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 ____	01/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1010h) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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	S9999		

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S9999	Continued From page 2 review, the facility has the following failures for 3 out of 6 residents (R6, R25 and R91) for a total sample of 30 residents reviewed for pressure ulcers: Failed to follow their wound prevention and management policy to ensure residents does not develop pressure ulcers. Failed ensure that residents received wound treatments. Failed to follow manufacture's instruction for proper settings on the low air mattress. Failed to maintain correct dressing per physician's order. Failed to monitor skin status for prevention of pressure ulcers. Failed to refer residents with new and worsening pressure ulcers to wound care physician for assessment and treatment. These failures resulted in R6 sustaining 4 new facility acquired pressure ulcers on her right lower extremities. R25 sustaining 2 facility acquired pressure ulcers on the sacral pressure ulcer that further deteriorate with size, characteristic and appearance, and left heel pressure ulcer that was identified on its late stage (Stage 3). R91 sustaining left buttock pressure ulcer that worsened. Findings include: R25 was 88 years old, initially admitted on 9/9/2022 with medical diagnoses of hemiplegia and hemiparesis. R25 brief interview of mental status 12/16/2022 has a score of 14 that means R25 cognitive status is intact. On 01/17/2023 at 11:22 AM. R25 stated that he cannot remember anyone did change his dressing today. R25 said that he has wound on his back and shook his head when asked if it gets any better. R25 was seen closing his eyes most of the time and fall asleep but responded short response during conversation.	S9999		

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S9999	Continued From page 3 On 01/18/2023 at 10:16 AM, V18 (Wound Coordinator / Licensed Practical Nurse) stated that R25 has unstageable pressure ulcers on both his left heel and sacrum and that both wounds were acquired in the facility. And the most recent was V18's left heel pressure ulcer that was initially identified on 1/3/2023. When asked about the status of both sacral and left heel pressure ulcers. V18 said, "It worsened, but there was a time that it was getting better. Both pressure ulcers are unstageable because of the presence of sloth." And when asked about the plan of care related to both pressure ulcers. V18 said, "I do not do care plan. It is done by the MDS coordinator. It is part of my contract when I accepted the job as wound coordinator not to do care plan." V18 was asked if she was coordinating with the person doing the care plan since she was the staff that is doing direct care such as changing the dressing and alike. V18 said, "If she (MDS Coordinator) asks me, I will give her information. But if you ask me what the interventions for R25's pressure ulcers right now. I don't have the information. I understand what you mean that it is supposed to be interdisciplinary coordination since I perform the care plan, there should be communication between me and the person doing the care plan to determine if interventions are effective." On 01/19/2023 at 09:08, V18 to perform treatment or pressure ulcer care of R25's sacral and left heel. Prior to dressing change V30 (Licensed Practical Nurse/LPN) stated that R25 had a lot of bowel movement earlier. And that she (V30) does not know what was ordered dressing for R25 sacral pressure ulcer. And that she (V30) and V10 (Certified Nursing Assistant/CNA) just cover it with dry dressing. Per physician order, the current and correct treatment is to cleanse sacral	S9999		

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S9999	Continued From page 4 pressure ulcer with (Type) topical antiseptic solution pack inside cavity with moist gauze and cover with dressing. After V18 took off the covered dressing that V30 placed. The inside of the wound (pressure ulcer) was packed with gauze that was brownish in color and was soaked with drainage. V18 said, "This is the gauze that I placed yesterday around 3:30 PM. After all the gauzed that was packed were taken out. Cavity of pressure ulcer became visible, and it was deep that it appears to be reaching the bones. Although a partial slough that cover portion of the bed of the pressure ulcer does not allow the bones to be seen. V18 stated, "Yes, it is deep enough that it may reach the bone." During dressing change V18 measured both sacral and left heel pressure ulcers. Sacral wound measures in centimeters: 5.0 by 6.0 by 2.0 (length by width by depth) with 7 to 2 o'clock undermining. V18 said that there was undermining when she inserted the stick with cotton tip underneath R25's wound moving from 7 to 2 o'clock. Left heel measurement in centimeters: 2.3 by 2.4. Then V18 said, "This is 100% slough." Pointing at R25's left heel pressure ulcers that the whole area was covered with slough. On 01/19/2023 at 10:06 AM, V18 (Wound Coordinator / Licensed Practical Nurse) was asked if nursing staff on the floor knows how to access wound treatment orders for them to place the correct dressing as ordered by physician in case dressing becomes soiled or wet. V18 said, "Staff (nursing) staff on the floor can access treatment orders. And must know what dressing to place when needed. They have been informed and instruction were given to them. But I totally agree with you. Wound treatment must be performed correctly by both nursing staff on the floor and wound care staff. V18 was asked about	S9999		

