STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145468	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel of Skokie, The	9615 North Knox Avenue Skokie, IL 60076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its call light policy by not having the call light within reach. This applies to 1 of 2 residents (R77) reviewed for accommodation of needs in a sample of 23. The findings include:R77 is a [AGE] year-old female having severely impaired cognition as per the Minimum Data Set (MDS) dated [DATE]. On 11/18/25 at 12:54 PM, the writer heard from the hallway that R77 was screaming for a spoon to eat her lunch with her door closed. On 11/18/25 at 12:55 PM, R77 was observed in her bed with a lunch tray, and a call light was found on the floor. R77 stated, I need a spoon. I don't know where my call light is. On 11/18/25 at 12:57 PM, V4 (Certified Nursing Assistant/CNA) brought a disposable spoon for R77, retrieved the call light from the floor, placed it within reach for R77, and stated, The call light should be accessible for residents, and I don't know what happened. On 11/20/25 at 9:40 AM, V2 (Director of Nursing/DON) stated that the call light should always be within reach of residents to call for assistance and that she will in-service staff on the call light policy. A review of R77's care plan documented that R77 was care planned for risk of falls, with interventions including ensuring the resident's call light is within reach and encouraging the resident to use it for assistance. The resident needs a prompt response to all requests for assistance. A review of the facility presented the call light policy (revised March 2018) statement document: In order to ensure residents' needs are promptly identified and met, the facility will utilize a resident call light system. The staff will respond to residents' requests and needs as identified.Procedure:5. Place the call light where the resident can always reach it.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement wound prevention interventions for a resident (R16) with a recent progression in dementia before a wound developed and failed to ensure pressure reduction devices were applied as ordered after the development of a pressure wound for one out of five residents reviewed for pressure ulcers in a total sample of 23. This failure resulted in R16 developing a blister to the right heel and stage one pressure injury to the right lateral foot. Findings Include: R16 is a [AGE] year old with the following diagnosis: dementia and Parkinson's disease. Due to R16's mental status, R16 could not be interviewed. On 11/20/25 at 2:23PM, V7 (CNA) stated R16 should have heel protector boots on at all times while in bed to prevent the foot wounds from getting worse. V7 reported R16 has been losing weight but does not know the cause. V7 stated the heel protectors were recently ordered within the last two weeks. V7 was unaware is R16 is at risk for developing pressure ulcers. On 11/20/25 at 2:27PM, R16 was in bed without the heel protectors on R16's feet. V8 (R16's care giver) was sitting at the bed side. V8 stated V8 assisted R16 back to bed around 2PM but didn't put the heel protectors on because it is too hard to put them on. V8 reported being hired by R16's family to sit with R16 from four to eight hours a day for four to five days a week. V8 stated R16 has recently had a mental decline and has been less mobile the last month even with therapy services and now needs assistance with repositioning in bed. V8 reported R16 had a blister develop to the right heel within the last one to two weeks. No other pressure redistribution/relieving devices were on R16's bed. On 11/20/25 at 2:33PM, V9 (Nurse) stated R16 has a dark red colored blister to the right heel that is about the size of a quarter. V9 reported V9 would need to check the chart but R16 could possibly be at risk for developing wounds due to being chairfast and incontinent. V9 stated R16 has had weight loss that is from an unknown cause. V9 reported wound prevention interventions are put in the computer by the wound care nurse and the staff nurses check off the interventions are in place on the Medication Administration Record and/or Treatment Administration Record (TAR). V9 stated the wound treatments need to be checked off on the TAR so prove the treatment was completed. V9 reported the heel protectors should be on at all times while R16 is in bed. V9 stated nurses and CNAs are responsible for making sure wound interventions are in place during rounds. V9 was unable to answer why R16 didn't have the heel protectors on at this time and reported V8 was at the bedside. On 11/20/25 at 2:40PM, V10 (Wound Care Coordinator) stated R16 currently has a blister to the right heel and a stage I to the right lateral foot. V10 reported R16 now needs assistance in bed because R16 is not moving in bed as much for about the