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 02/18/2022

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 2291137/IL143419	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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. 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure proper transferring of a resident from bed to shower chair resulting in resident sustaining a deep laceration of right ankle that	S9999		

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S9999	Continued From page 2 required hospital visit for suturing. This affected one (R1) of 3 residents reviewed for safe transfer in a total sample of 9. Findings include: On 2/15/22/ at 8:31am V7 (Family member) said that on 1/27/22, R1 was injured on R1's foot while being transferred to the shower chair by 2 staff. V7 said no mechanical lift was involved. V7 said R1's foot/ankle was gashed and R1 was sent to the hospital. R1's foot required 12 stitches and was sent back to facility. V7 said R1's foot kept bleeding over the next 3 days. On 1/30/22 at 8:15am, V7 saw R1's foot heavily bleeding and R1 was sent to the hospital again and was admitted. R1 was admitted to facility on 1/16/22 with diagnoses including but not limited to COVID, difficulty walking, muscle/generalized weakness, type 2 diabetes mellitus, unsteadiness on feet, congestive heart failure, atrial fibrillation, hypertension, dependence on oxygen. Review of R1's care plan did not include an Activities of Daily Livings (ADL) care plan, including transfer. R1's care plan was not updated for transfer after the incident. On 2/17/22 at 10:16am V19 (Restorative Nurse) said that he did not complete R1's ADL care plan. V19 said for some reason he just missed it. V19 said that he does not know the facility's policy in formulating and revision of resident's care plan and said he will get back to surveyor regarding the policy. V19 said that he did R1's MDS (Minimum Data Assessment) admission assessment dated 1/13/22, which documents Section G: Transfer: 1. Self-performance: coded 3 = extensive assistance, 2. Support: coded 3 = 2	S9999		

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S9999	Continued From page 3 + person physical assist. On 2/17/22 at 10:30am V6 (Nurse Consultant) said that initial resident care plan is formulated within 24hrs, and comprehensive care plan is developed within 7 days after the completion of the MDS assessment. On 2/16/22 at 11:16am V8 (Certified Nursing Assistant/CNA) said that he took care of R1 on the day of incident. V8 said that R1 is alert and oriented x 3, able to verbalize needs to staff. V8 said that during R1's transfer from bed to shower chair with V18 (CNA student) R1 sustained an injury to R1's right ankle, and R1 was sent out to the hospital for suturing. V8 explained that R1 is a 1 person assist during transfer, and V8 just asked V18 CNA student to hold the shower chair while he physically transferred R1. V8 does not know what happened and noticed blood on R1's right foot and he called V3 (Assistant Director of Nursing/ADON) to assess. V8 said that he was not given transfer training inservice after the incident. On 2/16/22 at 3:05pm V2 (Director of Nursing/DON) said that R1 is a 2 person assist, but V8 (CNA) can handle R1 by himself. V2 said that they removed/discarded the shower chair when surveyor asked to see the shower chair. Both V8 (CNA) and V18 (CNA student) were given instruction regarding safe transfer after the incident. R1's incident report dated 1/27/22 at 10am documented by V2 (DON) indicated R1 was transferring from bed to shower chair. R1 pivoted from bed to shower chair. R1 stated "My right knee buckles sometimes." When sitting down R1 sustained a right ankle open area. Pressure was	S9999		