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S9999	Continued From page 5 the process to document treatment that was done in the treatment administration record (TAR). And was also asked if it should be sign on the same day the treatment was done. V18 said, "I don't sign on the treatment administration record (TAR) after I performed the treatment. But I tried to sign it by the end of the day. And yes, sacral wound, you may say it worsen if the skin was intact with redness and later opens." V18 was asked, since there was a clear deterioration of R25's sacral pressure ulcer since 9/30/2022 until currently, why was the wound not seen by a wound doctor until 01/16/2023? V18 said, "I tried to do the treatment on my own. I guess it would help but there are times that R25's wounds seem to be improving." V18 was also asked about R25's left heel since it was discovered already in stage 3, if nursing staff was monitoring R25's left heel should it be in an earlier stage when it was easy to manage? V18 said, "I don't know. But when it was discovered, it was already stage 3." Per R25's notes dated 9/12/2022 in part reads that R25 skin on the sacral area was intact but with redness. Then foam dressing was applied. Per physician's order, foam dressing needs to be applied to R25's sacrum to start on 9/14/2022. Per R25's treatment administration record (TAR), for foam dressing was not signed as being perform on 9/14/2022 and from 9/20/2022 up to the end of the month no treatment was signed as being performed. On 9/30/2023, R25's sacrum pressure ulcer worsened from skin intact redness to open pressure ulcer measuring in centimeters as follows: 1.5 by 1.0 by 0.10 (length by width depth). Compared to sacral pressure ulcer assessment dated 01/16/2023 measuring in centimeters as follows: 4.0 by 6.0 by 1.5 (length by width by depth). As to R25's left heel pressure ulcer, it was first identified on 1/3/2023 as stage 3	S9999		

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S9999	Continued From page 6	S9999		

Continued From page 6

with measurement in centimeters as follows: 2.0 by 3.0 by 0.10 (length by width by depth). On 01/09/2023, left heel pressure ulcer was reclassified as to its stage from stage 3 to unstageable due to 100 % of the area of the pressure ulcer was covered with slough.

On 01/19/2023 at 11:34 AM, V33 (Wound Doctor) said, "I only see residents that was referred to me by the primary physician. And it was the first time R25 was referred to me, so I cannot make any determination or comparison as to the status of R25's pressure ulcers. But what is documented on her assessment dated 1/16/2023 was the basis of the status of the wound. Yes, the presence of slough means wound deterioration and that a skin intact with redness that opened means worsening of the wound. It can be attributed to many factors including not performing of treatment." Per V33 documentations: R25 was only seen 1 time on 01/16/2023 although R25's sacral pressure ulcer was initially identified as having redness on 09/12/2022 and opened on 09/30/2022 that worsen overtime per facility Wound Round Assessments. And only saw R6's 4 pressure ulcers on resident's right lower extremities after facility was informed that R6's wounds are being reviewed.

On 01/19/2023 at 12:12 PM, V2 (Director of Nursing/DON) said, "All pressure ulcers besides stage 1 must be seen as soon as possible by Wound Doctor. The process for the primary care physician to give a referral for the wound doctor to see resident."

