dressings changed. Right shoulder (R1) has multiple clear fluid intact blistered areas (and some of which had burst) along with areas of pink flesh and charred color skin			S9999			

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S9999	Continued from page 3 in areas from outer shoulder to mid upper arm. Multiple areas of subcutaneous tissue noted. Right hip (R1) area presented with pink flesh and evident of burst blisters. Nurse (V3) stated that upon initial findings, the area had a large clear fluid filled blister that had burst. Multiple detached areas of skin sporadically noted at both sites' indicative of burst blisters and/or friction causing skin flaps. When repositioned resident (R1) moans and facial grimaces as if in pain. Charge Nurse (V3) stated she (V3) had given pain med already. Room observed upon entry. Radiator cover intact at that time, but Charge Nurse (V3) reports it wasn't at time of incident and that she (V3) replaced the cover. Rolled bath blankets to form a protective wedge noted on right side of bed with resident. Nurse (V3) stated she (V3) applied that after the incident in an effort to prevent further such incident. Probable cause is that Resident (R1) may have attempted to get out of bed alone from the right side, may have tripped and fell landing on the radiator, may have gotten wedged between bed and wall and could not get self-up." R1's hospital records, dated 2/7/26, documents, in part, "Patient (R1) allegedly fell asleep on a heater. A 71-year-old female with dementia (R1) presented with thermal burns to the shoulder, hip, and arm, reportedly sustained after prolonged contact with a heater overnight. The history was obtained from a caregiver at the nursing home. Pain: Traumatic. She (R1) is nonverbal and only mumbles words-Examination revealed full thickness burns on the shoulder, a large but less deep burn on the hip, and burn extension down the arm R (right) shoulder and R (right) hip with partial deep and deep thickness burns with surrounding superficial burns. Dead skin present. Appears to be tender to palpation. Moans to pain. Presentation is most concerning for burns from falling asleep near heater. Will admit to burn ICU (intensive care unit) for resuscitation. Second degree burn of shoulder and upper extremity except wrist and hand, initial encounter. Surgical Procedure(s): Skin transplant; debridement of right shoulder and hip; possible allograft, autograft or synthetic material. Operative Procedure: The hip wound was excised tangentially down to punctate bleeding tissue. The arm was deeper, down to and through some of the deltoid muscle. There was a peninsula burn on the lower arm, which was excised and was able to be closed primarily with buried intradermal sutures. Thin split-thickness skin grafts were then harvested and carefully applied to the exact size and shape of the wounds. They were secured in place with staples. On the arm, a total of 400 cm2 of wound was excised with 150 cm2 from the right lower extremity and			S9999			

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S9999	Continued from page 4 250 cm2 from the right upper extremity. The deepest layer on the right upper extremity was muscle. The 400 cm2 of excised wound was closed with split-thickness skin graft, 150 cm2 to right lower extremity and 250 cm2 to the right upper extremity. Pt (patient/R1) nonverbal, does not follow commands, arms and legs stiff, strength 3/5. Pt moans and resists to pain. Poor tolerance to dressing change. Dressing: R Hip -Pink, moist, blanchable -moderate serous drainage, no odor -debrided, cleansed plus large burn. R shoulder/back -pink, red, white, serosanguinous drainage, no odor, mixed, some areas non blanching (center, white area), debrided/cleansed." R1's progress note, dated 2/07/26 at 5:15am, per V3 (Licensed Practical Nurse/LPN), documents, in part, "Nurse (V3) was called in the room by V8 (Certified Nursing Assistant/CNA) when entering the room resident (R1) was on the right side of the bed lying on her (R1) right side next to the wall. Staff transferred resident (R1) back to bed with 2 assist and she (R1) was positioned in bed for comfort call light within reach. Resident (R1) has no verbal complaints of pain. Upon body assessment blistered area was noted to her right shoulder and her right hip. MD (medical doctor) notified of incident new orders given to transfer resident to ER (emergency room) for further Eval. (evaluation). Attempted to notify family with no answer." R1's progress note, dated 2/07/26 at 8:39am, per V4 (Licensed Practical Nurse/LPN), documents, in part, "endorsed from previous nurse resident (R1) will be transferring to (hospital) for eval (evaluation) of impaired skin integrity (ambulance) currently in facility for departure." R1's progress note, dated 2/07/26 at 1:45pm, per V4 (Licensed Practical Nurse/LPN), documents, in part, "writer contacted (hospital) and spoke with ER (emergency room) Nurse. Writer was made aware resident (R1) is being transferred to (another/different hospital). Please F/U (follow up)." R1's progress note, dated 2/07/26 at 6:45pm, per V5 (Licensed Practical Nurse/LPN) documents, in part, "Resident (R1) admitted to the (hospital) d/t (due to) severe burns on right shoulder and right hip. DON (Director of Nursing/DON) made aware. all personal belongings remains in room and Medications secured on med Cart." R1's Ambulance Run Record, dated 2/07/2026, documents, in part, "AVPU (alert, verbal, pain, unresponsive):			S9999			

