STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000277	A. BUILDING: _____ B. WING _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-ELGIN	180 SOUTH STATE STREET ELGIN, IL 60123

(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 Investigation of complaint 1776411/IL97829	S 000		
S9999	Final Observations Statement of Licensure Violations (Licensure 1 of 1) 300.610a) 300.1010h) 300.1210a) 300.1210d)5) 300.3220f) 300.3240a) 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 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 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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. (B)

300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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,

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S9999	Continued From page 2 and prevent new pressure sores from developing. 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Based on observation, interview and record review, the facility failed to provide necessary care and services to promote healing, prevent infection and prevent facility acquired pressure ulcers from deterioration. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) This applies to 4 of 4 residents (R1 through R4) reviewed for pressure ulcers. These Regulations were not met as evidenced by: This failure resulted in R1 developing a facility acquired pressure ulcer from a stage 2 that had worsened to stage 4. R1 was sent to hospital and was identified with infection of the coccyx pressure ulcer and pain on the site. R1 had undergone two surgical debridements for the pressure ulcer. The findings include: 1. The POS (Physician Order Sheet) for the month of October 2017 showed that R1 is a 51	S9999		

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S9999	Continued From page 3	S9999		

year old with diagnoses of obesity, hydronephrosis, dementia without behavioral disturbance, mental disorders due to known physiological condition, multiple sclerosis, full incontinence of feces, severe sepsis without septic shock, muscle weakness, cognitive communication deficit, urinary tract infection and major depressive disorder.

The admission/discharge log showed that R1 was originally admitted to the facility on December 13, 2008. The log showed that R1 had multiple admissions to the hospital. The reason for hospital visits were mostly related to R1's urinary tract infection and kidney stones. The most recent hospitalization was on August 27, 2017 due to urinary tract infections and sepsis. R1 was readmitted back to the facility on September 8, 2017. The nurse's progress notes showed that R1 had no pressure ulcer when she was readmitted. However, the nurse's progress notes showed the following documentation regarding details of R1's developing pressure ulcer:
-September 30, 2017 showed that R1 had acquired a stage 2 pressure ulcer on the coccyx measuring 1 cm. in length x 1 cm. in width in length. The notes also showed that Zinc Oxide was applied and covered with foam dressing.
-October 1, 2017 showed that Z1 (Attending Physician) and Z2 (R1's family member) were notified regarding R1's pressure ulcer on the coccyx. The notes also showed a wound consultation was requested.
- October 3, 2017 showed that R1's pressure ulcer had increased in size to 3.2 cm in length; 2.3 cm in width; ;40 % slough , small exudate. The treatment order was changed to Hydrocolloid dressing by E3 (Licensed Practical Nurse/wound treatment nurse) and informed Z1 via fax. On October 3, 2017, Z1 responded via fax for an

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S9999	Continued From page 4	S9999		

order of "Wound Care."
- October 5, 2017, there was fax documentation from Z1 for order of "Wound Care and frequent repositioning."

The weekly pressure ulcer assessment showed the deterioration of R1's pressure ulcer:
-October 3, 2017, stage 2 pressure ulcer on the coccyx measured 3.20 cm. in length x 2.30 cm in width x 0.10 cm in depth.
-October 9, 2017, pressure ulcer measurement was 3.50 in length x 3 cm in width x 0.20 cm in depth, exudate on dressing.
-October 17, 2017, measurement was 3.50 cm in length x 3.30 cm in width x 0.20 cm. in depth, exudate on dressing
-October 23, 2017, measurement was 4.50 cm. in length x 3.30 cm in width x 2.0 in depth. The assessment showed that the pressure ulcer was "worse" and from a stage 2, now was "unstageable."

The above pressure ulcer assessments showed that R1's pressure ulcer had worsened in a matter of 22 days from 1cm x1 cm stage 2 (September 30, 2017) to 4.50 x 3.30 x 2.0 unstageable ulcer.

The progress notes from October 1, 2017 to October 25, 2017 showed no documentation that R1 was seen by the wound care physician specialist. The progress notes entered by E5 (Registered Nurse) on October 1, 2017 for a wound consultation was not followed.

Z1's order that was sent to facility via fax on October 3 and 5, 2017 for "Wound Care" was not followed nor the facility had verified with Z1 what encompasses "Wound Care."

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CITADEL CARE CENTER-ELGIN	180 SOUTH STATE STREET ELGIN, IL 60123

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S9999	Continued From page 5	S9999		

On October 31, 2017 at 2:00 P.M., E5 stated that on October 1, 2017, she updated Z1 regarding R1's pressure ulcer and there was a request for wound consultation. E5 further stated that wound consultation includes wound physician referral, nutritionist and wound care team to ensure correct treatment. E5 also stated that she did not inform the wound physician specialist and the nutritionist. E5 added that she instructed her CNA (Certified Nurse Assistant) for R1 to be turned and repositioned every 4 hours, as this is the "standard" to offload pressure from pressure points.

On October 31, 2017 at 10:30 A.M., E1 (Administrator) stated that facility did not make a referral to the wound care physician specialist. E1 also added that "wound care" order should have been clarified with Z1. E1 further stated that wound care physician specialist should have been made aware to determine correct treatment. E1 further stated that facility's practice was to turn and reposition residents every 2 hours at a minimum to offload pressure.

On October 31, 2017, E3 (Licensed practical Nurse) stated that R1 had been administered with enema from 4 times a day and was reduced to 2-3 times a day due to gastric problem. E3 also added that R1 was incontinent of stool and that the stool consistency was liquid like urine. As E3 added, incontinence care was provided. However, since R1 was incontinent, R1 was already wet with urine and stool by the time care was provided. E3 further stated that she did not verify with Z1 what the "Wound Care" order was. E3 also stated that the wound care physician was not notified until the 24th of October 2017. R1 was not seen by the wound care physician specialist since R1 was sent to the hospital on October 25,

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S9999	Continued From page 6	S9999		

2017 due to vomiting, pain on the buttocks area and chills.