R25's Health Records are as follows:

Per R25's notes dated 09/12/2022, reads in part

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S9999	Continued From page 7 that R25 has blanchable pink noted to sacral area. Notes dated 01/11/2023 in part reads that R25 left heel and sacral wound declined. R25's treatment administration records (TAR) for the months of September, October, and November 2022 have multiple days that were not signed as treatment ordered by physician was being performed on the sacral pressure ulcer. Per facility Wound Rounds assessment R25's pressure ulcer was initially opened on 09/30/2022 and later deteriorates as to size, characteristic and appearance. From 1.5 by 1.0 by 0.10 centimeters (length by width by depth) on 09/30/2022 to 4.0 by 6.0 by 1.5 centimeters (length by width by depth). And even increased in size when seen on 01/19/2023 with the following measurements: 5.0 by 6.0 by 2.0 centimeters (length by width by depth) with 7 to 2 o'clock undermining. Per V33 wound assessment, it was the first time she saw R25 when sacral pressure ulcer had already worsened. Per facility assessment Wound Rounds left heel was initially assessed on its late stage (Stage 3) on 01/03/2023. Later left heel pressure ulcer on assessment dated 01/09/2023 became unstageable due to slough white fibrinous covered 100% of the wound. Care plan for left heel was initiated on 01/08/2023, 5 days after pressure ulcer was identified. And later developed slough on 01/09/2023. Facility submitted Wound Care Pressure Ulcer Avoidability Assessment dated 09/30/2022 and signed by V33 (Wound Care Doctor) on 01/20/2023 although, V33 only saw R25 the first time on 01/16/2023. The same assessment was more than 3 months ago dated 09/30/2022 is still showing in progress today (01/20/2023). Dressings, Dry/Clean policy of the facility dated as revised 4/2022, in part reads:	S9999		

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S9999	Continued From page 8 The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Under preparation: Verify that there is a physician's order for this procedure. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. Check treatment record. Under documentation, the following information should be recorded in the resident's medical record, treatment sheet or designated wound form: The date and time the dressing was changed. On 1/17/23 at 11:30 AM, observed R91's wound care completed by V18 (Wound Care Nurse). Observed R91's left buttock area with an open wound noted with small portion of the wound was bright red and the rest of the wound was filled with a white thick non removable appearance. R91 stated, "This air mattress is too hard and makes my butt hurt." On 1/19/23 at 9:52 AM, V18 (Wound Care Nurse) stated, "I am a Licensed Practical Nurse for 4-years. I received my wound care certification in April 2022. I have been the only full-time wound care nurse here for the last two years. I work Monday thru Friday, and the weekend supervisor will complete the wound care treatments. V33 (Wound Care Physician) comes in the facility on Mondays, at least once per week to assess residents on her (V33) list. V33 only assess wounds that are declining, infected, or change in condition. Typically, I manage the wounds unless I think the wound physician needs to get involved. If I feel the wound physician needs to assess a wound, I will call the resident's primary care physician for an order to allow V33 to assess the resident. I'm not sure what the "PUSH" acronym or the score located on the wound summary	S9999		

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S9999	Continued From page 9 means. Once I enter the wound description the PUSH score is generated, the higher the number the worse the wound. However, in that square box underneath the title PUSH there is an arrow either pointing up or down. Arrow pointing up means the wound is worsening, and an arrow pointing down means the wound is improving. R91 was re-admitted to the facility on 1/9/23 with the Left buttock stage 3 pressure ulcer wound. On 1/10/23, I assessed R91's the left buttock wound, tissue was 100% bright beefy red, with scant serosanguineous drainage. R91's left buttock wound measures L[Length] 0.50cm x W [Width] 1.00cm x D[Depth] 0.10cm with the PUSH score of 5, no arrow was there because it was the first assessment completed. On 1/18/23 R91's left buttock wound was assessed as a stage 3 pressure ulcer wound, the tissue was 50% bright beefy red and 50% slough white fibrinous, with scant serosanguineous drainage. R91's left buttock wound measures L[Length] 2.00cm x W[Width] 0.50cm x D [Depth] 0.10cm with the PUSH score of 7 with the arrow pointing up, which indicated R91's wound has got worse. R91's wound interventions are an air mattress, encourage R91 to reposition, and heel boots while in bed. The air mattress is set per the resident's weight, he [R91] weighs 134 pounds. I noticed during R91's wound care that his [R91] air mattress was set at 300 pounds, which makes the mattress hard and firm. The air mattress is set at the wrong weight and can potentially cause the wound to worsen. R91 was not referred to V33, because I felt like I could handle the wound care alone. From 1/10/23 to 1/18/23, R91 wound did decline." On 1/19/23 at 11:30 AM, V33 (Wound Care Physician) stated, "I worked in this facility for two years, assessing, and treating referred residents	S9999		