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S9999	Continued from page 5 Painful, pain score of 5/10; Ambulance dispatched to (nursing home) for an emergency call due to a burn. The pt (patient) is a 71-year-old female (R1) getting transported to hospital er (emergency room). The pt is in need of ambulance services due to having dementia, unable to ambulate, bed confined, and muscle weakness." R1's "Transfers and Bed Mobility/Limited lift review (Nursing/restorative)," dated 11/12/25, documents, in part, "Bed Mobility: Roll left and right: Partial/Moderate assistance; Sit to lying: Substantial/Maximal assistance; and Lying to sitting on side of bed: Substantial/Maximal assistance. Transfer Ability: Sit to stand: Substantial/Maximal assistance; Chair/bed-to-chair transfer: Substantial/Maximal assistance. Ability to maintain standing balance: Poor; Recommendations for Transfers: Resident (R1) will be designated as "Substantial/maximal" assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort; Recommendations for Bed Mobility Physical Assistance Needs: "Substantial/maximal" assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort; and Bed Mobility Symbol Assignment: Residents requires a one person physical assistance from staff for bed mobility." R1's care plan, dated 8/11/25, documents, in part, "(R1) is at risk for falls R/T (related to) impaired mobility, history of falls," with a goal that documents, in part, "(R1) will have a safe environment maintained thru the next review," and with interventions that documents, in part, "Anticipate and meet individual needs of the resident (R1)." R1's care plan, dated 8/12/25, documents, in part, "(R1) presents with poor balance, decreased strength & impaired ambulation secondary to: unspecified dementia, unspecified severity, with other behavioral disturbance," with a goal that documents, in part, "(R1) will not sustain a fall related injury by the next review," and with interventions that documents, in part, "Assist resident (R1) to a standing position." R1's care plan, dated 11/12/25, documents, in part, "(R1) has an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Confusion, Dementia, Impaired Balance, Limited Mobility;" with a goal that documents, in part, "(R1) will remain free of complications related to immobility, including contractures, thrombus formation, skin breakdown, fall		S9999				

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S9999	Continued from page 6 related injuries through the next review," and interventions that documents, in part, "Bed mobility - the resident (R1) requires (1) staff member(s) to turn and reposition. Transfer - the resident (R1) requires the assistance of (1) staff member(s) when transferring." R1's care plan, dated 11/12/25, documents, in part, "(R1) has a "Self-Care Deficit" related to (Cognitive impairment, Limited Mobility, Dementia) and requires assistance with Bed mobility. Resident(R1) will benefit from participation in a Bed mobility program," with interventions that documents, in part, "Assist the resident (R1) with turning/positioning and finding a comfortable position as needed." R1's care plan, dated 11/12/25, documents, in part, "(R1) has been assessed and has been determined to need a mechanical lift for transfers R/t (related to): Will be designated as "ONE PERSON ASSIST", as they (R1) require Limited Assist and up to Extensive Assist with no more than 25% wt. (weight) bearing assistance. 1 = One Person Assistance, Impaired Cognition, Impaired Communication," with interventions that documents, in part, "Transfer with 1 staff assistance." R1's care plan, dated 10/01/25, documents, in part, "(R1) terminal illness - Alteration in Comfort R/T: Hospice," with interventions that documents, in part, "Provide cares per resident(R1) &/or family wishes to achieve acceptable level of comfort. Provide re-positioning per skin care plan and PRN (as needed) for comfort." R1's care plan, dated 11/12/25, documents, in part, "(R1) has limited physical mobility r/t Cognitive impairment, Limited Mobility, Dementia," with interventions that documents, in part, "MOBILITY: The resident requires (1) staff participation for mobility. Provide supportive care, assistance with mobility as needed. Document assistance as needed." On 2/12/26 on 10:01am, V1 (Administrator) said, "I was called early Saturday (2/07/26) in morning for a fall with injury and immediately came here (facility). It (fall with injury) was her (R1). She (R1) was going to be sent out. About 5:00am R1's fall with injury occurred. She (R1) was laying against the radiator, and the cover was knocked off. No, the cover to the		S9999				