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S9999	Continued From page 4 immediately applied. Bleeding ceased. Wound cleansed and wrapped with kerlix. R1 sent out to the hospital for further evaluation. R1 returned to facility. Final report: R1 will be screened by therapy for transfer and strengthening. R1's hospital emergency department report dated 1/27/22 provided by V2 (DON) indicated: The patient was transferring from bed to chair to go have a bath when she slid and struck the right ankle on the corner of a chair. There is a 6cm and a laceration on the anterior and lateral aspect of the right ankle just superior to the joint line. There is no penetration into the joint or through the fascia. Laceration repair 12 sutures. Diagnosis: Ankle laceration injury. Hospital Triage report dated 1/27/22 from V3 (ADON) indicated R1 is alert and oriented x4, reports being assisted by staff to shower chair, right ankle got caught. Laceration noted to right foot approx. 5x1x0.5cm. Wrapped in gauze, bleeding controlled. R1 denied chest pain, SOB (Shortness of Breath). R1's baseline 02 (oxygen) is at 3LPM (liters per minute) NC (nasal cannula) in use. R1 has history of Hypertension, Diabetes, CHF, Atrial fibrillation and on Eliquis. Surveyor informed V2 (DON) that her incident documentation is inconsistent with report given by V3 (ADON/nurse on duty when the incident happened) to the hospital. The report given by V3 (ADON), V18 (Student CNA) and V14 (Nurse Practitioner) were consistent. The incident report submitted by V2 (DON) to State Agency did not have measurement and description of the deep laceration on R1's right ankle. The incident report also did not indicate that a procedure was done at the hospital.	S9999		

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S9999	Continued From page 5 On 2/17/22 at 7:01am V18 (CNA Student) said that she has observed and helped CNAs do mechanical lift transfers for R1. V18 stated V18 does not know why they did not use a mechanical lift transfer for R1 on 1/27/22. V8 (CNA) did not explain to her why they did not use the mechanical lift. V18 (CNA student) said she assumed it is faster and quicker using physical lift. V18 said, "V8 asked me to hold the shower chair while V8 transferred R1 from bed to shower chair. R1 moved her foot and got caught at shower chair wheels." V18 said they did not notice it until they saw her right ankle was bleeding. They called V3 (ADON) who was the nurse in the unit. R1 did not complain of pain, and she did not feel the injury because she was diabetic. V18 said, "R1 is on a blood thinner medication and that's why she bleeds a lot." V18 stated she was not given in-service training for transfer technique by V2 (DON) after the incident. V18 said she does not have her clinical instructor in the facility, and she just report to V2 (DON) if she has any questions. V18 said that she started her CNA class last 1/3/22. On 2/16/22 at 1:35pm V14 (Nurse Practitioner) said she saw R1 on 1/27/22 after the incident. V14 said nursing reported that morning while R1 was getting a shower her right foot was caught by shower chair. A deep laceration at right ankle was present without active bleeding, pressure dressing was applied. R1 denied acute pain or distress. R1 was sent out to the hospital for suturing. R1 returned from hospital after suturing on the same day. V14 saw R1 on 1/28/22 for follow up. Nursing reported bleeding from the suture site at right ankle, manual pressure applied for 30 mins and applied pressure dressing. Blood thinning medication was held. R1 was sent again to hospital due to suture site	S9999		

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S9999	Continued From page 6 bleeding. V14 said R1 needs a minimum of 2 person assist for transfer. R1's Physician order sheet for January 2022 indicated: 1/27/22 - sent to Emergency for laceration in her right ankle. 1/28/22 - send to Emergency Room (ER) for treatment and eval due to Right Lower leg laceration ankle, and 1/30/22 - send to hospital ER for eval due to Right ankle stiches dehiscence. On 2/17/22 at 11:25am V20 (Therapy Director) said that she has provided therapy treatment with R1 several times. V20 said R1 needs maximum assistance with 2 person assist for transfer. R1 should not be transferred or be lifted with 1 person only. V20 said that no one should do the transfer until they know how R1's legs work or if R1 is strong enough to stand. V20 said that they reported to nursing that R1 is a maximum assist with 2 or more persons. V20 cannot remember the name of the nurse she gave report to. V20 said she suggested a mechanical lift for safe transfer. Facility's Care Plan policy documents: Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Interpretation and implementation: 12. The comprehensive, person-centered care plan is developed within 7 days of the completion of the required comprehensive assessment (MDS). 13. Assessments of resident are ongoing and care plans are revised as information about the residents and the residents' condition change.	S9999		

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S9999	Continued From page 7	S9999		

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