STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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 Facility Reported Incident of February 21, 2023/IL 157769	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 300.1210 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based in interview and record review, the facility failed to develop an effective fall intervention to include monitoring and supervision for a resident assessed to be high risk for falls, has history of falls, has poor safety awareness, and has impulsive behaviors. This affected 1 of 3 residents (R1) reviewed for falls and fall prevention. This failure resulted in R1 getting up unsupervised, falling to the floor which resulted in a forehead laceration which required sutures. Findings include: On 3-31-23 at 10:05 AM, R1 is primarily Spanish speaking and translator was needed. Surveyor attempted to carry conversation with R1 via translator and R1 was confused and unable to carry a meaningful conversation. On 3-31-23 at 11:23 AM, V2 (Director of Nurses/DON) said R1 is alert and able to make her needs known. V2 said R1 is confused and nonsensical per translator. V2 said R1 is unable to carry pertinent and meaningful conversation. V2 said R1 has poor safety awareness due to confusion, impulsive behaviors, and inability for redirection at times. V2 said R1 has moments of	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 2	S9999		

agitation in which she requires time to calm down and de-escalate. V2 said R1 has impulsive behaviors of changing her mind and will try to get up from chair or bed without telling staff. V2 said R1 does not use the call light despite encouragement from staff. V2 said R1 has dementia and encephalopathy. V2 said R1 is a high fall risk, and she thinks R1 has a history of falls. V2 said R1 had measures in place prior to recent fall. R1 was in a room close to the nurse station.

On 3-31-23 10:22 AM, V3 (Licensed Practical Nurse/LPN) said R1 is Spanish speaking and requires translator. V3 said R1 is alert, oriented x 1-2 with a translator, and confused at times. V3 said R1 is impulsive and will try to get up from bed without calling for assistance. V3 said R1 does not use the call light despite staff redirection. V3 said R1 is a high fall risk due to impulsive behavior and confusion. V3 said R1 is difficult to redirect due to confusion. V3 said R1 has history of falls.

On 3-31-23 at 10:43 AM, V4 (Certified Nurse Assistant/CNA) said R1 is Spanish speaking and can make her needs known with a translator. V4 said R1 is confused at times and will attempt to get up from bed and wheelchair without calling for assistance. V4 said the staff ensure call light is in reach however R1 does not use the call light. V4 said R1 is impulsive and will try to get up by herself. V4 said R1 has poor safety awareness due to confusion, impulsive behavior, and non-compliant with using call lights.

On 3-31-21 at 12:40 PM, V5 (LPN) said R1 is alert, confused (per her baseline), and is able to make her needs known through a translator. V5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 3 said R1 gives simple one-word responses instead of carrying a conversation and R1 has dementia. V5 said R1 has poor safety awareness because she is impulsive and does what she wants to do without calling for assistance. V5 said R1 is a high fall risk because she thinks she can still do things and has an unsteady gate. V5 said R1 tries to get up by herself all the time thus the staff has to provide frequent rounding as much as possible. V5 said R1 must be kept in public eye for observation and supervision. V5 said he is unsure of R1 having a history of falls. R1 can sometimes be redirected and still must be frequently rounded on. V5 said R1 is placed in doorway to room closest to the nurses' station due to fall risk and isolation precautions and Everyone walking by can see R1 in her doorway. R1 was on isolation and could not be out of her room due to isolation precautions. V5 said he saw R1 get up from wheelchair in the doorway, V5 got up and was unable to prevent R1 from falling when R1 got up by herself. V5 said he noted laceration on R1's forehead with moderate amount of blood. No other visible injuries noted. V5 said he cleansed the wound and provided pressure dressing, called 911, MD (medical doctor), and the family. Family would meet R1 at the hospital. V5 said he was not on duty when R1 came back. R1 came back with stitches to the forehead. On 3-31-23 at 10:56 AM, V6 (CNA) said R1 is alert, confused most of the time, and can use sign language to make her needs known. V6 said R1 has nonsensical conversations. V6 said R1 has poor safety awareness and will try to get up without asking for staff assistance. V6 said R1 high fall risk due to confusion. V6 said she is unaware of previous fall history for R1. V6 said she would check on all residents every 10	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 4 minutes. Face Sheet documents: Diagnosis Information: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. MDS (ARD 2-17-23) documents: Should Brief Interview for Mental Status be conducted? 0. No (resident is rarely/never understood). Transfer (Self-Performance): 3. Extensive assistance-resident involved in activity, staff provides weight-bearing support. Transfer (Support): 2. One-person physical assist. Balance During Transitions and Walking: Moving from seated to standing position: 2. Not steady, only able to stabilize with staff assistance. Surface-to-surface: 2. Not steady, only able to stabilize with staff assistance. Risk For Fall Care Plan documents falls on 12-14-20, 1-1-21, 2-10-21, 9-20-21, 6-27-22, 7-6-22, and 8-20-22, 2-18-23, and 2-21-23. Initial Reportable dated 2-21-23 documents: At 12:12 PM, alert resident lost her balance after standing from the wheelchair and fell to the floor. Observed with a moderate amount of bleeding from her forehead with skin tear. No other apparent injury. The resident denies loss of consciousness, difficulty breathing she was yelling and talking out loud in Spanish. 11 emergency services was called, cold compress applied to her forehead. Neuro-checks initiated and within normal limits. No change to baseline. Staff remained with resident till the emergency crews arrived. She was transported on the stretcher to local hospital ED for further evaluation and treatment. She was alert and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 5	S9999		