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S9999	Continued from page 7 radiator (R1's radiator heater) was not attached. I think it (radiator cover) came off when she (R1) fell out of bed. We (facility staff) completed a review of the whole facility's radiator heaters that day (2/07/26) and made sure all covers were secure. We (facility staff) did a FRI (facility reported incident)." On 2/12/26 at 10:08am, with V1 (Administrator) and V2 (Director of Nursing/DON), the cover to the radiator heater in R9, R1, R11, R12's was observed not secured and partially coming off. V7 (Maintenance Director/Housekeeping Manager) was called to room this by V1 and V7 stated, "Yeah, this (radiator heater cover in room 101) is loose, it requires more screws (observed after V1 stated an audit of the whole facility's radiator covers was done). The boilers are set to bring out 30 degrees Fahrenheit and the PTAC units in the room are both a heating and cooling system. The PTAC units can change the temperature per the residents desire." On 2/12/2026 at 11:42am, V3 (Licensed Practical Nurse/LPN) said, "Yes, I was the nurse (2/07/26, R1 fall with injury). Basically, I was called by CNA (V8/certified nursing assistant). The resident (R1) has a low bed and was found in between the bed and the heater. At the time when I entered the room, yes it (radiator heater cover) was off. I'm not sure if it (radiator heater cover) bumped off. V8 and I assisted R1 back to bed and I did a body assessment. It looked like blisters on the right shoulder and right hip. The skin (R1) was blistering up from shoulder going down. About 2x2 inches in size. The right hip was about 2x2 inches in size as well. I called the physician, got orders, applied dressings, and called an ambulance. R1 was sent to (hospital). I checked on her like 3:00am or 3:15am and she (R1) was sleeping. Yes, I actually seen her (R1). I can't remember if the curtain was closed. Yes, she (R1) can be very impulsive. She (R1) usually has someone (staff) with her (R1) all the time. R1 is at the nurse's station a lot. She's (R1) confused and not steady on her (R1) feet." On 2/12/2026 at 12:06pm, V8 (Certified Nursing Assistant/CNA) said, "Yes, she (R1) was one of the patients I had. I did work that day (2/07/26, R1 fall with injury). When I discovered she (R1) fell, she (R1) fell between bed and heater, and was burned on her (R1) arm and hip. The side of her (R1) was laying on the heater. The heater did not have a cover on. I am so		S9999				

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S9999	Continued from page 8 sorry that happened. I wish it didn't happen. It's (radiator heater cover) been off for some period of time. So many months back, it was over 9 months (radiator heater cover not secured). I don't know if anyone had reported it (radiator heater cover not secured). Another nurse V11 (Licensed Practical Nurse/LPN) can vouch for the radiator heater cover coming off all the time (prior to 2/07/26, R1 fall with injury). It (R1's burns) was nice size area (R1's burns). Sorta burned on both areas (right arm and right hip). Can't really give an approximate length. It happened around 5:15am (2/07/26). The last time I seen R1 before the fall was not at all. I didn't see her (R1) at all that shift. R1's curtain was pulled all the way across. My shift is from 11:00pm to 7:00am. Another CNA (V9/certified nursing assistant) asked me to help with another resident to put back to bed, and then I started doing POCs (point of care). We (night shift CNAs) come in at 11:00pm and are supposed to check on all the residents, but I didn't because I helped put another resident back to bed. I went back to my area, washed my hands, and started to put patient's POCs in the computer. I don't think there is enough staff to do everything we (staff) need to do. It probably took a good 30 minutes to help V9 get the resident back in bed. I was behind so I started on my POCs. Even if there is not a call off, which most of the time there is a call off, we (facility) could use another CNA, especially for the confused residents. I wanna say this here. When they (V2/Director of Nursing/DON) had called me and said they (V2) had to terminate me, I knew I should have done my rounds every 2 hours. I enjoyed working there. I was negligent, but the LPN is supposed to check them (residents) every 2 hours too. They (facility) terminated me because of this incident. V2 called me. There's not enough staff to take care of the confused residents. R1 should be a 1:1 all day and all night. She's (R1) confused and tries to get up all the time. No, she (R1) is not steady on her (R1) feet." Record review of V8's (certified nursing assistant/CNA) "Corrective Action," dated 2/10/26, documents, in part, "Reason for warning: CNA (V8) failed to make rounds every 2 hours as per facility protocol. CNA (V8) admits to rounding initially (11:00pm) and then again at 4:45am-5am. Resident (R1) on assignment fell causing multiple burns to body resulting in hospitalization. Relevant company/CBA policy violated: CBA pg. 38 #7 Physical or verbal abuse, neglect, or attempting to injure residents or other person Corrective action required: Termination."			S9999			

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S9999	Continued from page 9 On 2/12/26 at 12:39pm, V7 (Maintenance Director/Housekeeping) said that there's no documentation that we (facility) check the radiator heaters regularly, but we (facility) did start documenting heater checks the day (2/07/26) R1 fell. I was never notified of the heater being broken prior to the incident (2/07/26, R1 fall with injury). I was involved in checking the radiator heaters throughout the whole facility. 2 screws on each end were needed to secure the heater's cover. Just 2 heater covers weren't secured, and the rooms were R1's and now R9, R10, R11, R12's room. I'm not sure how all the rooms radiator heater's cover were checked and R9, R10, R11, R12's cover was still loose and needed 2 more screws today (2/12/26). It (R9, R10, R11, R12's room radiator cover) could have just became loose since the inspection (2/07/26)." On 2/12/26 at 1:01pm, V2 (Director of Nursing) said, "I was not aware that it (R1's radiator heater cover) had been previously broken. V3 called me at 5:00a.m. (2/07/26) to inform me that the CNA (V8) admitted she (V8) did not complete her (V8) rounding. She (V8) is a good CNA. I would switch her (V8) with some of the younger staff members. There is no documented evidence that any staff member went in and seen R1 prior to her (R1) fall (2/07/26, R1 fall with injury). R1 is confused. The staff are good at watching her (R1). No, I don't think she (R1) required 1:1 supervision. Yes, she (R1) can be impulsive and a fall risk." On 2/12/26 at 2:05pm, V7 (Maintenance Director/Housekeeping Manager) said, "Again, we (facility staff) were not documenting that we (facility staff) were checking the radiator heaters regularly, but we (facility) did start documenting heater checks the day R1 fell. We (facility staff) were just taking hot water temperatures, 6 rooms per week and the common area temperatures. Maintenance and housekeeping should be checking the radiator heaters daily, but there is no documented protocol for that until now. The facility has 2 types of heating systems. The radiators which is heated using 2 boilers, heats the whole facility. The boilers (two of them) are set at 72 degrees Fahrenheit, but the pressure is set let out 30 degrees Fahrenheit so when the boiler temperature reach the radiator, 30 degrees Fahrenheit is only let out. The PTAC unit subsidizes heat. The PTAC is forced air only and is thermostat controlled. On 2/12/26, V32, Physician said, "They (facility staff) called me and said she (R1) was laying on a heater and developed blisters (2/07/26). I don't know, I'm not a specialist. Try calling the hospital where she (R1) is		S9999				