last two weeks. V10 stated R16's dementia has progressed and now R16 is more confused and needs more assistance with ADL (activities of daily living) care. V10 reported the wounds were found on 11/10/25. V10 stated R16 has been being followed by the dietitian for a decrease in oral intake and weight loss. V10 stated if a resident isn't eating as much or getting the correct amount of protein then they are more prone to wound development. V10 reported while in bed R16 should have heel protectors in place at all times for off loading and should be being turned ever two hours. V10 denied having an order for the heel protectors in place before the wounds developed because R16 was moving around more. When asked if any interventions were put in place for wound prevention after the dementia progression was noticed, V10 stated they were focused on dietary interventions. V10 reported it is the nurses, CNAs, and wound care nurse's responsibility to check during rounds to make sure the heel protectors are in place when R16 is in bed. V10 denied that it is the care givers responsibility to put the heel protectors on and reported V8 is only there to monitor R16. V10 stated a score of 14 on the Braden scale indicates a resident is at moderate risk for developing wounds. V10 denied having any new laboratory levels completed since R16's decline. V10 reported a resident qualifies for a pressure reducing mattress if they need assistance with turning/repositioning in bed and if they have redness on their sacral area. When asked if R16 qualifies for a pressure reducing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress now, V10 stated yes because R16 has had a decline. When asked why R16 hasn't had the pressure reducing mattress in place already since staff knew about the decline, V10 reported V10 will call the physician to get the order now. On 11/20/25 at 3:12PM, V1 (Administrator) stated R16 has had a recent progression in dementia which had led to an overall decline within the last two weeks. On 11/21/25 at 10:32PM, V13 (Wound Nurse Practitioner) stated V13 saw R16 last week after a referral. V13 reported the heel blister to the right foot is likely due to wearing inserts that were too hard in the shoe and from friction. V13 stated R16 has a history of Parkinson's disease, dementia, is incontinent, and muscle weakness, which puts R16 at risk for developing wounds. V13 was unaware of R16's weight loss or nutritional status, but reported poor nutrition is a big factor in developing wounds. V13 stated V10 overseas the whole picture of the wound healing process where V13 cares for the wound through assessment and providing treatments. V13 reported interventions should include incontinence care, soft shoe inserts, turning from side to side went in bed, and heal protectors to help offload when in bed.The Braden Scale dated 10/2/25 documents a score of 15 indicating R16 is at risk for developing wounds due to being very moist, very limited mobility, walks occasionally, has a slightly limited sensory, has adequate nutrition, and friction and sheer are a potential problem.A Skin/Wound note dated 11/10/25 documents upon skin check, a blister was noted to the right heel and a skin alteration to the right lateral foot. The nurse practitioner was notified and a treatment order was obtained and carried out.The Braden Scale dated 11/10/25 documents a score of 14 indicating R16 is at a moderate risk for developing pressure ulcers. R16's activity level was changed from walk occasionally to chair fast which increased R16's score.The Physician Order Sheet documents offloading device on feet while in bed every shift for wound prevention was ordered on 11/13/25. A low air loss mattress was ordered on 11/20/25. Wound care treatments to the right lateral foot and right heel were ordered on 11/10/25. The weights document R16 has had a 36.5 pound weight loss from 04/2025 through 11/2025. The last three months of dietary notes reviewed and document the weight loss is likely multifactorial from an increase in energy expenditure from tremors, feeding difficulty, and underlying disease process. A Nutrition note dated 10/15/25 documents R16 has had a 17.33% significant weight loss over the past six months. R16 has mild anemia and is at risk for poor nutrition. The weight loss is likely multifactorial. R16 remains at risk for malnutrition given significant prior weight loss, borderline anemia and is a skin breakdown risk. Goal is to prevent further weight loss and skin breakdown.The Wound Assessment Details Report dated 11/17/25 documents the right heel wound is classified as a blister that was identified on 11/10/25. The wound was facility acquired. Skin is intact. The wound measures 2.2 cm x 3 cm by unknown. Interventions include to wear offloading devices on feet while in bed. The Wound Assessment Details report dated 11/17/25 documents the right lateral