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S9999	Continued From page 10	S9999		

with all pressure ulcers, vascular ulcers, surgical wounds, all stage non-healing wounds and infected skin areas. Once I assess a resident my documentation is on an application, V2 (DON) and V18 has access to those assessments. I have not assessed R91's wound, because I have not received any referral from R91's physician or V18. If a resident has a stage 3 wound, I will think certainly, I should have been referred to assess that resident's wound. If a wound goes from 100% beefy red to 50% slough, and larger in size, the wound has worsened. The air mattress is an intervention of residents with pressure ulcers. The air mattress settings are based on the resident's weight. If the air mattress is set at a higher weight, it could potentially cause a wound and or an existing wound to worsen."

On 1/19/23 at 12:10 PM, V2(DON) stated, "V18 needs to refer a resident to V33 with a referral from the resident's physician. V33 is supposed to see all pressure ulcers as soon as possible. V18 should obtain an order for the wound care physician as soon as possible for all wounds. The air mattresses are set on the resident's weight for proper air distribution for residents with pressure ulcers. If the bed is set on a higher weight, it could potentially cause their wound to worsen."

Reviewed R91's medical record documented in part: R91 was re-admitted on 1/9/23 with medical diagnoses of neuropathy, end stage renal disease, type 2 diabetes, liver transplant, kidney transplant, gastrostomy, gastritis, urinary tract infection, dysphasia, abnormal gait immobility, lack of coordination, hyperkalemia, heart failure, acute respiratory failure malnutrition, depressive disorder, seizures, chronic pain, cirrhosis of the liver, sepsis, and pneumonia. Physician order-dated 1/11/23, left buttock-cleanse with normal

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S9999	Continued From page 11 saline, apply (brand) non-adherent wound contact dressing, adaptic, and foam dressing every day shift on Tuesday, Thursday, Saturday, and Sunday. Face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS], care plans, medication administration record, treatment administration record, and progress notes. Policy; Documents in part -Prevention of Pressure Ulcers/Injuries dated 7/2017 "Support Surfaces and Pressure Redistribution' -Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors "Monitoring" -Evaluate, report and document potential changes in the skin -Review the interventions and strategies for effectiveness on an ongoing basis R6 is an 80-year-old female initially admitted to the facility 11/28/2017. R6's diagnosis includes but is not limited to, Parkinson's Disease, Unspecified Dementia, Functional Quadriplegia, Dysphagia, Gastrostomy, Fracture of Lower End of Femur. R6 was hospitalized from 11/23/22-11/26/22 for distal right femur fracture and readmitted with right lower extremity (RLE) hinge brace and an order for the brace to be worn at all times except for hygiene. Skin was intact upon readmission based on Nursing Admission/Readmission Assessment completed on 11/26/22. R6's Braden Score for predicting pressure sore risk on 11/26/22 was assessed as being at high risk based on score of 10. R6 is NPO and receiving all nutrition from enteral feedings via gastrostomy tube.	S9999		

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S9999	Continued From page 12	S9999		

Continued From page 12

R6 developed four pressure injuries identified on 01/11/23 in the following locations: right Achilles, right lateral lower leg, right inner ankle, and right outer ankle. Per facility document titled, "Wound Assessment Details Report" dated 01/12/23 performed by V18 (Wound Care Coordinator) documents in part, right Achilles unstageable with wound measurements (2.3x2.5x0.1) 100% slough white fibrinous, right lateral lower leg unstageable with wound measurements (0.90x2.0x0.1) 100% slough white fibrinous, right inner ankle unstageable with wound measurements (1.4x2.0x0.1) 95% slough white fibrinous 5% bright beefy red, right outer ankle unstageable with wound measurements (4.5x1.3x0.1) 95% slough white fibrinous 5% bright beefy red.