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S9999	Continued from page 10 at about the burns. Burns from a heater all depends on nutrition, age, and comorbidities. I don't know. Talk with hospice regarding pain and burns. Hospice is really good at keeping resident's pain under control." On 2/13/26 at 11:35am, V15, Hospice Registered Nurse/RN said, "Yes, I am familiar with R1. End-stage Alzheimer's disease was her (R1) hospice diagnosis. She (R1) is alert with reduced spontaneity and alert to self only. She (R1) has episodes of confusion, more so in the evening, during which she (R1) becomes agitated. She (R1) is at high risk for falls because she (R1) attempts to get up on her (R1) own. She (R1) believes she (R1) can do things independently but is unable to do so safely. She (R1) is a feeder and requires total care. She (R1) is on a pureed diet and is at risk for aspiration. She (R1) had a seizure a few months ago. Her (R1) skin is intact, and she (R1) is incontinent. She (R1) has never really expressed pain, though she (R1) occasionally demonstrates facial grimacing. Music therapy is used to help calm her (R1). She (R1) requires total care with ADLs (activities of daily living). On a couple of occasions, she (R1) fed herself and participated minimally in washing up. Her (R1) cognition is impaired. She (R1) responds to simple yes or no questions but does not provide details. She (R1) does not speak much. I (R1) saw her (R1) on the 6th (2/06/26) and had been following her (R1) since August 10, 2025. Most of the time, she (R1) is in the dining room or at the nurse's station with staff, especially in the evening when she (R1) sundowns. Not only was she (R1) transported by 911 to (hospital), but she (R1) was also admitted. Since we (hospice staff) did not know the reason for admission, we (hospice staff) had to discharge her (R1) from hospice so the hospital could complete any necessary interventions." On 2/13/2026 at 3:04 pm, V9 (Certified Nursing Assistant/CNA) said, "Yes, V8 (certified nursing assistant/CNA) helped me put a resident back to bed that night (2/6/26) at the start of the shift. The resident was in a geri-chair attempting to get out; however, she (resident) did not fall out of the chair. I cannot remember which resident. The radiator cover (R1's) was not intact or secured, and it would come off before R1 fell and was burned (2/07/26). I really cannot recall the details because I am usually not assigned to that area. I cannot say how long it (R1's radiator heater cover) had been broken, but it was broken before that day (2/07/26). I'm sorry, I do not know for how long." On 2/13/26 at 1:16pm, V16, Hospice Physician said, "R1 is a cognitively impaired patient with dementia. She		S9999				

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S9999	Continued from page 11 (R1) speaks very little, and when she (R1) does, her (R1) speech is mostly nonsensical. She (R1) is prone to agitation, has impaired judgment, and demonstrates nonsensical speech. Her (R1) balance is poor, she (R1) experiences sleep disturbances, and she (R1) is at high risk for falls. Blistering of the skin can be painful and also places her at risk for infection." On 2/13/26 at 4:18pm, V11 (Licensed Practical Nurse/LPN) said, "I work from 11:00 p.m. to 7:00 a.m. I did not work that day (2/6/26). I work every other weekend. Yes, I am familiar with her (R1). She (R1) was on hospice and would frequently attempt to get up and fall. I do not know why housekeeping did not notice the issue (R1's radiator heat covered not secured). It (R1's radiator heater) was in disrepair. I am not aware of whether anyone reported it (unsecured radiator heater cover in R1's room). To my knowledge, it (R1's radiator heat cover not secured) had been that way for at least a couple of months. Housekeeping staff come in and clean every day, and never did anything about the radiator. I have not been there recently, so I cannot provide additional information." On 2/14/26 at 11:34am, V7 (Maintenance Director/Housekeeping Manager), "She's (R1) thin, and I believe she (R1) can fit right in between the radiator and the floor. Like nudged in between. I believe it was like a noodle, but not a wet noodle. A noodle is kinda thin, and if you lay it on the radiator, even if it's a 30 degree Fahrenheit it'll still burn the skin." 2. R5's face sheet documents in part the following diagnoses: unspecified dementia, severe with other behavioral disturbance, traumatic subdural hemorrhage with loss of consciousness, age related osteoporosis, altered mental status, unspecified fall, lymphedema, moderate protein calorie malnutrition, muscle wasting and atrophy, and vertigo. R5 was admitted to the facility on 11/3/2025. R5's admission records CT of Brain (10/30/2025) documents "Findings: The Ventricles and Sulci are within normal limits, without hydrocephalus. No extra-axial fluid collection is identified. There is no intracranial hemorrhage or focal mass effect. No midline shift is visualized. Impression: 1. No intracranial hemorrhage or mass effect". R5's Minimum Data Set (11/10/2025) documents in part a brief interview of mental status (BIMS) summary score of 8, indicating that R5 has cognitive impairment and requires supervision with activities of daily living.		S9999				

