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	IL6010078	A. BUILDING: _____ B. WING _____	C 12/27/2024

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 2499718/IL181659 Facility Reported Incident of 12/8/24: IL182535	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)3)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		

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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:

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.

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 identify and treat wounds on a resident (R1) before R1 was sent out to the hospital for one of three residents reviewed for wound care in a total sample of eight. This failure resulted in the unidentified wounds being present on R1's heels

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for an unknown amount of time without being treated.

Findings Include:

R1 is an 82 year old with the following diagnosis: type 2 diabetes, peripheral vascular disease (PVD), and rheumatoid arthritis.

A Nursing note dated 11/3/24 documents R1 had a boil on the sacrum that burst and left an open area. The nurse practitioner was notified and ordered to cleanse the wound daily and apply a dry dressing. A Physician note dated 11/13/24 documents R1 currently has no concerns and is at baseline.

The Treatment Nurse Initial Skin Alteration Review dated 11/4/24 documents a full thickness wound to the sacrum was identified on 11/3/24 and measured 0.3 cm x 0.3 cm x 1 cm. The wound bed had 100% granulation tissue with a small amount of serous drainage. R1 turns and repositions independently. A preventative measure includes daily skin checks during CNA rounds.

On 12/24/24 at 12:37PM, V14 (Nurse) stated R1 was sent out the morning of 11/20/24 for altered mental status changes. V14 denied performing a skin assessment on R1 before leaving for the hospital because V14 was a newer nurse and wasn't aware V14 should do that. When asked why doing a skin assessment before a resident leaves the facility is beneficial, V14 reported the nurse needs to be responsible in being aware of what condition the resident left the facility in, so if anything comes up the facility can say who was at fault.

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On 12/24/24 at 2:12PM, V15 (Wound Care Nurse) stated R1 was being seen by wound care for a wound to the sacrum. V15 reported a full head to toe assessment must be performed daily on resident's with wounds. V15 stated V15 along with the CNAs and floor nurses are responsible for completing the daily skin assessments. V15 reported V15 likes to do a skin assessment before the resident leaves the facility so the facility knows what wounds occurred at the facility and what wounds did not happen at the facility. V15 denied being aware of any wounds to R1's ankle or heels.

On 12/26/24 at 1:55PM, V16 (Wound Physician) stated a wound needs to be treated as soon as it develops because the wound could decline or not heal from not being treated. V16 reported the expectation of staff is to have due diligence in checking the skin if a resident is prone to developing the skin. V16 was unable to say how long the wounds on the left heel and left ankle took to develop.

On 12/26/24 at 3:41PM, V18 (DON) stated R1 had a wound to the sacrum that was being treated at the facility. V18 reported if a wound develops in the facility, then staff need to identify the wound and treat it.

The Weekly Skin Alteration Review dated 11/11/24 documents a full thickness wound to the sacrum that measured 0.3 cm x 0.3 cm x 0.8 cm. The wound bed had 100% beefy red granulation tissue with a small amount of serous drainage. The drainage had no odor. The wound is documented as improving as evidenced by decreased depth. The family was called and notified of the wound changes on this day.

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The Weekly Skin Alteration Review dated 11/19/24 documents a full thickness wound to the sacrum that measured 0.5 cm x 0.3 cm x 0.9 cm. The wound bed had 100% beefy red granulation tissues with a scant amount of serous drainage. The wound was stable due to no changes.

The Wound Physician note dated 11/19/24 documents this was the initial evaluation by the wound care physician. R1 was in no acute distress. The wound on the sacrum is a full thickness wound that measured 0.5 cm x 0.3 cm x 0.9 cm. The wound is documented as being caused by an abscess that spontaneously drained. The dressing was changed to iodoform to be changed daily. There was no other documentation that R1 had any wounds to the left ankle or heel.

The Bath and Skin Report Sheet dated 11/2024 documents skin assessments were completed on shower days on 11/2/24, 11/6/24, and 11/9/24 and the only documented wound is to the sacrum.

A Nursing note dated 11/20/24 documents R1 showed signs of altered mental status and was sent out to the hospital. R1 was admitted to the hospital with a diagnosis of altered mental status and congestive heart failure.