On 01/18/23 at 11:24 AM, V8 (Registered Nurse/RN) stated that before 01/03/23, R6 was wearing a right lower extremity leg brace all the time and that there were special instructions not to remove it. V8 stated that before 01/03/23, R6's leg brace was not being removed for any reason. V8 stated that the Certified Nursing Assistants notify the nurses if any skin alterations are identified.

On 01/18/23 at 2:33 PM, surveyors observed V18 (Wound Care Coordinator) providing wound care treatment to R6. V18 stated that R6 had four unstageable pressure wounds that were caused by the friction from R6's right lower extremity leg brace. V18 stated that the hinge type of brace is known to cause friction which is a risk factor for developing a skin alteration. V18 stated that the unstageable pressure wounds were identified when R6's leg brace was taken off to give R6 a shower (01/11/23). V18 stated that the wound care doctor was at the facility on Monday

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 ______	01/20/2023

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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S9999	Continued From page 13 (01/16/23) but did not see R6 or R6's pressure wounds. V18 stated that the wound care physician did not see R6 because V18 did not refer R6 to the wound care physician. V18 stated that V18 only refers residents with wounds to the wound care physician if the wounds are declining or infected or healing is not progressing. Surveyors observed right inner ankle, right outer ankle, and right Achilles covered with alginate dressing. When alginate dressing was removed surveyors observed the right inner ankle, right outer ankle, and right Achilles covered in slough with drainage. V18 stated that V18 used a different treatment dressing (alginate) other than what is ordered ({brand} enzymatic wound debriding agent, adaptic dressing) because V18 had observed an increase in drainage from these wounds yesterday during wound treatment. V18 stated, "I haven't had a chance to change the treatment order yet." Surveyors observed V18 take measurements of wounds. V18 verbalized out loud the measurements obtained with the results as follows: right inner ankle (1.5x2.3x0.1), right outer ankle (4.5x1.4x0.1), right lateral leg (1.6x1.6x0.1). No measurement was provided for the wound to right Achilles. On 01/19/23 at 9:30 AM, V34 (Nurse Practitioner/NP) stated that V34 was not aware that R6 had developed pressure wounds and that the last time V34 had seen R6 was on 12/7/22. V34 stated, "I remember them calling me about R6 needing a doppler study, but I was not notified about the four unstageable pressure wounds. It looks like they notified R6's primary physician." V34 stated that R6 is wearing a hinge brace which is known to cause friction which has the potential to lead to skin issues. V34 stated that if the staff was conducting daily skin checks they would observe any signs of skin deterioration on	S9999		

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	IL6015168	A. BUILDING: ______ B. WING ______	01/20/2023

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S9999	Continued From page 14 pressure point areas quickly. On 01/19/23 at 11:40 AM, V33 (Wound Care Physician) stated that V33 assesses and treats residents referred with all pressure ulcers, vascular ulcers, surgical ulcers, surgical wounds and all stages of non-healing wounds and infected skin areas. V33 stated that V33 works on a consult basis, and therefore the nurse needs to obtain an order from the primary physician for V33 to assess a resident. V33 stated V33 was consulted today to assess R6, and that it is the initial assessment for R6, so it is the first time V33 is doing measurements of R6's wounds. V33 attributes R6's unstageable pressure wounds to the leg brace worn by R6 and stated that the brace can cause friction which is a risk factor for developing pressure wound(s). V33 stated that the facility should be doing daily skin checks to identify skin changes. V33 stated that it is important for the wound treatment orders to be followed as prescribed and that the nurse should not be changing the order(s). On 01/19/23 at 12:00 PM, V18 (Wound Care Coordinator) provided to surveyor documents titled, Visit Report for R6 on 01/19/23 signed by V33 at 10:58:06 AM on 01/19/23 which documents in part that R6 has an unstageable pressure injury on right lateral lower log, right Achilles area, right lateral ankle and right medial ankle since 01/11/23, and the patient had a right leg brace for acute complex fracture of distal femoral metaphysis since 11/23/22, the patient is at increased risk for pressure injury due to the decreased mobility and the patient should be on a turning schedule. Measurements of the pressure injuries are documented as follows: right lateral leg (1.0x1.8x0.1) with small amount of serous drainage and large (67-100%) amount of necrotic	S9999		

