

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 02/08/2026	
NAME OF PROVIDER OR SUPPLIER PRAIRIE OASIS				STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH , SOUTH HOLLAND, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000			02/19/2026	
	Complaint Investigation 2666025/25910974						
S9999	Final Observations		S9999			02/19/2026	
	Statement of Licensure Violaions:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	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.						
	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.						

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 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: 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 ensure timely assessment and implementation of preventative measures to prevent the development of a pressure ulcer for one (R1) of three residents reviewed for pressure ulcers. This failure resulted in R1 developing a facility-acquired Stage 3 pressure ulcer to the coccyx. Findings include: R1 is a 78-year-old resident admitted to the facility on 10/3/2025 to 11/13/25 with diagnoses including but not limited to: atrial fibrillation, seizure, hypertension, cerebrovascular accident, obesity, depression, cognitive and communication deficit, dementia, cerebral amyloid angiopathy, anxiety, history of encephalopathy, and coronary artery disease. R1's (MDS) Minimal Data Set assessment of 10/13/2025, section C, the BIMS (Brief Interviewed Mental Status) score was 03/15 (severely impaired cognition). MDS of 10/13/2025, GG section R1 is dependent on self-care-Helper does all the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. R1 is dependent on mobility assistance and requires roll left and right, sit to			S9999			

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S9999	Continued from page 2 lying tub/shower transfer: The ability to get in and out of a tub/shower. R1 requires helper does all of the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On 2/7/2025 at 1:45 PM, V4 (Wound Care Nurse) said, "(R1) had no wound impairment on admission and stage 2 on the coccyx area was noted on 10/31/2025. We have shower sheets and skin alteration sheets for the nursing assistants to fill out when they observe any skin impairment. The floor nurse will notify the physician and obtain orders if I am not in the building. I will add the resident to the wound physician for the weekly rounds and do the treatment for the residents when I am in the building. The nurses are expected to do treatment if I am not in the building". The surveyor requested shower sheets, skin impairment sheets, and nursing routine skin assessment but V4 said, the facility does not keep shower sheets or skin impairment sheets past a month per facility policy. V4 said, "I assessed (R1) on 10/31/2025, called the physician, and added the air mattress, dietary supplements, and added (R1) to the list of the wound physician rounds. R1's physician's order dated 10/03/2025 reads in part, "Skin assessment weekly on shower or bath day." Per record review: 10/3/25: admission, intact skin 10/3–10/31: no documented weekly assessments 10/31/25: Stage 2 identified 11/11/25: Stage 3 documented Record review of 11/11/2025 V5 (Wound Care Physician) progress notes noted a stage 3 pressure ulcer to the sacrum measuring 4 x 5.5 x 0.1 cm with light sero-sanguinous drainage and fair healing potential and estimated time to heal 4 - 6 Months. On 2/7/2026 at 3:53 PM, V2 (Director of Nursing) said, nurses are expected to complete the skin assessment, check the shower skin assessment, and any skin impairment to be assessed, call the physician, and	S9999					

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S9999	Continued from page 3 obtain orders. V2 stated, "We have a wound care nurse who will complete the assessment and treatment. I cannot put a timeframe on when a wound will develop and turn into stage 2. I expected the nurses to turn, reposition, and keep residents dry and clean, and monitor the skin. Also, we take into consideration nutrition and keep residents hydrated." The surveyor requested skin assessments, shower sheets, and only received the skin assessment from admission on 10/03/2025 and 10/31/2025, when R1 already had a stage 2 pressure ulcer to the coccyx area. V2 said the facility does not keep records of showers past the current month or the entire last month. V2 and V3 (Director of Clinical Service) both reviewed records for routine skin assessment under the electronic medical records with the surveyor, but none were found. V3 said skin assessments are expected to be added under the MAR (Medication Administration Records) for the nurses to complete. When questioned about how frequently V3 said per standard of care, on admission, and weekly for 4 weeks. During the records review with V2 and V3 of the MAR, no skin assessments were found as per the physician's order. Care plan and interventions updated on 10/31/2025 reads, skin will be checked during routine care on a daily basis, and during the weekly and biweekly bath or shower schedule. No additional assessments were provided by the facility at the time of this survey. In the absence of documentation, the facility failed to demonstrate that required skin assessments were completed or that the pressure ulcer was unavoidable in accordance with professional standards of practice and facility policy. On 2/7/2026 at 4:47 PM, V1(Administrator) provided the facility policy titled "Pressure Injury and Skin Condition Assessment Policy" dated 9/2016, reads: Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure ulcers, assuring interventions are implemented. Standards: 2-Residents identified by the Braden scale of being at high risk of skin breakdown will have a weekly skin assessment x4 by a licensed nurse. 4-Each resident will be observed for skin breakdown			S9999			

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S9999	Continued from page 4 daily during care on assigned bath day by the CNA (Certified Nursing Assistant). Changes shall be promptly reported to the charge nurse, who will perform the initial assessment. Wound Care Skin Inspection Table Bath twice weekly or as necessary. Avoid hot water; use a mild cleansing agent that minimizes irritation and dryness of the skin. During the cleaning process, care should be taken to minimize the force and friction applied to the skin. Documentation of weekly head-to-toe assessment by the licensed nurse in the resident's chart or on the facility-approved form. Daily head-to-toe skin assessment by caregivers. (B)			S9999			