Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010078	A. BUILDING: ____ B. WING ____	C 10/04/2022

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: 2297670/IL151564	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)5) 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 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** Statement of Licensure Violations	

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to perform a daily skin assessment to assess for any new wounds and the facility failed to perform the dressing changes to the wounds as ordered. This affected 1 of 3 (R1) residents reviewed for pressure ulcer care. This failure resulted in the wounds not being treated as soon as they developed, and it resulted in the wounds deteriorating by increasing in size.

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S9999	Continued From page 2 Findings Include: R1 is an 83-year-old with the following diagnosis: malignant neoplasm of the prostate, COVID-19, protein calorie malnutrition, dementia, and adult failure to thrive. R1 admitted to the facility on 3/23/22. A Nursing note dated 07/01/22 documents R1 readmitted to the facility from the hospital. R1 has a skin tear to the right buttocks. The Treatment Nurse Initial Skin Alteration review dated 07/05/22 documents there is a partial thickness wound to the coccyx that was first noted on 07/01/22. R1 was admitted with this wound after a hospitalization. There's also a partial thickness wound to the right anterior thigh and a left heel deep tissue injury that were present on admission. The Bath and Skin Report Sheet dated 07/2022 documents R1 received skin assessments on 07/09/22 and no new areas of skin concerns are documented. Treatment for recurrent skin issues is in progress. The Minimum Data Set dated 7/8/22 documents R1 has 1 unstageable deep tissue injury at this time. The Braden Scale dated 07/08/22 documents a Braden score of 11 which indicates R1 is at high risk for developing pressure ulcers. A Nursing note dated 07/12/22 documents R1 continues with poor appetite and fluid intake. R1 exited the facility alert, clean, and dry.	S9999		

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The Hospital Record dated 07/12/22 documents R1 was admitted for evaluation of failure to thrive. R1 was noted to have a urinary tract infection and was started on IV antibiotics. The family is still deciding on a G tube. R1 was noted to have a left hip deep tissue injury with a 3.5 x 5 cm blister. Also noted is a full thickness pressure injury (the wound extends through all layers of the skin into the subcutaneous tissue) on the left lateral ankle, a right heel deep tissue injury, and a right hip deep tissue injury are also noted.

R1 readmitted to the facility from the hospital on 07/18/22. The Treatment Nurse Initial Skin Alteration Review dated 07/19/22 documents R1 has a stage 2 to the right and left hip, A non-stageable pressure injury to the left lateral ankle, a deep tissue injury to the left medial lateral foot. All staff teaching for each wound is documented that the nurse is to apply a new dressing per treatment orders.

The Treatment Administration Record dated is 07/2022 documents the ordered dressing changes for the left and hip were not completed on 07/22/22, 07/24/22, and 07/30/22. The Treatment Administration record dated 09/2022 documents the ordered dressing change for the left heel, left lateral foot, left lateral ankle, sacrum and left and right hip were not completed on 09/03/22 and 09/04/22.

The Weekly Skin Alteration Review dated 08/26/22 and 09/02/22 documents the wound to the left and right hip are now unstageable, have increased in size, and are worsening.

On 09/28/22 at 3:01PM, V4 (Nurse) stated, "I believe the one time I sent R1 out to the hospital it was for not eating and drinking. We do body

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S9999	Continued From page 4 checks before they leave the facility as long as it's not an emergency. No, I don't believe R1 went out via 911. If there was a wound already documented and been treated then I would not have charted it on the note for R1 going out. If I found something new on the skin assessment I did before R1 left then I would have documented it. Skin checks are done on shower days twice a week or when the CNA's change them. If the CNA see something abnormal then they come tell the nurse. We notify the wound care nurse and follow the treatment plan. If wound care nurse is not here then the floor nurses will do the treatment. We usually know who needs dressing changes from just being familiar with them. Otherwise, you can find that information in the TAR (Treatment Administration Record) and what to do for the wound when it needs to be changed. I know for sure when I sent R1 out that that R1 didn't have anything on R1's hips." On 09/28/22 at 4:33PM, V5 (Nurse) stated, "Skin checks are scheduled for shower days and they are also done when wound care does their rounds. When wound care is not here to do the dressings then it is up to the staff nurses to complete those. You find the order in the TAR and do the treatment. It should come up on your screen in the computer that a resident has a dressing that needs to be changed. They should always be changed if they're ordered." On 09/29/22 at 9:57AM, V6 (CNA) stated, "If something was new in those days that I worked with R1 then I would've told the nurse. I don't remember seeing any new wounds on R1 from when R1 got back (7/5/22) from the hospital until R1 went out again (7/12/22). Anytime you find something new the nurse should be told immediately."	S9999		