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	IL6015168	A. BUILDING: ____ B. WING ____	01/20/2023

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S9999	Continued From page 15 tissue within the wound bed including Adherent Slough; right Achilles (2.2x2.5x0.1) with medium amount of serous drainage and large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough; right medial malleolus (right inner ankle) (1.0x2.0x0.1) with medium amount of serous drainage and large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough; right lateral malleolus (right outer ankle) (4.2x1.3x0.1) with medium amount of serous drainage and large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough. Note there is a discrepancy between the measurements provided on V33's documentation compared to the wound measurements taken by V18 and observed by surveyors on 01/18/23. On 01/19/23 at 12:09 PM, V2 (DON) stated that the overall goal is to keep resident's skin condition intact and not have any acquired pressure injuries. V2 stated that R6 was wearing a hinge leg brace which can cause friction and that the brace was the cause of pressure wounds R6 acquired. V2 stated that the interventions put in place when R6 returned from the hospital with the leg brace included checking the leg brace every shift and doing daily skin checks. V2 stated that the purpose of the daily skin check is to monitor the skin for any breakdown or issues with circulation. V2 stated that it is the nurse's responsibility is to do the daily skin checks. V2 stated that when a wound is identified the resident should be seen as soon as possible by the wound care physician. V2 stated that the skin treatment orders should be followed as prescribed and not changed because if the orders are changed it is not possible to know if the treatment was effective or not which could hinder the wound healing process.	S9999		

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	IL6015168	A. BUILDING: ______ B. WING ______	01/20/2023

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S9999	Continued From page 16 On 01/20/23 at 9:52 AM, V35 (Registered Dietitian) stated that R6 is receiving tube feeding formula and a commercial protein supplement via feeding tube for nutrition which is providing a total of 1320 calories, 77 gm protein. V35 estimated R6's nutritional needs as 1040-1300 calories, 62-73 grams protein. V35 stated R6 is receiving adequate nutrition from tube feedings with use of commercial protein supplement. R6's MDS (Minimum Data Set) dated 12/02/22 BIMS (Brief Interview for Mental Status) score is 0 indicating severe cognitive response (rarely/never understood) and section G (Functional Status) documents in part R6 requires total dependence for transfer and extensive assistance with bed mobility, dressing, toilet use and personal hygiene and limited range of motion on both upper and lower extremities. R6's Order Summary Report dated 01/18/23 documents in part check circulation, motion, sensation of right lower extremity every shift for brace right lower extremity (RLE) (12/06/22), check skin daily (12/06/22), and skin check daily under brace (RLE) every evening shift (12/14/22). R6's Treatment Administration Record dated 01/01/23-present documents in part, right lower leg: cleanse with normal saline, apply (Brand) enzymatic wound debriding agent to open areas, adaptic, dry dressing every day shift for RLE wounds dated 01/12/23. Facility policy titled, "Prevention of Pressure Ulcers/Injuries" dated July 2017 documents, in part assess the resident on admission for existing pressure ulcer/injury risk factors and repeat the risk assessment weekly, identify areas of	S9999		

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	IL6015168	A. BUILDING: ______ B. WING ______	01/20/2023

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S9999	Continued From page 17	S9999		

impaired circulation due to pressure from positioning or medical devices and inspect the skin on daily basis, identify any signs of developing pressure injuries (i.e. non-blanchable erythema) and inspect pressure points.