On October 31, 2017 at 1:40 P.M., E4 (Licensed Practical Nurse/Wound Treatment Nurse) stated that R1's pressure ulcer had deteriorated too fast from September 30, 2017 to October 3, 2017 based on the size measurement. E4 also stated that the pressure ulcer became unstageable on October 24, 2017 and that was when a referral was made to wound care physician specialist. However, R1 was not seen by the wound care physician specialist since R1 was sent out to the hospital on October 25, 2017 due to vomiting.

The progress notes dated October 25, 2017 showed that R1 was sent to the hospital due to emesis, pain on the buttocks area and chills.

The hospital record showed that R1 was admitted October 25, 2017. R1 was referred for pressure ulcer consultation.
The ED (Emergency Department) report dated October 25, 2017 showed that R1 was noted with a "large wound noted to coccyx and sacral area. Patient's states 10/10 pain to site. Wound is deep, moderate amount of yellow drainage noted to site."

The hospital's wound care progress note report dated October 26, 2017 showed that there was a "strong foul odor coming from the wound. Wound has signs of infection....Sacrum wound 5.5 cm. x 5.0 cm. x 2.5 cm, unstageable pressure injury, present on admission, with moderate amount of serous drainage with foul odor present.. Wound bed is moist, grey black necrotic tissue. Wound edges have 0.5 cm undermining of from 4 o'clock, and 3.0 cm. undermining from 1 o'clock to 3 o'clock. Periwound has 3 cm blanchable

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S9999	Continued From page 7	S9999		

erythema and warmth... Recommendations: need to follow with (wound care physician specialist) for debridement on October 27, 2017 ....Reposition every 2 hours at minimum to reduce pressure on at risk areas and wounds..."

The hospital wound progress report showed that R1's pressure ulcer on the coccyx was debrided on October 27, 2017 and a second debridement was scheduled on October 31, 2017. The progress notes showed that R1 has a stage 4 pressure ulcer on the coccyx.

The pressure ulcer culture result dated October 25, 2017 showed there was an infection.

On October 31, 2017 at 2:30 P.M., Z1 stated that "(R1's) pressure ulcer could have been avoided if aggressive measures were implemented such as frequent turning and repositioning to relieve pressure; timeliness of providing incontinence care to maintain (R1) clean and dry; and a timely follow up with wound care physician specialist to determine correct treatment and prevent worsening of the wound." Z1 further stated, that even though R1 has diagnosis of Multiple Sclerosis with reduced immobility, these were not the primary reasons of R1's worsening pressure ulcer. Z1 also stated that "(R1) does not have osteomyelitis based on the bone scan result (done October 26, 2017) and it should not affect the wound's deterioration."

R1's current care plan provided by the facility showed no specific interventions such as turning and repositioning schedule, and the timeliness of incontinence care to ensure R1 was maintained clean and dry.

The MDS (Minimum Data Set) dated September

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S9999	Continued From page 8	S9999		

15 and 22 of 2017 showed that R1 requires extensive assistance with 2 person assistance for bed mobility and transfer. The MDS also showed that R1 was incontinent of bowel and bladder elimination.

2. On October 30, 2017 at 12:15 P.M., 1:30 P.M., 3:20 P.M., R2 was lying in bed on a supine position.

On October 30, 2017 at 12:20 P.M., E9 (Licensed Practical Nurse) provided pressure ulcer treatment to R2. E8 (Certified Nurse Assistants) assisted E9. E8 and E9 turned R2 to sides to expose the pressure ulcer for treatment. R2's incontinent adult brief was moderately soaked with urine. E9 has a newly acquired stage 2 pressure ulcer on the coccyx that was unbeknownst to staff. R2 has an existing stage 2 pressure ulcer on the left buttock. The stage 2 on the coccyx was exposed and had no dressing. E8 stated that she was not paying attention whether the stage 2 pressure ulcer on the coccyx was there when she provided incontinence care at 11: 30 A.M.

The MDS dated August 18, 2017 showed R2 requires extensive assistance from staff for bed mobility and transfer.

3. On October 30, 2017 at 12:45 P.M., 1:45 P.M., 3:55 P.M., R3 was lying in bed in a supine position. R3 was in same position during these observations.

On October 30, 2017 at 1:45 P.M., E4 applied antibiotic ointment to R3's multiple stage 2 pressure ulcers on bilateral buttocks. E4 did not apply dressing to cover the multiple stage 2 pressure ulcers. E4 responded when asked how

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S9999	Continued From page 9	S9999		

the pressure ulcers were protected from contaminants such as feces. E4 stated that staff just have to provide incontinence care.

The current care plan provided by the facility October 30,2017 showed that R3 has to be turned and repositioned at least every 2 hours, more often as needed or requested. The care plan was not followed based on observations made.

4. On October 30, 2017 at 12:15 P.M., 1:30 P.M., 3:20 P.M., R4 was lying in bed in a supine position. R4 was in same position during these observations.

The MDS dated October 03, 2017 showed that R4 requires extensive to total assistance from staff for bed mobility and transfer.

The current care plan provided by the facility dated August 03, 2017 showed that R4 is at risk for impaired skin integrity related to impaired mobility and incontinence associated with cerebral infarction and quadriplegia.

The facility's undated policy for pressure ulcer treatment and guidelines showed that residents be turned and repositioned every 2 hours for mobility. The policy was not followed based on observations made.

(A)