foot wound is classified as a stage 1 pressure ulceration that was identified on 11/10/25. The wound was facility acquired. The wound is 50% intact skin with 50% non-blanchable redness. The wound measures 7.5 cm x 1.2 cm by unknown.The Wound Nurse Practitioner note dated 11/17/25 documents the primary care physician requested R16 to be seen by the wound care nurse practitioner for skin alterations/lesions. R16 has a wound to the right heel that is classified as a blister. R16 is deconditioned with multiple medical problems and risk factors that may cause wound worsening, delayed healing, infection, or new wound formation. Plan is to complete treatment as ordered, offload, and continue with skin alteration prevention protocol of the facility. The right heel blister measures 3 cm x 3.5 cm x 0. The skin is intact.The Pressure Ulcer Unavoidability Screen dated 11/11/25 documents R16 has a pressure ulcer to the right lateral foot and a blister to the right heel. R16 is up in the chair daily and has a caregiver that spends a few hours with R16. R16 has had changes in weight and is being followed by the dietitian. There is no score or statements in this screen indicating why the right heel and right lateral foot wounds were unavoidable. The Care Plan dated 11/10/25 documents R16 has an actual skin breakdown related to blister on the right heel and a stage one on the right lateral foot. Interventions include protect heels and provide new soft shoe per wound physician recommendation. There is no documentation of any care plan or (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions that were put in place before R16 developed the wounds to the right foot and heel even though R16 was at risk based on the Braden scale score and the Nutrition noted on 10/15/25 identifying R16's significant weight loss, noting a goal to prevent skin breakdown. The Treatment Administration Record (TAR) dated 11/2025 documents the ordered right heel and right lateral foot wound care treatment were not completed on 11/19/25. The box for this day was not checked off on the TAR as having been completed.The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as five (severe cognitive impairment). Section GG of the MDS indicates R16 uses a wheelchair for a mobility device. R16 needs supervision/touching assistance with bed mobility and partial/moderate assistance with transfers. Walking wasn't not attempted due to medical condition or safety concerns. Section M of the MDS documents R16 is at risk for developing pressure ulcers but does not currently have any unhealed pressure ulcers. Recommended treatments for this time are pressure reducing device for chair and bed.The policy titled, Prevention of Pressure Ulcers/Injuries, that is undated documents, Purpose: the purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors in interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk assessment: 1. Assess the resident on admission for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Prevention:. Mobility/repositioning: 1. Choose a frequency for repositioning based on the resident's mobility, the support service and use, skin condition and tolerance, and the resident's stated preferences .4. Reposition more frequently as needed, based on the condition of the skin and the residence comfort. 5. Encourage residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Support surfaces and pressure distribution: Select appropriate support services based on the resident's mobility, continence, skin, moisture and perfusion, body size, weight, and overall risk factors

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their Oxygen Administration Policy. Facility failed to follow physician's order for oxygen administration. This deficient practice affects one resident (R8) of three residents reviewed for oxygen administration in a total sample of 23.Findings Include On 11/18/25 at 10:15AM, observed R8 in bed, oxygen concentrator at bedside. Oxygen concentrator is set to 3L (Liters) per minute via nasal cannula.On 11/18/25 at 11:00AM, observed and confirmed with V5 (Nurse) that R8's oxygen setting is at 3L per minute. V5 also stated that R8 is on continuous oxygen administration at 3L per minute.R8 is a [AGE] year-old male resident under hospice care for diagnosis of COPD (Chronic Obstructive Pulmonary Disease) started on 7/18/25.Physician order sheet reviewed. Order for Oxygen at 1 liter per minute per nasal cannula continuously with an order start date of 9/5/25.11/20/25 at 10AM, V2 DON (Director of Nursing) stated that the expectation is for the nurses to follow the physician order for oxygen administrator. Stated that if the oxygen needs to be increased, the nurse should call the attending physician and get an order for it.Oxygen Administration Policy with a revised date of October 2010, reads in part: The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.