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S9999	Continued from page 12 Additionally, the minimum data set does not document any use of anti-coagulation or anti-platelet use during the look-back period. R5's fall risk assessment (11/22/2026) documents in part the R5 is at high risk for falls. R5's care plan documents in part that R5 has a history of falls due to dizziness, vertigo, dementia and altered mental status. R5 has interventions including but not limited to: "Educate (R5's)/family/caregivers about safety reminders and what to do if a fall occurs." (11/14/2025), "Ensure that (R5) is wearing appropriate footwear (Specify and describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in w/c." (11/14/2025), Monitor resident when up and ambulating and encourage resident to participate in activities." (11/24/2025), "Be sure (R5's) call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. (11/14/2025), and "Anticipate and meet the resident's needs" (11/14/2025). On 2/13/2026 at 11:07 AM, observed R5 sitting in a wheeled recliner in the dining room with V13 (R5's Family Member). Observed approximately 2.5-inch scar over R5's left eyelid. R5 stated, "I fell 2 times," and held up 2 fingers. R5 stated, "it was painful". R5 was confused and unable to answer further questions. V13 explained, "Yes, I do know that (R5) has had multiple falls here (at the facility). You can see the scar on (R5's) eyelid, that's from when (R5) had the brain bleed. I don't know how much mentally (R5) has changed, but (R5) doesn't walk anymore. (R5) was placed on hospice by (Family Member) due to the bleed, we were under the impression that (R5) was going to die any minute, but (R5) is still here. I have not received any education from the facility about safety measures and what to do when a fall occurs". R5's progress notes n 11/22/2025 at 3:47 PM, documents, "Resident was walking in hallway after visitor left at 3:25pm. CNA (Certified Nursing Assistant) brought resident to nurses station stated that resident fell in hallway. Fall was unwitnessed resident observed bleeding from eyebrow area small laceration over left eye. Residents did not remember falling. Assessed resident found no other injuries cleaned wound and applied ice for swelling. (Private Ambulance Company) initially called would take more than an hour, 911 then called 171/78 P88 97.8 R18 O2 96% r/a. Family and DON		S9999				

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S9999	Continued from page 13 notified. Neuro checks are to begin". At 23:36, "Follow up call to hospital resident has subdural hematoma. Will remain for observation". R5's progress notes do not indicate that R5's family was educated on safety reminders and what to do if a fall occurs per the care plan prior to this fall. No evidence was presented to the survey team prior to the exit of the survey that documents that the facility educated the family on safety reminders/what to do if a fall occurs prior to the exit of the survey. Facility's incident report for R5's fall on 11/22/2025 at 3:25 PM, documents, "Resident was found on the floor in the hallway by the CNA resident did not remember falling... Resident taken to hospital? Y (Yes). Injury Type: Laceration Injury Location: 59) Left Forehead. Predisposing Physiological Factors Confused, Gait imbalance Predisposing Situation Factors: Improper Footwear". R5's discharge Minimum Data Set (11/22/2025) does not document that R5 had any use of anti-coagulation or anti-platelet use during the look-back period (including the date of the fall). Hospital records (11/22/2025) document in part, "Principal/Secondary diagnosis Subdural hematoma-likely subacute- no neurosurgical intervention, dementia- continue supportive care, anemia- no acute blood loss, Mild Renal Insufficiency...Concise Hospital Course and Treatment Plan Status Post Fall Subacute Hematoma Patient was seen by neurosurgery- was monitored closely with neuro checks frequent No need for surgical intervention. Patient to be seen by PT OT- discharge back to skilled nursing facility with fall precautions... left eyelid laceration no evidence of infection...(R5) is a 79-year old lady in nursing home resident- Prairie Oasis. She does have a history of cognitive impairment dementia. Patient was admitted from skilled nursing facility following a fall. Was found to have subdural hematoma. Patient was admitted to the medical floor with neurosurgery on consult...". R5's progress notes on 11/24/2025 at 5:56 PM, documents, "Resident returned from (Hospital) per Stretcher in stable condition. dx: Subdural Hematoma s/p fall no redness or drainage noted. (R5) have sutures to the left brow. Follow up in 3 weeks neurosurgery (ADDRESS REDACTED) (ADVANCED PRACTICE NURSE) recommends PT/OT to reevaluate, will repeat the head CT in four weeks & CBC in week time. v/s 142/88 P 56 R 17 T 97.6 no change in medications" On 2/17/2026 at 1:50 PM, V24 (Certified Nursing			S9999			

