STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146118	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairieview at the Garlands	6000 Garlands Lane Barrington, IL 60010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to thoroughly assess, identify, treat, monitor, and implement adequate interventions to prevent the development and/or worsening of pressure ulcers for one of one (R7) resident reviewed for pressure ulcers. This failure resulted in R7 developing an unstageable pressure ulcer on the left heel, an open skin impairment to the sacral area, and a reddened area to the right upper, inner thigh.Findings include:R7 is an [AGE] year-old resident admitted to the facility on [DATE] with diagnoses, in part but not limited to heart disease, peripheral vascular disease, congestive heart failure, and cerebral infarction. MDS (minimum data set) dated 01/07/2026, indicates R7 is moderately cognitively impaired; and had no skin impairments upon admission.On 05/05/2026 at 9:20 AM, V2 (Director of Nursing) and V4 (Registered Nurse) were observed assessing the pressure ulcer on R7's left heel (back of heel). Sock was removed; there was no dressing covering the wound. V2 stated normally cream and gauze are placed on the wound but sometimes it's left open. The wound appeared red/pink and had yellow exudate in the middle (covering about 70% of wound). Wound was not measured at this time. V2 stated V22 (Wound Care Nurse) will come to the facility on Thursday or Friday of this week. The sock and shoe were placed back on; no wound dressing applied. V4 stated the wound dressing is changed twice a week and as needed during night shift.On 05/06/2026 at 10:24 AM, V14 (Registered Nurse), V12 (Certified Nursing Assistant), and V17 (Certified Nursing Assistant) assisted R7 to the bathroom for incontinent care. It was observed that there was an open skin impairment to the sacral area, measuring 2 cm (centimeters) x 1.5 cm, and a reddened area to the right upper, inner thigh measuring 1.5 cm x 1 cm. The open skin impairment on the sacral area was red with pink surrounding the opening and was non-blanchable; the patch of skin above the wound, extending upwards toward the back was red/purple in color. The reddened area on the thigh was a meaty red color, and the top layer of skin was no longer intact. V14 quietly exclaimed, Oh Sh** and stated they were unaware of this skin injury; V14 stated there are PRN (as needed) orders for barrier cream for the peri area; during this observation, cream was not present upon removal of the brief and cream was not placed when a new brief was placed, V14 confirmed they did not visualize cream during brief change.R7's record review of the Medical Inpatient History and Physical documentation obtained, upon admission, from an outside facility for care dated 03/01/2026 stated in part but not limited to, R7 admitted with a stage II sacral pressure injury to be treated with Medi honey and foam, and a left heel unstageable injury to be treated with foam; a wound consult recommended at this time.On 05/07/2026 at 10:30 AM, record review of the 03/13/2026 re-admission note in EHR (electronic health record) stated in part but not limited to, skin assessment done, buttocks intact, left heel with unstageable wound measuring 1.3 cm x 1cm. Care plan was not updated at this time.On 05/06/2026 at 12:08 PM, record review of Skin Assessment with Bath/Shower sheets from 01/26/2026 and 02/06/2026, no indications were documented about any skin impairments or changes to skin.All Skin Assessment with Bath/Shower sheets between 01/26/2026 and 04/21/2026 have no indication of sacral skin impairments and only 03/31/2026 and 04/21/2026 have mention of bandage and old skin impairment with circle indicators at the left heel.R7's record review of nursing notes entered by in-house nursing staff and an outside (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound care nurse stated but not limited to:01/07/2026 written by V19 (Registered Nurse): Scalp: dry skin with dry, scabbed areas noted on top of head, left hand: 1.5 cm U-shaped skin tear, left elbow: small, scabbed area, no other skin issues noted01/11/2026 written by V21 (Registered Nurse): groin: redness with intact skin, buttocks/heels intact, no additional skin concerns01/16/2026 written by V22 (Wound Care Nurse): left hand skin tear (0.5 cm x 1 x 0 cm), dry and scabbed, groin, redness persists, treatment include initiating Lotrisone, Nystatin powder discontinued01/19/2026 written by V18 (Registered Nurse): groin redness with bleeding, buttocks with blanchable redness; moisture barrier applied, left heel deep tissue injury (DTI) identified and treated with normal saline cleanse, Betadine application and bordered dressing, heel protectors (booties) applied bilaterally.R7's record review of wound care progress notes indicated the DTI (deep tissue injury) to the left heel's progression fluctuated in measurements between 01/20/2026 - 02/27/2026, however the care plan initiated upon admission, 01/07/2026, states in part but not limited to: Potential/actual impairment to skin integrity related to: Fragile skin and incontinence was not updated to include a care plan for the DTI, when the DTI was identified on 01/19/2026.On 05/05/2026 at 1:30 PM, V2 was interviewed regarding wound care. V2 stated wounds are assessed and dressings are changed, daily, by in-house nurses on the night shift (7P-7A). V2 stated the expectation with any changes to wounds or previously intact skin should be brought to their attention, as soon as possible. V2 stated the expectation for skin assessment of residents is to assess the skin, upon admission and daily, report any changes to the wound care team and document these changes. V12 (Certified Nursing Assistant) and V13 (Certified Nursing Assistant) stated, in separate interviews, while providing showers to residents, shower sheets are completed to address any skin changes or abnormalities. These changes are then relayed to the nurse on duty and/or V2.On 05/06/2026 at 10:00 AM, V15 (MDS Coordinator) was interviewed regarding care plans and MDS (minimum data set) standards within the facility. V15 stated the expectation for care plans is for any member of the IDT (interdepartmental disciplinary team) to update care plans when any changes occur to the needs/requirements of the residents. V15 stated they initiate and finalize the initial MDS, and then the expectation is they are notified if/when any changes need to be made. Regarding initial MDS and care plan creation, V15 