STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005854	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF GLENVIEW,THE	1700 EAST LAKE AVENUE GLENVIEW, IL 60025

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S 000	Initial Comments Complaint Investigation 2293404/IL146425	S 000		
S9999	Final Observations Statement of Licensure Violations 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 pressure sores from developing.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow its wound care policy and procedures and individual resident care plans to prevent and manage facility-acquired pressure ulcers for 1 (R5) of 3 residents reviewed for pressure ulcers from a sample of 3. These failures resulted in R5 sustaining 2 facility-acquired pressure ulcers to the sacrum and left ischial tuberosity (pelvis area).

Findings include:

On 4/27/22 at 11:20 AM, surveyor requested a wound report from V2 (Director of Nurses/DON). The report showed all pressure ulcers that were actively being treated by the facility. Shown on

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S9999	Continued From page 2 this report were two facility-acquired pressure ulcers for R5: #1. Sacrum; facility-acquired pressure ulceration; active status, clinical stage 4. #2. Left Ischial tuberosity; facility-acquired pressure ulceration, active status, clinical stage "unstageable." Facility wound assessment detailed report of R5's wounds conducted by V7 (Wound Nurse Coordinator) dated 3/9/22 showed the sacrum wound measured 3.20 centimeters in length, 3.00 centimeters wide, and 0.30 centimeters depth. Undermining was present in the wound (pocket or eroded skin underneath wound edges), and an overall area of 9.60 centimeters. A second facility wound assessment detailed report for R5's other facility-acquired pressure ulcer dated 3/9/22 showed the left ischial tuberosity measured 1.50 centimeters length, 0.80 centimeters wide, and 0.10 depth, with a clinical stage 3. R5 is an alert and oriented 71 year old resident with diagnoses of Multiple Sclerosis, Neuromuscular dysfunction of the bladder, and anemia. On 4/27/22 at 11:40 AM, R5 was observed lying on her back with both feet encased in blue-colored boots propped up on the foot board of the bed. R5 stated, "Are you here to help me?" Surveyor identified self and asked if R5 could use the call light to ask for help. R5 stated, "Good luck with that." Surveyor asked R5 to clarify. R5 stated, "I'm very uncomfortable on my back, and I've been on it since this morning." Surveyor asked if she knew who her nurse and aide were. R5 stated, "I don't know their names; they don't even have identification on them or even tell me	S9999		

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who they are. I see them once and then they disappear." Surveyor asked if she is ever assisted in repositioning in bed. R5 stated, "No, you've got to be kidding me. I've already told my sister and brothers about this problem, and they actually can watch me on that thing (pointing to an electronic virtual assistant). I can't do much myself, and I need someone to turn me. I can't do it at all." V5 (Registered Nurse/RN) came into the room and asked R5 if she needed assistance. R5 stated, "Yes I need to get turned." Surveyor asked V5 when she last came in to see R5. V5 stated, "I saw her earlier when I got in around 7-7:30 (AM), and I gave R5 her medications. Why; is there a problem?" Surveyor asked who R5's aide was today. V5 stated, "I think it's V6 (Certified Nursing Assistant/CNA) today. Do you need her?" Surveyor asked V5 if she knew when R5 was last repositioned. V5 stated, "I'm not sure, but I can ask her CNA." Surveyor requested to view R5's wounds on her backside and V5 (RN) called in V6 (CNA) to assist in turning R5 to allow surveyor to view the wounds. V5 stated, "This first wound is the left ischial stage 3 and it's facility-acquired. It's stable, and it was last seen by the wound doctor last week, I think. The other wound is on her sacrum. It is a stage 4 and also facility-acquired. It has undermining." Surveyor asked when the wound dressings were last changed as there were no apparent markings or dates on the dressings to signify when they were last changed. V5 stated, "We no longer initial and date the wound dressings according to our corporate consultant." Surveyor asked how she knew the wound care was done if the dressings were not dated and initialed by the nurse conducting the dressing change, V5 stated, "I don't know, but I know that we have not been marking the dressings for a while now." Surveyor asked who did the dressing changes normally. V5 stated,

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"That would be the wound nurse (V7), but she has been off duty for a week. I think she's due back today because they called her in." Surveyor asked if the dressings appeared clean and dry. V5 stated, "No, they need changing. I was going to do that today, but I was told the wound nurse was coming back so I didn't do them."

On 4/27/22 at 11:40 AM, V15 (Caregiver) stated, "I have been (R5)'s caregiver, and I am just here to be her companion. I am here most of the day and I have to ask the CNAs here to come in and help her, because they expect me to do things for her, and I can't do that." Surveyor asked if she ever sees the aides come in the room to reposition (R5). V15 stated, "Sometimes you'll get an aide to come in and turn R5. She needs two people but there's just one (aide) that does it." Surveyor asked how frequently the aides or nurses will come in. V15 stated, "I'll see the nurse once maybe in the morning to give medications, but then I don't see them until the next shift comes. R5 mostly has problems getting someone in to see her when I'm gone." R5 nodded in agreement and stated, "Yes, in the evening and especially at night."

R5's Minimum Data Set (MDS) dated 2/1/22 shows R5 with a Brief Interview for mental Status (BIMS) score of 12, indicating mild cognitive impairment. This same MDS shows R5 requiring extensive assistance in bed mobility (turning and repositioning in bed) and requiring a minimum of 2 persons to accomplish this task.