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S9999	Continued From page 5 On 09/29/22 at 12:57PM, V10 (Wound Care Coordinator) stated, "R1 went out in the beginning of July with COVID and came back a couple days later on 7/5. That time when R1 came back R1 had a stage 2 to the coccyx. R1 also had a right anterior thigh abrasion and a DTI to the left heel. R1 was sent out on 7/12 to get a G-tube placed for not eating. R1 came back on 7/18. When R1 came back R1 had a stage 2 to the right and left hip, a DTI to the left foot, and DTI to the left lateral ankle. For a couple weeks the wound were stable in the beginning of July but after that he had an overall decline which the wounds did not do well with. R1 was at risk (for developing wounds) after R1 came back from the first hospitalization with wounds. Skin assessments are done on shower days and when the CNA's are doing patient care. They do patient care whenever the resident needs to be changed so sometimes residents are being checked more than once a day. If anything new is found then it should be reported to me immediately. Skin assessments are also done before a resident goes out and when they come back. We do this to be sure they don't have anything new before leaving the facility. We make sure we're able to tell the difference between what wounds they got at the hospital and what they got here. As long as there's not a 911 call or a code the skin assessment should be done before they leave the facility. Whenever I am not in the building then the floor nurse does the dressing change. They could find how to do the dressing change in the TAR. A dressing change should always be done if there's an order for it." On 09/29/22 at 2:07PM, V2 (DON) stated, "Skin checks are done with showers and during incontinent care. They are also done when they	S9999		

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S9999	Continued From page 6 come back from the hospital to identify if they have any new ones. When V10 is not here, V10 leaves a list on the homepage so the staff nurses can see who needs wound care for that shift. There is no reason why the wound care should not be done. I know we've had to have talked with them about signing it off on the TAR like it is supposed to be done because if it's not signed off then it is considered not done. If any new areas are noted then V10 should be told immediately. Either the nurse or the CNA can tell V10." On 09/29/22 at 2:31PM, V11 (Wound Physician) stated, "I do not advise to skip out on any treatments that are ordered because it has the potential for deteriorating the wounds. This also means if they were not doing the dressings as ordered then they weren't inspecting the wounds either. The wound should be inspected with each dressing change because if there are any changes to the wound then I need to be notified as soon as possible to make adjustments to the treatment if needed." When asked how many wound treatments are safe to skip, V11 responded, "I can't give a specific number because I doubt there has been any clinical studies on it but in general no wound treatment should be skipped." The Care Plan dated 03/24/22 documents R1 is monitored for alteration and skin integrity. An intervention for this care plan is documented as the skin will be checked during routine care on a daily basis and during the weekly/biweekly bath or shower schedule. Any skin integrity issues/concerns will be conveyed to the charge nurse for further evaluation and/or treatment changes/new interventions and the physician will be called as needed. The Care Plan dated 07/05/22 documents R1 has an alteration in skin	S9999		

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S9999	Continued From page 7 integrity and is at risk for additional and/or worsening of skin integrity issues related to impaired cognition, incontinent of bowel, impaired nutritional status, decreased sensory perception, comorbidities, and cancer. The same interventions listed in the previous care plan are also documented for this care plan. The policy titled, "Pressure Ulcer Prevention," dated 09/2014 documents, "Purpose: To prevent and treat pressure sores. Procedure: ...2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures ... Note: daily skin checks will be done by CNA's during routine care ..." The policy titled, "Pressure Injury and Skin Condition Assessment Policy," dated 09/2016 documents, "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented. Standards: ...4. Each resident will be observed for skin breakdown daily during care and on the assigned birthday by the CNA. Changes shall be promptly reported to the charge nurse who performed the initial assessment ...6. Caregivers are responsible for promptly notifying the charge nurse of skin observations, including but not limited to: redness swelling, bruises, skin tears, blisters, excoriations, wound drainage, crusts, skills, any type of lesion, skin discoloration, bleeding, and changes in skin temperature ...16. Dressings which are applied to pressure injuries, skin tears, wounds, lesions or incisions shall include the date of the procedure. Dressings will be checked daily for placement, cleanliness, and signs and symptoms of infection...22. Physician order treatments shall be	S9999		

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S9999	Continued From page 8 initialed by the staff and the treatment administration record after each administration. Other nursing measures not involving medication shall be documented in the progress notes ...23. A licensed nurse shall observe conditions of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented ..." (B)	S9999		