stated their procedure is to review the admission paperwork and medical records and the admission information from the facility staff to initiate these initial documents/plans. V15 stated the initial MDS created for R7 was based solely off the admission note from the facility staff that stated, skin was intact, and failed to include the information from the medical documents presented on admission. V15 stated the DTI that R7 is experiencing was facility acquired due to the admission note not referencing any redness to the area.On 05/06/26 at 4:30 PM, V22 (Wound Care Nurse) was interviewed regarding wound care. V22 stated their goal is to visit the facility, weekly, on Thursday or Friday, but there are some weeks they cannot make it or will try to come on the weekend. V22 stated they provide care to any skilled resident with a new wound and follow up with wound that the nursing staff request assistance with. V22 stated their expectation is for dressings to be done, according to the physician's orders, and that they are reached out to with concerns. V22 stated the expectations they have of facility staff are for the CNAs to do skin checks upon showering/bathing residents and for nurses to do their weekly skin checks. V22 stated their expectation if a wound is discovered without the ordered dressing in place would be to alert the appropriate staff and apply the treatment, according to the physician's orders.Record review of V22's initial wound care nursing note dated 01/16/2026 has no mention of issues with the heel or sacral area.Record review of V22's follow-up wound care nursing note dated 01/20/2026 gives measurements for the DTI to the left heel that was discovered on 01/19/2026 (1.5cm x 1.4cm x 0cm) but does not address the sacral redness noted on 01/29/2026 in V18's nursing note.On 05/06/26 at 4:40 PM, V18 (Registered Nurse) was interviewed regarding the nursing note entered on 01/19/2026 regarding R7's skin assessment. V18 stated the redness was on the sacrum and down to the buttocks. V18 stated they do not remember when they first noticed the redness. V18 stated wound care and V2 were notified at this time.On 05/06/26 at 4:55 PM, V19 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(Registered Nurse) was interviewed regarding their admission nursing note on 01/07/2026. V19 stated they work night shifts only, one day per week, and does not recall performing this assessment. V19 stated they would have performed the assessment if it was not done on day shift, when assessments are typically performed.On 05/06/2026 at 1:10 PM, V20 (Medical Director) was interviewed and states that they oversee all residents in the facility and visit the facility 4 days per week (between themselves and their nurse practitioners). V20 stated they occasionally do skin assessments but don't like to double up with wound care. V20 stated they handle wound care prior to the contracted wound care team evaluating and then wound care team takes over all wound care. V20 stated the expectation is for in-house nurses to relay information to their team, unless it's a pressure injury. V20 stated they want pressure ulcers brought straight to wound care. V20 stated they are not aware of any redness to the sacral area until 05/06/2026 when contacted by facility staff. V20 stated that upon initial admission and re-admission, they review the admission note and all notes from previous facility/medical records to ensure orders and care plans are appropriate for the residents.Facility Policy titled, Wound Care dated 12/06/2022 states in part but not limited to:The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Verify that there is a physician's order for this procedure.Review the resident's care plan to assess any special needs of the resident.10. Place one gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water.Facility Policy titled, Skin Assessment dated 09/24/2020 stated in part but not limited to:On admission, the Nursing admission Assessment and the Braden Scale will be completed. The doctor will be notified of the treatment as needed.On admission, the admitting nurse will identify all skin issues including but not limited to: any discolored area, rashes, bruises, skin tears, pressure ulcers, tubes, open areas, including stage/classification of wound, quality of tissue and measurements.If a member is identified as high risk (score of 12 or less) for skin breakdown, the Braden Scale will be completed weekly times 4 weeks on admission.Upon identification of a pressure ulcer, the Braden Scale will be updated.The Wound Assessment Flow Sheet will be completed weekly or when a significant change is noted. The Care Plan will be updated and interventions carried out as indicated. Any pressure ulcer presenting as a Stage II or more will be seen by a Wound Care Specialist in consultation with the attending physician.The facilities' Prevention Protocol will be implemented on all residents identified at moderate to high risk (Braden score of 12 or below) and/or are identified to have co-morbidities that will impact skin integrity or impede the healing process. Prevention protocol may include:- Pressure reduction/relief- Skin careThe nurse will identify the necessary therapeutic interventions appropriate for the resident's individualized needs to reduce the risk of skin breakdown and/or treat existing wounds based on the member's clinical condition and risk factors.For those residents admitted with wounds, the nurse will notify the Director of Nursing/or designee who will follow the resident's progress weekly toward wound healing.If pressure ulcer occurs, the Director of Nursing/ or designee. It will be determined why the event was unavoidable, what clinical conditions and/or non-compliance issues contributed to the decline, and what all possible and appropriate interventions have been aggressively implemented but not changed the course of tissue decline. Document what new interventions (if any) are to be implemented and any education provided to the residents and family.The Director of Nursing and/or designee will make all changes to the MDS and implement a new care plan to reflect the individualized needs of the residents.Facility Policy titled, Care Plan Policy dated 12/06/2022 states in part but not limited to:3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the residents' conditionb. when the desired outcome is not metc. when the resident has been readmitted to the facility from a hospital stayd. at least quarterly, in conjunction with the required quarterly MDS assessment