(A)

Statement of Licensure Violations (2 of 2)

300.610a)
300.1010h)
300.1210b)
300.1210d)2)

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not

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S9999	Continued From page 18	S9999		

limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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.

These requirements were Not Met as evidenced by:

Based on observation, interview and record review, the facility failed to provide oral nutritional supplement as prescribed by physician. This failure resulted in a significant weight loss (>5% change over a span of 1 month and >10% change over a span of 6-month period) for 1 (R57) of 7 residents reviewed for nutrition in a total sample of 30.

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S9999	Continued From page 19	S9999		

Findings include:

On 01/17/23 at 12:16 PM, surveyor observed V10 (Certified Nursing Assistant/CNA) feeding R57 in the unit dining room, with R57 eating very slowly with eyes closed and overall poor intake less than 50% of lunch meal. No supplement observed on lunch tray.

On 01/18/23 at 08:55 AM, surveyor observed V37 (Restorative Coordinator) feeding R57 in unit dining room. No commercial oral supplement observed on breakfast tray. No commercial oral supplement listed on R57's meal ticket.

On 01/18/23 at 9:13 AM, V16 (Speech Language Pathologist) stated that R57 requires 1:1 feeding assistance.

On 01/18/23 at 11:25 AM, V19 (Certified Nursing Assistant/CNA) re-weighed R57 upon request of the surveyor using the wheelchair scale on the unit. V19 stated that this is the scale used by staff to weight V19 every month. Surveyor observed R57 being weighed in R57's wheelchair with fleece lap blanket and sheet. This weight was 198.4 pounds. The weight reading was confirmed by V19 saying the weight scale reading out loud. After lunch at 2:08 PM, V19 transferred R57 to bed and R57's wheelchair was weighed without R57 sitting in it. R57's wheelchair plus the additional items of the fleece lap blanket and sheet was wheeled back onto the unit scale and the weight of was 80.4 pounds. The weight reading was confirmed by V19 saying the weight scale reading out loud. The difference between these two numbers makes the weight of R57 to be 118 pounds.

On 01/18/23 at 12:21 PM, V8 (Registered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 20 Nurse/RN) stated that V8 did not give anyone on the unit Ensure supplement this morning as part of medication pass. V8 stated that there is not any Ensure supplement on the nursing unit or in the medication cart to give out. V8 stated that R57 did not receive (Brand) nutritional supplement this morning from nursing. On 01/19/23 at 9:40 AM, V34 (Nurse Practitioner/NP) stated that V34 has not seen R57 in person since 11/2022 but V34 did give a verbal order over the phone to approve R57 for labs, chest x-ray, speech evaluation and calorie counts. V34 stated that V34's expectation is that if R57 has an order for oral supplement then R57 should be receiving the supplement as ordered and that the purpose of the supplement is to provide R57 with additional calories to prevent weight loss. V34 stated that R57's weight loss is not desired or planned and is concerning since R57 is continuing to lose weight. On 1/19/23 at 9:45 AM, V26 (Dietary Manager) stated that when commercial oral supplements such as (Brand) are ordered with meals then the (Brand) oral nutritional supplement is provided by the kitchen and put on resident meal trays for that meal. V26 stated that if a resident has a physician order for (Brand) oral nutritional supplement, then that supplement will be listed on the resident's meal ticket, so the kitchen staff knows to add the supplement to the resident's meal tray. V26 stated that (Brand) oral nutritional supplement was in stock and available in the kitchen for use. V26 stated that a doctor or registered dietitian can order a supplement and that the staff notifies the kitchen when this occurs so that the kitchen can enter this information into the kitchen computer system which then generates the supplement on the meal ticket. V26 reviewed	S9999		