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S9999	Continued from page 14 Assistant) affirmed that V24 was assigned to care for R5 on 11/22/2025 when (R5) had fell. V24 explained, "I definitely remember that day. (R5) was visiting with family in the dining room. One of my other residents I was assigned to was unstable, having a lot of behaviors, so I was trying to manage that. During that time, I remember (R5) walking with the family member out of the dining room. The next thing I know, I heard (R5) had fallen in the hallway. I don't recall the family member there then, I recall (R5) sitting at the nurse's station with a knot on her head. It was like the size of a quarter. Ever since that fall, (R5) has had more mobility issues and stability issues. (R5) used to be up walking but since that fall, (R5) has been in a wheelchair since. I think what happened was the family left (R5) in the room alone... I don't know why someone would leave (R5) alone." V24 affirmed that R5 is confused at baseline and can be impulsive. On 2/18/2026 at 5:08 PM, V40 (Licensed Practical Nurse) affirmed that V40 no longer works at the facility but was assigned to care for R5 on 11/22/2025 when R5 fell. V40 explained, "From what I can remember, (R5) was visiting a family member and then R5 fell in the hallway. I saw (R5) and the family member in the dining room before the fall. I remember (R5) had a laceration to her eye and was bleeding. I sent (R5) to the hospital for evaluation, and she got stitches for the laceration". V40 was unsure what footwear R5 was wearing at the time of the fall. V40 stated, "(R5) is very confused and has a history of dementia. (R5) can be really stubborn and hard-headed too as part of her disease process, so she can be resistive to cares. I don't know if (R5) needs more supervision than the average resident, but (R5) is impulsive. (R5) does have a history of behaviors". R5's progress notes on 12/18/2025 at 8:45 AM, documents, "Writer spoke to RN (REDACTED), Resident is admitted to (REDACTED) Hospital, Dx: Subdural Hematoma. management notified." There is no documentation of a fall within R5's progress notes for this incident. Facility's incident report for R5's fall on 12/17/2025 at 10:00 PM, documents "Resident observed on the floor in her room lying on the left side by her bed. observed a raised area on her left cheek bone. no open area or bruising noted. able to move all extremities without moving... (V36, Physician) notified. Send resident to hospital if unable to start IV fluids... Resident taken to hospital? Y (Yes)... Injury type: other Injury location: 4) Face... Level of consciousness confused/disoriented..."			S9999			

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S9999	Continued from page 15 R5's Hospital Records (12/18/2025) document in part, "(R5) is a 79Yrs-old female with a history of dementia lymphedema, osteoporosis, cardiomegaly, and vertigo presented to ED from NH (nursing home) via EMS for fall. Per EMS, pt fell and hit her head. Pt also has failure to thrive and is actively declining. Refusing medications and meals at nursing home... CT shows large right subdural hematoma with increased mass effect and midline shift, neurosurgery was consulted from ED with recommendations to admit to ICU and Keppra 500 mg twice daily... Patient is critically ill with subdural hematoma requiring close monitoring of neuro checks..." CT of the head was completed during the hospitalization (and compared to the 11/23/2025 CT) documenting, "Findings: Large right subdural hematoma, significantly increased in size. Currently 2.5 cm and previously 1.6 cm thickness. Significant mass effect on right cerebral sulci increased. Midline shift towards the left measures 0.4 cm, previously 0.2 cm. Effacement of right lateral ventricle posterior horn is increased. No ventricular dilation. No dilation of the temporal horn. No intraventricular hemorrhage... Impression: Large right subdural hematoma, significantly increased. Increased mass effect and midline shift..." R5's hospitalist physician documented on 12/18/2025, "...The risk associated with the patient's management today was critical (resulting from brain compression, subdural hematoma). I spoke with (the patient's POA). I had spoken (with the patient's POA) on the patient's last admission. The patient has had a steady decline since being admitted to the nursing home. But at baseline, she can walk the halls, feed herself and dress herself but does not always know the year and can get frustrated easily. I discussed with (the POA) that the subdural hematoma is causing additional compression and (R5) is symptomatic, slightly lethargic with left-sided weakness. Surgery can help with this situation but if the dementia has been progressively advancing, the surgery may not result in (R5) getting back to (R5's) baseline. We reviewed that surgical evacuation can be done safely, but it is more important to consider functional outcomes and if (R5) would have wanted a procedure like that. (The POA) is going to consider hospice vs. hematoma evacuation..." R5's discharge Minimum Data Set (12/17/2025) does not document that R5 had any use of anti-coagulation or anti-platelet use during the look-back period (including the date of the fall). R5's physician orders (12/26/2025) document in part R5's order to admit to hospice care and do not document any current or historical use of anti-coagulant/anti-platelet medications.			S9999			