The Hospital Records dated 11/19/24 documents R1 presented from the nursing home with altered mental status. A skin assessment was performed by the wound care team. A full thickness wound to the sacrum was noted. The wound is down to the bone and has a foul odor. There is also dark discoloration to the left heel consistent with a deep tissue injury. The left lateral ankle and hallux has a small opening to the skin with eschar present. This is consistent with an unstageable

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pressure injury. R1 was admitted to the hospital with a diagnosis of sacral wound infection and altered mental status.

The Care Plan dated 5/8/20 documents R1 is at risk for alteration in skin integrity due to skin being occasionally exposed to moisture due to incontinence and being at risk for friction/shearing. An intervention includes to check skin during routine care on a daily basis and during the bi-weekly bath or shower schedule.

The Care Plan dated 4/17/23 documents R1 has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to diabetes, anemia, abnormal posture, and peripheral vascular disease. An intervention includes to check skin during routine care on a daily basis and during the weekly/biweekly bath or shower schedule.

The Care Plan dated 12/1/23 documents R1 has PVD and is at increased risk of skin integrity issues with a potential for diminished blood flow to the lower extremities. An intervention includes to observe for discoloration for the skin.

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." The policy titled, "Pressure Injury and Skin Condition Assessment Policy," 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

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for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the Charge Nurse who will perform the initial assessment ...6. Care givers are responsible for promptly notifying the Charge Nurse of skin observations, including but not limited to: A. redness/swelling B. bruises C. skin tears D. blisters E. excoriations F. wound drainage G. crusts H. scales I. any type of lesion J. skin discoloration K. bleeding L. changes in skin temperature" The policy titled, "Discharge/Transfer of Resident," dated 04/2014 documents, " ...7. Complete Transfer Form accurately and completely including vital signs. Ensure that resident's current physical and psycho/social assessment, medications, and current treatment is completely described and available to the receiving facility upon transfer ...10. Thoroughly assess resident prior to discharge/transfer."
(B)

Statement of Licensure Violations (2 of 2):

300.610a)
300.1210b)
300.1210c)
300.1210d)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

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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 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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to monitor a high fall risk resident (R2) during a scheduled monitoring period for one out of three residents reviewed for falls in a total

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sample of eight. This failure resulted in R2 suffering a right fractured hip after falling from a chair while reaching out for a nearby object when unsupervised.

Findings Include:

R2 is an 87 year old with the following diagnosis: history of falling, dementia, and age-related osteoporosis.

A Nursing note dated 12/8/24 documents it was reported by the CNA (V9) that R2 slid out of a chair attempting to reach for something that was in another chair. V9 reported R2 fell onto the right hip. R2 denied any pain upon assessment and was placed back into bed. X-rays of the hip/pelvis were ordered. R2 remains alert and oriented times one per baseline.

The Unusual Occurrence Final Investigative Report Form dated 12/13/24 documents R2 slid out of a chair while attempting to reach for something that was in another chair. R2 fell onto the right hip. R2 was sent out to the hospital for evaluation. R2 returned from the hospital with a diagnosis of a closed femur fracture. A statement from V9 documents V9 was providing care to another resident in the room when R2 was noted reaching for an object in another chair. V9 reported the object was a few feet away from R2 and R2 fell onto the right side while reaching to get it.

The Hospital Record dated 12/8/24 documents R2 presented to the hospital after a fall. R2 is alert and oriented times one per baseline. X-ray of the hip was consistent with a right femoral neck fracture. R2 was admitted and ortho was consulted for surgery. R2's admitting diagnosis

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was displaced fracture of the right femoral neck.

On 12/20/24 at 1:59PM, R2 was sitting in a chair in R2's room. V2 (CNA) was sitting within arm's reach of R2. R2 was unable to answer any questions due to mental status. V2 reported R2 fell and broke the right hip but was not able to answer and detailed questions about the fall. V2 stated R2 has a behavior of constantly trying to get up without asking for assistance. V2 reported R2 is always confused and needs multiple attempts to redirect before R2 will listen. V2 stated one staff member is assigned to sit in the room to monitor residents due to being high fall risk. V2 reported if any other care tasks need to be completed while assigned to monitoring then another staff member must come and sit with the residents in the room to make sure they stay safe.