Physician Orders dated 9/27/21 read, "Frequent turning and repositioning at least every two hours and as appropriate every shift for immobility."

During interview on 4/27/22 at 12:28 PM V7

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S9999	Continued From page 5 (Wound Nurse) stated, "I was off for 6 days and I got a call back from V2 (DON) to come back because public health was here." Surveyor asked about the wound dressings policy. V7 stated, "I was told by our wound consultant that we were not supposed to label the dressings of when they are changed due to infection control." Surveyor asked how labeling the wound dressing was an infection control issue. V7 stated, "I guess because when you use a pen to mark the dressing before putting it on the wound, it could be an infection control problem." Surveyor asked if this was also true of not labeling any pain patch medications or other transdermal medications applied on a patient. V7 stated, "I see what you mean. I don't know why then, but I will let our corporate know." On 4/27/22 at 1:00 PM, V2 (DON) informed surveyor that they were going to start labeling of wound dressings, and the nurses would initial the dressing changes to denote when these wounds were treated and when wound dressings and bandages were changed. On 4/27/22 at 4:30 PM, surveyor observed wound care for R5 with V7 (Wound Care Nurse) and V9 (Wound Doctor). R5 was turned to her right side to reveal an open area appearing as a hole on her sacral area. V9 performed a debridement procedure with a scalpel to remove slough and dead necrotic skin around the area of the wound. Below the sacral area was feces in between R5's buttocks which was not cleaned prior to the procedure. V9 explained to surveyor, "I'm lightly debriding the area with this scalpel." Surveyor asked if there was any undermining or tunneling of the wound. V9 stated, "There is no tunneling, but there is undermining at 7:00 o'clock to 3:00 o'clock, and it approximately undermines 1.8	S9999		

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inches in." As V9 finished the debridement procedure, V7 (Wound Nurse) finished the dressing change on the wound and surveyor asked about the feces that was present prior to the doctor starting the procedure. V7 stated, "I don't know; I'm not sure why she wasn't cleaned up before V9 started the debridement." V7 called in a nursing aide (V13) to clean R5. Surveyor asked V13 (CNA) why R5 wasn't cleaned up prior to the procedure. V13 stated, "I don't know. (R5) is not my resident. I was just called to come and clean her up, but R5 is V14's (CNA) resident."

Surveyor interviewed V9 (Wound Doctor) after the debridement procedure about the absence of labelling and initialing of wound dressings when they are conducted. V9 stated, "I don't decide on when the bandages/dressings are signed off by the nurse; that's a facility decision." Surveyor asked the importance of dating the wound bandages. V9 stated, "I would think that it's so the nurse conducting the dressing change knows that the wound was treated and dressings were changed. However, that is not my decision to make." Surveyor asked about the importance of turning and repositioning. V9 stated, "That is of utmost importance of off-loading to relieve pressure off the wound and pressure points. I mention this in my assessments and orders."

On 5/2/22 at 11:20 AM, V7 (Wound Nurse) was asked about her wound assessments for R5. V7 stated, "I always write on the wound assessments to turn and reposition and to off-load the site and we continue with her air loss mattress. It's the wound doctor's order and we care plan this." Surveyor asked how they verified that this was being carried out. V7 stated, "I ask the CNAs directly and they tell me 'Yes.'" Surveyor asked how often R5 needed to be repositioned while in

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bed. V7 stated, "R5 needs to be repositioned at least every 2 hours or as needed. That's the order from the doctor." Surveyor asked if there was any documentation for this. V7 stated, "I know that it's in the TAR (Treatment Administration Record)." TARs for R5 were provided to the surveyor which showed "Frequent turning and repositioning at least every two hours and appropriate every shift for immobility." This same TAR shows an electronic signature by the nurse once per shift, denoting the resident was repositioned once per eight-hour shift.

R5's wound care plan reads in part: (R5) has stage 4 pressure ulcer to sacral area; Diagnosis multiple sclerosis and immobility; incontinent of bowel, seizure disorder. 3/2/22 left hip unstageable. Goal: (R5) pressure ulcer to sacrum area and left ischial area will show signs of improvement. Interventions: Administer treatments as ordered by physician and monitor for effectiveness with each dressing change. Apply off-loading device while in bed. Assess/record wound healing; Observe dressing to ensure it is intact and adhering; Teach resident the importance of changing positions for prevention and decline of pressure ulcers; Encourage small frequent position changes; The resident requires pressure prevention device air mattress; Turn/reposition at least every 2 hours or requested by resident more often as needed."

On 5/2/22 at 2:40 PM, R5 was observed in bed lying on her back. Surveyor asked R5 if anyone came to reposition her in bed. R5 stated, "Well my caregiver was here, and I can tell you they came in twice and only one aide came to help me. I need two people because I can't do it myself and I keep telling them that. I guess I'm lucky they even come in now since you've been

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S9999	Continued From page 8 here (referring to surveyor)." Facility policy revised April 2022 titled "Pressure Ulcers/skin Breakdown Protocol" reads in part (but not limited to): "The nursing staff and practitioner will assess and document an individual's significant risk factor for developing pressure ulcers; for example immobility, recent wight loss and history of pressure ulcers. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width, present dates or necrotic tissue; pain assessment; resident's mobility status, current treatments, including support surfaces and all active diagnoses. Treatment/Management: The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. Label tape or dressing with date, time, and initials. Place on clean field." (B)	S9999		