

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2025	
NAME OF PROVIDER OR SUPPLIER EDEN VISTA PROSPECT HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST EUCLID AVENUE , PROSPECT HEIGHTS, Illinois, 60070			
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S0000	Initial Comments		S0000				
	Annual Certification Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violation: 300.610a)300.1210b)300.1210d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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						

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 pressure sores from developing. These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure ongoing monitoring, assessment to identify worsening of skin impairment and notify the physician for appropriate treatment in a timely manner. This failure resulted in R11's Moisture Associated Skin Disorder (MASD) on left buttocks to progress to sacral/coccyx area stage 3 pressure ulcer with slough formation. This deficiency affects one (R11) of one resident in the sample of 9 reviewed for Wound Care Management. Findings Include: On 12/9/25 at 11:36AM, Observed V15 CNA (Certified Nurse Assistant) and V16 CNA repositioned R11 to her left side for wound care. Observed open wound on sacrococcygeal area without dressing exposed to disposable adult brief soiled with urine. V16 said that she provided incontinence care to R11 this morning at around 7:00am and her wound dressing fell off. She forgot to inform the V17 RN (Registered Nurse) and V3 Assistant DON (ADON)/Wound Care Coordinator (WCC). V3 said that V16 CNA should notify her or the floor nurse this morning when R11's wound dressing fell off. The open wound should be covered to prevent infection and enhance healing. V3 provided wound care to R11. V3 said that R11's wound deteriorated from left buttocks MASD (Moisture Associated Skin Disorder) to pressure ulcer on sacrococcygeal area with 80% slough formation and 20% reddish tissue with serosanguinous drainage. V3 measured wound and obtained 1.5cm x 1cm x 0.1cm. V3 said that R11's wound worsens from last week when she saw her with V19 Wound Care Physician during wound rounds. V3 is not aware of this deterioration or worsening until today. V3 said that R11 wound treatment is being done by floor nurses, she only sees R11 during wound rounds as needed. V3 applied same treatment ordered for MASD, Zinc oxide and xeroform gauze covered with dry dressing. On 12/9/25 at 11:54AM, Surveyor asked V3 ADON/WCC if the treatment she applied for R11's deteriorated wound on sacrococcygeal is an appropriate treatment. V3 said that the treatment she applied is for MASD and is not appropriate treatment for open wound with slough formation. She said that she applied it for now until she received ordered from the physician On 12/9/25 at 12:01PM, Informed V2 DON (Director of Nursing) of above concerns and requested for policies.		S9999				

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S9999	Continued from page 2 On 12/9/25 at 1:17PM, Telephone interviewed with V18 RN (Registered Nurse). She said that she is the regular night shift nurse who took care of R11 on 10pm to 6am shift. She said that she provides treatment with zinc oxide cream and xeroform dressing on R11's left buttock MASD. The left buttock is dry, healed, skin intact and no open wound. She is not aware and did not see the pressure ulcer /open wound on sacrococcygeal area. She is aware that any skin changes or skin deterioration should be documented and notify the physician for appropriate treatment orders. On 12/9/25 at 2:05PM, V17 RN said that she is the regular morning shift (6am to 2pm) nurse who took care of R11 yesterday. She said that R11 has open wound in between her buttocks, sacrococcygeal area, with irregular wound edges, pinkish wound tissue, serosanguineous drainage, estimated quarter in size, it was from previous wound that re-open, but she cannot remember when. She has been applying zinc oxide, xeroform and covered with bordered dressing. On 12/9/25 at 3:05PM, Reviewed R11's medical records with V2 DON. R11 is admitted on 9/5/25 with diagnosis listed in part but not limited to History of falling, displaced Tri malleolar fracture of left lower leg, Closed fracture with routine healing, Subluxation of left ankle joint, Muscle weakness, Muscle wasting, Unsteadiness on feet and hearing loss. Active Physician order sheet indicated: Apply to Left buttocks Zinc oxide external paste 20% topically and xeroform then cover with dry dressing after cleaning with normal saline (NS) every shift and as needed for wound care (ordered 11/19/25). Apply to left buttocks Calcium alginate silver external pad 4"x 8" topically after cleansing with NS one time a day, and every 8 hours as needed for wound care ordered 12/9/25 after surveyor observed the open wound/ pressure ulcer. Most recent Braden scale assessment for predicting pressure sore risk done on 11/3/25 indicated severe risk for skin impairment. Comprehensive care plan indicated: R11 has a pressure ulcer and has potential for further skin impairment related to fragile skin, impaired/limited mobility, and incontinence/exposure to moisture. Left buttocks MASD. Most recent wound assessment done by V19 Wound Care Physician on 12/3/25 indicated: Non pressure wound of the left buttocks partial thickness/ MASD, healing good, measures 1.58cm x 1.06cm x 0.1cm, light serous exudate open areas with exposed dermis. V3 WCC documented in R11's progress notes after surveyor wound observation indicated: "Skin issues notes: During dressing change, R11 was observed with deteriorating left buttocks with increase surface to coccyx/sacral area". Informed V2 of concerns in wound care management to ensure ongoing monitoring assessment and			S9999			

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S9999	Continued from page 3 coordination of care to identify worsening of skin impairment and notify the physician for appropriate treatment in a timely manner. The accurate identification of wound site so there is no confusion or discrepancy in wound treatment. Writing of treatment orders on the same site for different etiology. On 12/10/25 at 10:04AM, Observed R11's sacrococcygeal pressure ulcer with V2 DON and V3 ADON/WCC. V2 said that there is no skin impairment on left buttock. There is pressure ulcer with slough formation on left sacrococcygeal area. On 12/11/25 at 10:12AM, Telephone interview with V19 Wound Care Physician (WCP). He said that R11's MASD on left buttocks deteriorated to Stage 3 pressure ulcer on sacrococcygeal area. After wound debridement, 10% thick necrotic tissue, 20% slough and 70 granulation tissue. Reviewed V19 WCP wound report and informed of the discrepancy and inconsistency from observation made yesterday pertaining to the wound location. V19 said that he will update and send his report. V19 Wound Care Physician updated progress notes dated 12/10/25 for R11's wound report indicated: Wound originally at left buttock but has localized to sacral/coccyx area. Will change location to sacrum/coccyx. Facility's policy on Pressure Injury Prevention and Wound Care Management revised 8/25/25 indicated: Purpose: to provide health staff with the standards of care and processes to be followed for all residents: *To identify factors that places the residents at risks for the development of pressure injuries and to implement appropriate interventions to prevent the development of clinically avoidable wounds. *To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. *To promote healing of existing pressure injuries and wounds. Policy: *It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care.			S9999			

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S9999	Continued from page 4 * The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless unavoidable *A resident who has pressure injury will receive care and services to promote healing and to prevent additional ulcers. Procedure: 5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse. 6. Residents at risk for the development of pressure injury will have their individualized care interventions and approaches documented in the resident care plan. 7. Skin impairments a. Weekly documentation will include pertinent characteristic of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues and description of any drainage, eschar, necrosis, odor, tunnelling, or undermining. 11. Daily, the clinicians responsible for caring for the resident will assess the status of dressing if present and evaluate for complications such as infection and or uncontrolled pain 14. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly or with significant change in condition. Prevention and Treatment Guidelines: 4. Wounds will be treated based on etiology of the wound. 10. Nursing staff should update the attending physician immediately of wounds that have developed complications and or not healing as anticipated. Facility's policy on Physician orders revision date 11/13/24 indicated: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with			S9999			

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S9999	Continued from page 5 professional standards. (B)			S9999			