On 12/24/24 at 10:10AM, V9 (CNA) stated V9 got R2 ready for the morning then sat R2 in a chair while V9 began providing morning care to R2's roommate. V9 reported there was linen sitting on another chair about three to four feet away from R2 and R2 began reaching for the linen. V9 stated by the time V9 looked up and saw R2 reaching that it was too late to tell R2 to stop because R2 was in the middle of falling. V9 reported R2 has a behavior of trying to get up unassisted and walk alone. V9 stated R2 is a high fall risk because R2 is confused and R2's gait is unsteady. V9 reported V9 should have gotten another staff member to watch R2 but V9 did not think R2 would try to get up unassisted at that time. V9 stated V9 was responsible for monitoring the residents in that room at the time R2 fell.

On 12/24/24 at 10:24AM, V10 (Nurse) stated V9 came to the nurse's station and told V10 that R2

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fell while reaching for something that was in another chair. V10 reported R2 is a high fall risk because R2 walks on R2's tippy toes and is only alert and oriented times one. V10 stated R2 needs constant redirection and supervision due to being impulsive. V10 reported a staff member is always sitting in R2's room monitoring residents. V10 reported if the person assigned to monitoring needs to take care of someone else then another staff should be notified so R2 can be monitored. V10 denied V9 asking for assistance the day R2 fell. V10 said, "I was kind of shocked she fell with a CNA in the room with her."

On 12/24/24 at 10:36AM, V11 (Former Restorative Nurse) stated V11 resigned before the fall but knows R2 is impulsive and has an unsteady gait. V11 reported the CNAs have monitoring schedules for that room because R2 is such a high fall risk. V11 stated staff switches out throughout the shift so R2 can be constantly monitored. V11 reported the only responsibility staff has during their monitoring time is to monitor the high fall risk residents to make sure they don't fall. V11 stated another staff should be notified to help watch R2 is the staff scheduled for monitoring needs to perform another task during that time.

On 12/24/24 at 12:26PM, V13 (Therapy Director) stated R2 was discharged from therapy on 12/3 after reaching the highest performance level. V13 reported they were working with R2 because R2 is a high fall risk and very unsafe. V13 stated R2 has an unsteady gait and is impulsive. V13 reported R2 needs 1:1 supervision to maintain safety.

On 12/26/24 at 3:11PM, V17 (Medical Director) stated R2 fell in early December and suffered a

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hip fracture. V17 reported R2 fell while reaching for something while in a sitting position. V17 stated R2 has severe dementia but is not lethargic. V17 reported being aware the CNAs having a monitoring schedule for R2. V17 stated staff needs to be monitoring residents and redirecting them when get up unassisted during the monitoring time. V17 reported if another resident is in need of care, then more staff need to be called into the room to monitor R2 to make sure R2 does not fall. V17 stated the main priority when staff is assigned to monitoring is to monitor the high fall risk residents and keep them from falling.

On 12/26/24 at 3:41PM, V18 (DON) stated an intervention to help R2 from falling is to have staff in the room with R2 or have R2 sit at the nurse's station. V18 reported if the CNA responsible for monitor needs to leave the room or take care of another resident then a nurse or another CNA needs to be called into the room to make sure monitoring is continued.

The Physical Therapy Discharge Summary dated 11/29/24 documents R2 resides in a long term care facility and 24 hour a day supervision is needed. R2 needs partial/moderate assistance with transfers and walking.

The Daily Assignment Sheet dated 12/8/24 documents V9 was assigned to monitoring at 9AM until 10AM. V9 was also assigned to provide care for the room R2 resided in.

The Fall Report dated 12/8/24 documents V9 reported R2 was reaching for an object in another chair and fell out of the chair hitting R2's right hip. Upon attempting to have R2 stand, R2 showed facial grimacing and was unable to stand. R2 is

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alert to person only. Predisposing physiological factors to the fall are documented as gait imbalance, impaired memory, incontinent, and agitation. Predisposing situation factors are documented as incident occurred during unassisted transfer.

The Care Plan dated 1/1/24 documents R2 is high risk for falls related to confusion, being unaware of safety needs, unsteady gait, impulsiveness, and history of falls.

The Care Plan dated 12/11/24 documents R2 fractured the right hip. Appropriate interventions are documented.

The Minimum Data Set (MDS) dated 10/4/24 documents the Brief Interview for Mental Status score as five (severe cognitive impairment). Section GG of the MDS documents R2 needs partial/moderate assistance with bed mobility, transfers, and walking.

The policy titled, "Fall Prevention Program," dated 2/28/14 documents, " It is the policy of the 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 ...In addition to the use of Standard Fall Precautions, the following interventions will be implemented for resident identified at risk. 1. The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 and the plan of care." (A)	S9999		