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S9999	Continued from page 16 R5's progress notes on 12/20/2025 at 10:55 PM, document, "Receive resident from hospital, Color good, lungs, skin warm and dry to touch. No noted or voice pain, distress, congestion, SOB, at this time. Skin assessment shows singles lumen lv site to both lower arms. Resident alert, moving around and sitting up in bed. Mouth dry, lips dry, oral care done via CNA. Tissue intact, with dime sizes surface scab area to left knee. Resident has no teeth. Visual and auditory skills in normal range. Vitals 123/77-18-98% room air-temp 97.3-pulse 52. (V36, Physician) paged. Bed in low position. Staff receive close monitor, due to resident already sitting up in bed." On 12/20/2025, "Hospice Eval to be done" and "Admission Diagnosis subdural hematoma". On 1/5/2026, "Resident observed for Significant Change in Status MDS 2/2 overall declines in ADLs and admissions to hospice services" R5's Significant Change Minimum Data Set (1/5/2025) documents in part a BIMS summary score of 5, indicating severe cognitive impairment and requires maximum assistance/is dependent on staff for activities of daily living. Additionally, the Minimum Data Set does not document any use of anti-coagulation or anti-platelet use during the look-back period. This indicates that in comparison to the MDS (11/10/2025), R5 has had significant cognitive decline and significant decline in activities of daily living. On 2/13/2024 at 3:22 PM, V5 (Licensed Practical Nurse) affirmed that V5 is familiar with R5 and has been assigned to care for R5 in the past. V5 affirmed that V5 was assigned to care for R5 when R5 had a fall on 12/17/2026. V5 explained V5 went into R5's room and observed R5 on the ground. V5 could not recall exactly what happened, but V5 remembered R5 did have a fall and had a raised area to R5's cheek. V5 placed R5 at the nurse's station, called R5's physician and sent R5 to the hospital for evaluation. R5 came back on hospice. V5 recalled that R5's call light was within reach but R5 "probably doesn't have the cognition to be able to use a call light". V5 stated, "Yes, (R5) needs a lot of supervision. (R5) is often 1:1 monitoring when up, (R5) needs that. You can't leave (R5) alone, (R5) needs to be in your eyesight". When asked why R1 was left alone in the room at the time of the fall, V5 stated, "(R5) was in bed. There's no intervention that I know of for increased monitoring when in bed, it's just standard of practice rounds, every 2 hours". When asked if R5 was wearing proper footwear when R5 fell, V5 replied, "When (R5) fell, (R5) had been in bed, so I don't think (R5) would have been wearing any footwear". V5 stated that after the incident report is completed, it is supposed		S9999				

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S9999	Continued from page 17 to carry over to the progress notes, so V5 was unsure why the incident report didn't carry over. On 2/17/2026 at 11:31 AM, V36, Physician affirmed V36 is R5's primary care physician. V36 stated, "I am unsure if (R5's) subdural hematoma was chronic vs acute, I do not know of any history of any subdural hematoma prior to (R5's) admission. Subdural hematomas in nature are generally caused by trauma. Sometimes they can be caused by blood thinners-- was (R5) on any blood thinners? If (R5) wasn't on blood thinners, then I don't know. I know in the hospital they were discussing about surgery, but I don't think (R5) was a candidate, so they admitted (R5) to hospice. I agree with the hospice admission". On 2/18/2026 at 2:17 PM, V2, Director of Nursing affirmed that V2 is responsible for managing the fall programming in the facility. V2 affirmed that V2 was familiar with R5 and affirmed that R5 had a history of falls. V2 reviewed R5's care plan and fall reports. V2 could not recall the specifics of R5's falls. V2 stated, "after the first fall, I put in the care plan for R5 to be monitored while up and for increased activities." V2 affirmed that R5's care plan does not address any increased supervision needs while in bed or in the resident room. V2 stated, "(R5) has dementia, she's alert but confused. She can be impulsive and likes to move around. Residents with dementia, in general, need more supervision. We have a lot of residents with dementia here". V2 reviewed R5's electronic health record and stated, "I cannot find anything that documents (R5) did not have the brain bleed prior to the fall". V2 affirmed that V2 could not locate documentation that R5's family members were in-serviced on safety measures and what to do if a fall occurred. Record review of facility's policy titled, "Supervision and Safety," dated 3/15, documents, in part, "Policy: Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Our facility-orientated approach to safety addresses risks for groups of residents such as wanderers, behaviors, aggressiveness, confusion, etc. Safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. Staff will use various sources to identify resident risk factors. Resident supervision is a core component to resident safety. Rounds should be made at least every 2 hours. The type and frequency of supervision is determined by the individual resident assessment needs. Staff to decrease safety risk factors as much as		S9999				

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NAME OF PROVIDER OR SUPPLIER PRAIRIE OASIS				STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH , SOUTH HOLLAND, Illinois, 60473			
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S9999	Continued from page 18 possible. Staff to make visual rounds on residents minimally every two hours and more often if necessary based on residents' assessment needs." Record review of facility's policy titled, "Fall Prevention Program," dated 2/10/26, documents, in part, "Policy: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to ensure ongoing effectiveness. This fall prevention plan is a site-specific plan to eliminate or reduce the risks of falls. The Fall Prevention Program includes the following components: Methods to identify risk factors. Methods to identify residents at risk. Use and implementation of professional standards of practice. Changes in interventions that were unsuccessful.; Care plan incorporates: a. Identification of risk/issue b. Interventions are reviewed and/or changed with each fall, as appropriate. c. Preventative measures. Standards: 1. A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. 2. A Fall Risk Assessment will be performed at least quarterly and with each significant change in condition and after any fall incident. 3. Safety interventions will be implemented for each resident identified at risk using a standard protocol. Accident/Incident Reports involving falls will be reviewed by the Director of Nursing and the IDT to ensure appropriate care and services were provided and determine possible safety interventions. Fall incidents will be discussed with IDT as they occur during Facility's Morning Meeting to determine Because Factor and appropriate interventions. The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations and tracking all incidents on facility approved form. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. The residents' environment will be kept clear of clutter which would affect ambulation and remove hazards. 7. Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or a chair and provide care as assigned in accordance with the plan of care. Rounds may be more frequent if deemed necessary.		S9999				