talking at the time of transfer, no apparent distress. NP (Nurse Practitioner) to primary MD (Medical Doctor), DON, and family was notified of fall and transfer to hospital. The resident returned from hospital at 6:00 PM with sutures to forehead and to remove sutures in 7-10 days. PT/OT (Physical Therapy/Occupational Therapy) to eval and treat. Final report to follow.

Final Reportable dated 2-28-23 documents: At 12:12 PM, alert resident lost her balance after standing from the wheelchair and fell to the floor. Observed with a moderate amount of bleeding from her forehead with skin tear. No other apparent injury. The resident denies loss of consciousness, difficulty breathing she was yelling and talking out loud in Spanish. (11 emergency services was called, cold compress applied to her forehead. Neuro-checks initiated and within normal limits. No change to baseline. Staff remained with resident till the emergency crews arrived. She was transported on the stretcher to local hospital ED for further evaluation and treatment. She was alert and talking at the time of transfer, no apparent distress. NP to primary MD, DON, and family was notified of fall and transfer to hospital. The resident returned from hospital at 6:00 PM with sutures to forehead and to remove sutures in 7-10 days. PT/OT to eval and treat. Final report to follow. 2-28-23- The resident is stable and receiving PT/OT. The sutures will be removed 3-3-23. Care plan reviewed and updated.

Incident Audit Report dated 2-21-23 documents: Prior to the incident, resident was taken to the toilet by the CNA, and she was sitting in her wheelchair by her room doorway closer to the nursing station. Just about 10 minutes later at 12:12 PM, this nurse observed the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 6	S9999		

standing up from her wheelchair, rushed to her and was unable to redirect in time. Observed the resident falling face down to the floor in the hallway. The resident leaned towards left side laying on the ground. Observed with a moderate amount of bleeding from her forehead with skin tear.

Hospital Record dated 2-21-23 documents: 91 YO female presents after fall. History obtained from patient's nurse at facility, who states earlier this morning she was witnessed to stand up from her wheelchair and fall forward before staff could come to assist her, is not able to ambulation her own at baseline. She fell forward hitting her head but was not witnessed to lose consciousness, was screaming, and yelling immediately afterward c/o of pain to left shoulder and hand. Patient states she has pain there but denies headache. Rest of history limited as patient is Ao (alert and orientated) x1 at baseline due to dementia.

Progress Note dated 2-21-23 documents: Note Text: Pt. returned from (local) Hospital E.R. with Dx. of Laceration to her Forehead and had 6 stitches covered with gauze dressing. No c/o headache or pain upon return.

On 4-4-23 at 9:10 AM, Administrator, Assistant Director of Nurses, Maintenance Director, and the surveyor were able to measure the distance from V5's (Licensed Practical Nurse) seat at the nurses' station to R1's doorway of previous room. The distance was approximately 28 feet.

Falls and Fall Risk, Managing Policy (revised March 2018) documents: Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006563	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-WILMETTE	432 POPLAR DRIVE WILMETTE, IL 60091

(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
S9999	Continued From page 7 prevent the resident from falling and to try to minimize complications from falling. "B"	S9999		