Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015168	A. BUILDING: ______ B. WING ______	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF NORTHBROOK, THE	3300 MILWAUKEE AVE. NORTHBROOK, IL 60062

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S 000	Initial Comments Complaint Investigation # 2094298/ IL 123501	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)3)5) 300.1220)b)2) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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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:
2)All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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.

Section 300.1220 Supervision of Nursing Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status,

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S9999	Continued From page 2 discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were NOT met evidenced by: Based on observation, interview, and record review, facility failed to identify and assess pressure wounds on a resident's left ankle and sacrum. This failure resulted in R3's pressure wounds deteriorating to unstageable wounds with slough and necrotic tissue before receiving treatment. This applies to 1 of 3 residents (R3) reviewed for pressure ulcers in a sample of 5. The findings include: The Physician's Order Sheet dated 11/20/20 shows R3 has diagnoses including Diffuse Traumatic Brain Injury, Acute Respiratory Failure with Hypoxia, Fracture of the Right Calcaneus, Fracture of the Lumbar Vertebra, and Passenger injured in collision in Motor Vehicle Accident. R3's Braden Skin Risk Assessment dated 9/28/20 shows that R3 scored a 15 (At risk) for skin breakdown.	S9999		

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R3's initial Wound Assessment Detail Report dated 10/19/20 shows that R3 developed a facility acquired pressure ulcer on her left ankle. The wound is described as a deep tissue pressure injury, 70% deep maroon and 30 % bright beefy red. The wound edges are distinct and attached and there is moderate serous drainage. The wound measures 2 x 2 x 0.1 cm. The picture of the wound shows a dark, indurated wound bed with dry flaking skin surrounding the wound. This same document states, "Seen by wound MD. New wound present on left ankle outer. New treatment order given."

R3's Nurse's Notes date 10/19/20 state, "Nurse -wound care report that resident has deep tissue 2 by 2 on left outer ankle. Continue to monitor the resident on her ankle."

The Treatment Administration Record (TAR) dated 10/2020 show no new treatment orders for the left ankle until 10/21/20 (2 days after wound was found)

R3's Physician's Order Sheet dated 11/2020 shows that the Prevalon Boot for left lower extremity skin protection was not ordered until 11/15/20.

The first Wound Physician Assessment is dated 11/2/20 and states, "Wound is open. The wound is currently classified as an unstageable/unclassified wound with etiology of pressure ulcer and is located on the left lateral malleolus. The wound measure 1.3 x 1.5 x 0.1 cm. There is a medium amount of serous drainage noted. There is no granulation within the wound bed. There is a large amount of necrotic tissue within the wound bed including adherent slough ..."

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R3's initial Wound Assessment Detail Report dated 11/3/20 shows that R3 developed a facility acquired pressure wound to her left buttocks. The wound is described as unstageable, 30% bright pink or red and 70% slough white fibrinous. The wound edges are distinct and attached and there is moderate serous drainage. The wound measures 3 x 3.5 x 0.10 cm. The picture of the wound shows a dark dry wound bed with a lighter colored moist wound bed underneath. This same document states, "Wound present on left buttock with black tissue. Wound cleansed and dressing applied ..."

R3's Nurse's Notes dated 11/3/20 at 10:33AM state, "CNA called this nurse to check on pt's left buttock. Noted an open area about a quarter size, without bleeding. Skin cleaned with NS then applied with medi honey and dry dressing until seen by Wound Nurse. Pt. denies pain. Repositioned to her right. side ..."

R3's Nurse's Notes dated 11/3/20 at 1:18PM state, "The writer was requested to check residents left buttock as she has a new wound. Assessment done. Noted an unstageable wound on left buttock measuring 3 x 3.5 x 0.1 cm with 30% granulation tissue and 70% slough. Wound edges well defined and attached. Moderate serous drainage noted. Peri wound noted with redness. Wound cleansed and dressing applied. Will upgrade the mattress ... Will keep the head of bed at 30 degrees ..."

On 11/20/20 at 11:20 AM V4 (Wound Care RN) stated, "(R3) has a wound on her left ankle that has slough- we are using (debriding medication) on the wound. It started as a DTI- then it went to unstageable with slough. It needs debridement if

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it is ever going to heal. She goes to a wound clinic outside of the facility. I don't know how she got the wound. I just took over this position when the wound nurse had to be off. Her buttocks wound is not any bigger but it is not getting any better. We are using medi-honey and calcium alginate. Her son takes her to the wound clinic every week and they measure it but we measure it too. The wound clinic does not send us any reports."

On 11/20/20 at 10:55AM, R3 was sitting up in her wheelchair in her room. R3 was sitting on a (pressure relieving) cushion. R3 appeared to be sliding slightly forward in her wheelchair. She appeared somewhat uncomfortable but denied pain. V3 (Registered Nurse) stated that R3's dressings were changed about one hour before by V4.

On 11/20/20 at 2:30 PM, V2 (Director of Nursing) was asked about R3's wounds and the inaccuracy of the assessments. V1 stated the facility had recently done an in-service on the identification and assessment of wounds.

R3's Current Care Plan states, "Skin check every shift during care. Report immediately/ accordingly to wound RN/MD any new or deteriorating skin problem. Assess for possible causes to develop pressure ulcer such as pressure, friction, moisture, immobility and other contributing factors."

The facility policy entitled Prevention of Pressure Ulcers/Injuries dated July 2017 states, "Inspect the skin on a daily basis when performing or assisting with personal or ADLs. A. Identify any signs of developing pressure injuries (i.e. non-blanchable erythema), b. Inspect pressure

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S9999	Continued From page 6 points ..." This same policy states, "Deep Tissue Pressure Injury is intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface." and "The Unstageable pressure ulcer appears as a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar (devitalized tissue)." " B "	S9999		