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S9999	Continued from page 19 All nursing personnel will be informed of residents who are at risk of falling. The fall risk classification will be identified on the care plan. Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care." Record review of facility policy titled, "Care Plan," dated 3/15/22, documents, in part, "Policy: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. 5. Care plans are reviewed and discussed individually. a. Concerns, problems, needs, and or strengths are listed based on resident's individual needs. Physicians' orders and personal care and nursing 11eeds are also listed based upon comprehensive assessments. b. Approaches are written clearly to be understood by all. Approaches include specific departments and staff member(s) responsible. Approaches must reflect Interdisciplinary Team involvement. c. All concerns, problems, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem-oriented goals relative to medical and nursing diagnosis, realistic, measurable, and directed towards increased functional levels. The Interdisciplinary Team is responsible for the implementation of resident care management. All interdisciplinary Team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress or lack of progress with possible reasons for and any new problems. The Care Plan Coordinator is responsible for in-service training for all departments and shifts to assure understanding of the care plan process and each person's responsibility and participation in the care plan." Record review of facility's "Facility Assessment Tool," dated 2/12/26, documents, in part, "Requirement: Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care of staff needs, as well as your ability to provide services to the residents in your facility. Using a competency-based approach focuses on		S9999				

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S9999	Continued from page 20 ensuring that each resident is provided with care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. Indicate if you may accept residents with, or your residents may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management: Psychiatric/Mood Disorders: Impaired Cognition, Mental Disorder, Behavior that Needs Interventions No Acute Psychiatric Problems: YES. List the types of care that your resident population requires and that you provide for your resident population: Mobility and fall/fall with injury prevention: YES; Person Centered Care: YES." Record review of facility policy titled, "Burns: Emergency Procedures," dated 4/14, documents, in part, "Policy: All residents experiencing a burn will be assessed and treated immediately." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life... Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care." Record review of facility job description titled, "Maintenance/Housekeeping Manager," dated October, documents, in part, "Position Purpose: The primary purpose of the Housekeeping and Maintenance Manager is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current, federal, state and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner. In addition, the incumbent is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and may be directed by the Administrator to assure that our facility is maintained in a clean, safe, and comfortable manner. 3. Ensure operational efficiency of electrical equipment and mechanical systems through timely inspection and repair. 5. Implement workplace safety policies and standards. Assumes responsibility for knowing and maintaining established facility and departmental objectives, policies/procedures including general sanitation,			S9999			

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S9999	Continued from page 21 safety, environmental and infection control standards." Record review of facility job description titled, "LPN (Licensed Practical Nurse) Job Description," undated, documents, in part, "Job Summary: The primary purpose of your job position is to provide direct nursing care to the residents and to supervise the day to day nursing activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility to ensure the highest degree of quality care.; Ensure that resident care procedures are followed in rendering nursing care. Make multiple daily rounds on your shift to ensure acceptable standards are met." Record review of facility job description titled, "Certified Nursing Assistant Job Description," undated, documents, in part, "Purpose: To assist the Charge Nurse in providing nursing care to residents as assigned under the direct supervision of the Director of Nursing. Services are to be in accordance with nursing standards, policy and procedure and practices of the facility and state requirements. Duties and Responsibilities: Provide necessary nursing care to all residents timely as required. Visually monitor residents minimally every 2 hours. Report all defective equipment immediately to Charge Nurse or Maintenance." Record review of facility job description titled, "Housekeeper/Laundry Worker, undated, documents, in part, "Job Summary: The primary purpose of the Housekeeper/ Laundry Worker is to perform the day-to-day activities of the Housekeeper/ Laundry Department in accordance with current federal, state and local standards, guidelines and regulations governing our facility and as may be directed by the Administrator and/or of laundry to assure that our facility is maintained in a clean, safe and sanitary manner and that an adequate supply of linen in on hand at all times to meet the needs of the residents. Assure that assigned work areas are maintained in a clean, safe and sanitary manner. Report all hazardous conditions or equipment to your supervisor. Report all hazardous conditions or equipment to the Laundry Supervisor. Assure that equipment is cleaned and properly stored at the end of the shift. Keep supervisor informed of supply needs. Report all equipment malfunctions or breakdowns to your supervisor as soon as practical. Keep work areas(s) free of hazardous conditions, i.e., spills, excess laundry		S9999				

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S9999	Continued from page 22 carts, baskets, supplies, equipment, etc." (A)		S9999				