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S9999	Continued From page 21 R57's menu profile in the kitchen computer system and stated that R57 does not have (Brand) nutritional supplement listed on R57's meals tickets and therefore is not receiving (Brand) nutritional supplement from the kitchen. On 01/19/23 at 10:00AM, V31 (Dietary Technician) stated that calorie counts were conducted last week but only given to V31 this morning to calculate. V31 stated that R57 is consuming an average intake of 732 calories per day based on the calorie count results and that R57 is not consuming enough calories to maintain R57's weight. V31 reviewed electronic medical record and stated, "I do see the order for (Brand) oral nutritional supplement." V31 stated that R57 is not receiving (Brand) oral nutritional supplement from the kitchen at this time. V31 stated that if a resident had an order for a supplement but was not receiving the supplement the resident may not be able to maintain weight, and this could cause further weight loss because the purpose of the supplement is to provide extra calories. V31 stated that V31 was not aware of R57's weight loss and that a weight loss puts a resident into a high-risk category, which would require a referral to the registered dietitian for an assessment. On 01/19/23 at 10:47 AM, surveyor conducted interview with V35 (Registered Dietitian) over the phone. V35 stated that V35 worked remotely this week and that V35 had not been notified about R57's weight loss this month yet. V35 stated that current interventions in place include use of (Brand) oral nutritional supplement once per day at breakfast meal which would provide approximately 350 calories. V35 was not aware that the kitchen was not giving R57 the (Brand) oral nutritional supplement and stated, "I am	S9999		

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S9999	Continued From page 22 surprised that the kitchen has not been giving what is ordered." V35 stated that if a resident is not receiving a supplement as ordered, it has the potential risk for causing continued weight loss. V35 reviewed the diet technician's progress note documenting the calorie count results and stated that the calories R57 is consuming is not adequate and that without increasing R57's calorie intake, further weight loss is likely. R57 was admitted to the facility on 10/31/16 and has diagnoses which includes but not limited to: Unspecified Dementia, Hemiplegia and Hemiparesis Following Cerebrovascular Disease Affecting Right Dominant Side, Type 2 Diabetes Mellitus, Schizoaffective Disorder. R57's Order Summary Report dated 01/18/23 documents in part (Brand) oral nutritional supplement, one time a day for supplement at breakfast with order date from 11/08/22. R57's MDS (Minimum Data Set) from 11/15/22 BIMS (Brief Interview for Mental Status) was not calculated but indicated in section C0600 resident was unable to complete BIMS and indicated short and long-term memory problem. R57's MDS section G (Functional Status) dated 11/15/22 documents in part, limited assistance with eating and section GG (Functional Abilities and Goals) substantial/maximal assistance with eating. R57's care plan dated 11/09/22 documents in part, R57 is underweight, malnourished and to provide diet supplement as prescribed by physician. R57's Nutrition/Dietary progress note dated 01/19/23 completed by V35 at 11:15 AM documents in part, R57 has had a significant	S9999		

Illinois Department of Public Health

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S9999	Continued From page 23 weight loss based on -9.7% change in 1 month, -10.5% change in 3 months, and -16% change in 6 months. V35 used the following weights to complete the progress note: (01/11/23) 122.4 pounds, (12/5/22) 135.5 pounds, (10/5/22) 136.8 pounds, (07/1/22) 146.2 pounds. V35 assessed R57's BMI (20.4) as being low for R57's age and that calorie count results show R57's average daily intake is 732 kcals which is not enough to maintain and/or gain weight. Facility document titled, "Weights & Vitals" dated 01/18/23 documents, in part, R57's weights as follows: (1/11/23) 122.6 pounds, (12/5/22) 135.5 pounds, (11/8/22) 135.5 pounds, (10/13/22) 136.8 pounds, (7/8/22) 146.4 pounds. Facility policy titled, "Nutrition (Impaired)/Unplanned Weight loss - Clinical Protocol" dated 09/2017 documents, in part, that the staff will report to the physician significant weight losses. Facility policy titled, "Supplements" undated documents in part that nutritional supplements will be provided as ordered to clients, nursing and dietary will distribute the nutritional supplement. (B)	S9999		