STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009179	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF STERLING,THE	105 EAST 23RD STREET STERLING, IL 61081

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S 000	Initial Comments Complaint Investigation 2410626/IL169051	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)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.	S9999		

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 failed to prevent a resident from developing pressure injuries and failed to identify pressure injuries prior to becoming stage 3, and unstageable for 1 of 3 residents (R1) reviewed for pressure injuries in the sample of 3.

The findings include:

R1's census report shows she was admitted to the facility on 10/26/23 and re-admitted on 1/19/24. Her diagnoses include obesity,

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hemiplegia and hemiparesis following a cerebral infarction affecting left non dominant side. The facility assessment of 11/30/23 documents R1 is a moderate risk for developing pressure sores due to being chairfast and very limited mobility. The 10/27/23 care plan documents R1 is at risk for impaired skin integrity related to advanced age, decreased mobility, diabetes, and a history of pressure injuries.

R1's December 2023 TAR (Treatment Administration Record) shows an order upon admission to notify the MD with any change in skin/document every night shift for admission.

The wound rounds report shows an unstageable wound to the right heel identified on 11/28/23. R1's care plan documents a blister to the right heel, and on 12/5/23 the blister increased in size and measured 5 cm (length) by 5.2 cm (width) and was full of fluid and dark dry surrounding edges. The notes show podiatry was managing the heel wound.

R1's 11/13/23 podiatry progress notes show she had no pressure wounds or concerns with her heels. The 12/8/23 progress note shows she had developed wounds to her bottom and now to her right heel. The exam shows a 4 cm by 3 cm fluid filled pressure blister located to the posterior right heel. The 12/27/23 progress notes show the wound to be 4.5 cm x 3.5 cm and 0.1 cm (depth). The plan of care shows R1 was recommended for the initiation of local wound care and follow-up with the wound center.

R1's 12/4/23 progress notes for skin/wound note shows V6 LPN/ wounds (Licensed Practical Nurse) documented a stage 3 pressure wound identified on the left buttock. The wound

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measured 2.2 cm wide by 1.2 cm in depth and 0.1 cm. V6 noted R1 had a decline in mobility and spending more time in bed related to a recent diagnosis of Covid 19.

R1's initial physician wound evaluation and management summary of 12/7/23 shows V7 (Wound physician) assessed the left medial buttock to have a stage 3 pressure wound measuring 1.0 cm (length) by 0.7 cm (width) and 0.3 cm (depth).

On 1/24/24 at 2:15 PM, V6 stated she initially identified the buttock wound at a stage 3. It had not been reported to her by staff. V6 was in R1's room and did a skin check on her buttocks. V6 said pressure wounds should be identified prior to a stage 3 and should be found at a stage 1. V6 said R1 had covid and was wanting to stay in bed longer, and her mobility had declined, which puts her at a higher risk for skin breakdown. V6 said R1 should have had a skin check daily, and the wound should have been identified earlier. V6 said the blister on R1's heel was caused by friction/pressure.

On 1/24/24 at 10:47 AM, V5 CNA (Certified Nursing Assistant) said R1 is alert and knows what is going on. R1 can be non-compliant with some care, she likes to be sitting in her chair. V5 said R1 can move herself but must have help to get R1 onto her side. R1 cannot move her legs and get them up on the bed. Once on her side, R1will stay in that position.

On 1/24/24 at 10:40 AM, R1 said she has pain on her bottom because she was sitting in the chair too long and staff did not turn her. R1 was observed using the upper side rail to sit up to the edge of the bed and said "oh my butt" when she

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sat up straight.

On 1/24/24 at 11:45 AM, R1's wound to the buttocks was observed to be clean, no redness noted on the edges, and no drainage.

On 1/24/24 at 10:23 AM, V4 LPN said when R1 is in bed she can move her upper body, maybe shift herself, but cannot reposition herself. Staff has to make sure to move her side to side. V4 said skin checks are done with showers and the CNAs report any redness, open areas, or bruising to the nurse and mark the shower sheets.

On 1/25/24 at 11:20 AM, V11 FNP (Family Nurse Practitioner) of podiatry said R1's heel ulcer could have been prevented. She has been seeing R1 as a patient for a very long time, and she had no problems with pressure injuries until she went to the nursing home. V11 said if (R1) was on daily skin checks, the nurse would have noted the heels to be reddened or maybe a little purple before having a pressure blister. V11 said if a wound is not identified, and no treatment or prevention is put in place the wound will become advanced (worsen). V11 said R1's heel had worsened and was referred to the wound clinic for further care and treatment.

On 1/24/24 at 2:40 PM, V9 LPN said residents get repositioned every 1.5 to 2 hours. When performing a skin check, areas checked would include the buttocks, any bony prominence and the heels to see if any wounds or breakdown are present. V9 said any open areas are documented in the progress notes and reported to V6, and the physician. Residents are on daily skin checks, and it is noted on the TAR.

On 1/25/24 at 11:20 AM, V12 FNP usually said

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S9999	Continued From page 5 skin issues can be found during showers, toileting, and giving care. V12 said, "I would expect wounds/skin issues to be identified a stage 1 when the skin is becoming reddened and even at a stage 2 when the skin is starting to open up. Something should have been noticed sooner. It is not typical for a non-terminal resident to develop pressure wounds in just a few hours. If she (R1) had been turned or taken to the bathroom, they should have noticed". The facility's July 2017 policy for prevention of pressure ulcers/injuries document the purpose is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADL's (activities of daily living). a. Identify any signs of developing pressure injuries b. inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.). (B)	S9999		