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
	IL6005854	A. BUILDING: _____ B. WING _____	C 01/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF GLENVIEW,THE	1700 EAST LAKE AVENUE GLENVIEW, IL 60025

(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 Original Complaint Investigation 2097861/IL127435 Facility Reported Incidents(FRIs) FRI to 9/25/2020 / IL127555	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.680 a) 300.680c) 300.1210b) 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 Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.
c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.

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.

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)

These Regulations are not met as evidenced by:

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S9999	Continued From page 2 Based on interview and record review the facility failed to ensure a resident was free from abuse for one (R2) of three residents reviewed for abuse in a sample of ten. This failure resulted in R2's left hip being fractured. Findings include: The facility's Abuse Prevention Program undated documents, "Abuse Prevention Policy: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment." The facility's Final Report of Incident dated 9/30/2020 documents, Investigation: A complete investigation was done regarding the residents discoloration bruised area which resulted in a fractured hip. Five nurses and two Certified Nurses Assistants/CNA's and as well as one agency CNA were suspended pending investigation after multiple interviews regarding the timeline of the injury. During the investigation, it was revealed that there were multiple attempts for a indwelling catheter insertion on 9/22/20 in which the resident became uncooperative and resistant towards the procedure. During the procedure V11/CNA and V12/CNA were told by V7/ Licensed Practical Nurse/LPN to hold the right hand and left leg of (R2) in order to insert the catheter. Multiple attempts were done by V7/LPN without successful placement. V7/LPN then asked V13/LPN to come and try insertion of the catheter. V13/ LPN came to the room, attempted to insert catheter once but met resistance she stopped immediately. V13/LPN then stated to V7/LPN not to attempt again. V14/LPN then came to the room to attempt	S9999		

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S9999	Continued From page 3 catheter insertion with the presence of V7/LPN. V11/CNA and V12/CNA. V14/LPN attempted once and met the same resistance and therefore stopped the procedure and told V7/LPN not to attempt again. V12/CNA was interviewed and stated (R2) was not cooperative and resistive towards the procedure. V11/CNA stated she held the residents right hand and another CNA held residents left hand and leg. V11/CNA was interviewed and stated she had to hold resident's leg as means for the assigned nurse to place the catheter. V11/CNA stated she held the resident's leg as resident was not cooperative and very stiff. V15/CNA was interviewed and stated that when she started her shift, she noticed that (R2) was exhibiting signs of pain which was unusual behavior for this resident. V15/CNA expressed her concern to V8/Registered Nurse/RN who stated that it is due to the resident having multiple attempts at catheter insertion earlier in the day. V15/CNA stated she assisted V8/RN at the beginning of her shift by holding the left foot of (R2) while V7/LPN held the left leg/thigh in order to re-attempt catheter insertion which was then successfull. The Facility received orders to complete X-Ray for (R2's) that identified questionable fracture of left hip. On 9/25/20 (R2) was noted with significant change of increased pain and swelling and physician order was obtained for resident to transfer to local hospital for further evaluation and treatment. V8/RN called hospital for resident's status and was informed that (R2) was admitted with diagnosis of fracture of head of left hip and atrial fibrillation. Conclusion: Thorough investigation was	S9999		

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S9999	Continued From page 4 completed. Based on the investigation it is concluded, the left hip fracture and discoloration was likely caused by multiple attempts to reinsert (R2's) catheter. Staff members that are currently suspended pending investigation will be re-educated on the Abuse Policy and Abuse Reporting Procedure, residents Rights with emphasis on resident's right to refuse treatment, change in resident condition/status policy and indwelling catheter insertion for nurses." On 1/2/21 at 12:00 PM V2/Director of Nurses stated, "So here is the report along with the in-services. It appears the resident's hands and legs were held by staff to place a catheter and it took several attempts. The staff involved were suspended and then all were re-educated on resident rights to refuse treatment, catheter insertion, abuse and reporting abuse. It was determined that the left hip fracture occurred during the catheter insertion." (A)	S9999		