STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SHF510534	A. BUILDING: _____ B. WING _____	08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS MANOR	111 SOUTH WALNUT STREET OAKLAND, IL 61943

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A 000	Initial Comment Annual Licensure Survey 295.6000 a) 12) 295.4010 d) e) g) 1) A) 295.8000 a) 1)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; Based on observation, interview, and record	A4010		

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A4010	Continued From page 1	A4010		

review the establishment failed to ensure that two (R1 and R3) of three service plans reviewed contained the level of service and assistance required, if any, with activities of daily living. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

1.) On 8/18/26 at 2:30PM E4 Resident Assistant stated that R1 has to be reminded to come to meals and to change her clothes and would need to be assisted in an evacuation.

On 8/18/26 at 2:15PM, E1 Executive Director stated that R1 has shown aggression toward staff, including blocking E1's door from allowing her exit.

R1's establishment provided service plan dated 1/28/26 does not document any assistance with activities of daily living, reminders, or behaviors.

2.) On 8/18/26 at 1:15PM, R2 was sitting in his recliner wearing a cast on his left arm. R2 denies knowing how he broke it.

On 8/18/26 at 1:30PM, E1 Executive Director stated, "(R2) was on hospice and they just took him off and we don't agree with that decision."

On 8/18/26 at 2:45PM, E5 Resident Assistant statd that R2's buttock wound is now closed and that R2 has graduated from hospice.

The establishment provided reportable dated 7/21/26 documents that R2 fell getting out of the shower and broke his left wrist.

On 8/19/26 at 10:00AM, observed E9 Resident

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A4010	Continued From page 2 Assistant assist R2 to stand. R2 was provided with a walker and was sitting on a cushion to prevent further skin breakdown. R2 was very weak. R2's establishment provided service plan dated 10/30/25 documents admission to the establishment on 10/12/25 with no assistance needed for any activity of daily living. There is no updated service plan documenting a history of falls, interventions, injuries, or hospice care. 3.) On 8/18/26 at 1:45PM observed full length side rails on both sides of R3's bed. On 8/19/26 at 10:30AM E9 Resident Assistant transferred R3 from the wheel chair to the toilet and then stated, "(R3) can't use her left shoulder very well since she broke it. She can't really walk on her own and she can't get out of bed without one of us helping her." The establishment provided reportable dated 12/12/25 documents that R3 fell out of her wheel chair resulting in a broken left shoulder. The establishment provided service plan dated 6/18/26 does not document any assistance required for activities of daily living, does not document side rails being utilized for mobility or to prevent falls, nor does it document any falls with injury and interventions to prevent further injuries.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation	A6000		

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A6000	Continued From page 3 Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 12) The right to be free of chemical and physical restraints; Based on observation, interview, and record review the establishment failed to ensure one (R3) of three residents reviewed for resident rights were free of physical restraints. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R3's service plan documents admission to the establishment on 11/16/19. R3's physician assessment dated 6/18/26 documents that R3 requires assistance with toileting, transferring, bathing, and evacuation. On 8/19/26 at 10:30AM, E9 Resident Assistant pivot transferred R3 from the wheel chair to the toilet. "She can't get out of bed without one of us helping her." On 8/18/26 at 1:45PM, R3's bed was made with full length siderails on R3's bed. On 8/18/26 at 4:30PM R3 was laying in bed with both full length siderails up. R3 was laying in the	A6000		

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A6000	Continued From page 4 bed awake. On 8/18/26 at 4:35PM, E8 Resident Assistant states, "The family wants her to have the siderails. She can't get out of the bed on her own with them up, so she yells and we come and let her out." On 8/19/26 at 10:35AM, E9 Resident Assistant states that R3 cannot remove the siderails on her own. "(R3) just yells out and we let the sides down." On 8/19/26 at 11:30AM, E1 Executive Director states that (R3's) family provided the bed and the full length siderails, and that the full length siderails have been on R3's bed for at least a year.	A6000		
A8000	Section 295.8000 Food Service This Regulation is not met as evidenced by: Type 2 Violation Section 295.8000 Food Service a) If food service is provided by the establishment or by contract with a food service provider, the following requirements shall be met: 1) Food services shall meet the Food Service Sanitation Code (77 Ill. Adm. Code 750) and any applicable local requirements. Based on observation, interview, and record review the establishment failed to ensure that a	A8000		

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A8000	Continued From page 5 Certified Dietary Manager was on staff and managing the establishment kitchen practices, failed to ensure safe eggs were served to a high risk population, and failed to ensure that leftovers were disposed of in an appropriate amount of time before re-serving.This failure creates a substantial probability of harm to a resident or residents. Findings include: On 8/18/26 at 12:45PM E1 Executive Director stated that the cooks have taken food safety coursework, but that no one has a Certified Dietary Manager certificate. On 8/19/26 at 8:15AM observed an employee's food and drink from home stored in the resident refrigerator. On 8/19/26 at 8:15AM, E3 Cook confirmed that employee food and drink is not supposed to be co-mingled with resident food and drink to prevent cross contamination. On 8/19/26 at 8:20AM, the eggs in the refrigerator were not marked as pasteurized. On 8/19/26 at 8:22AM, E3 Cook confirmed that the eggs in the refrigerator are not pasteurized and then stated that R4 like to order eggs sunny side up, but that she makes them over easy for her instead and thought that over easy was an acceptable way to serve eggs to residents. On 8/19/26 at 9:50AM, E3 Cook stated, "leftovers are usually kept for a week and we serve them until then." The United States Department of Agriculture	A8000		

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A8000	Continued From page 6 Food Safety and Inspection Service Guide dated 7/31/20" Store Leftovers Safely" documents that leftovers can be kept in the refrigerator for a maximum of four days. On 8/19/26 at 9:55AM, the following leftovers were in the refrigerator with dates including: baked beans 8/15/26, cooked vegetables 8/14/26, and BBQ ribs 8/15/26. On 8/19/26 at 11:32AM Z3 Local Health Department Environmental Services Director confirmed that the establishment cannot use unpasteurized eggs and make sunny side up or overeasy eggs and that a week is too long for any leftover in the refrigerator to be served, especially to an at risk population.	A8000		