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Illinois Department of Public Health

		(X1) PROVIDER/SU		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	or correction.	IDEIVIII 107 (110	THE THE PARTY OF T	A. BUILDING:		001111	
		IL6000269		B. WING		01/1	12/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CITADEL	. CARE CENTER-KAN	IKAKEE		TRIVER PLA EE, IL 60901			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE ' MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	Annual Licensure a	nd Certification	Survey				
S9999	Final Observations			S9999			
	Statement of Licens	sure Violations					
	300.610a) 300.1210a) 300.1210b) 300.1210d)3)						
	Section 300.610 Resident Care Policies						
	a) The facility procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformed and other policies shall complete the facility and shall by this committee, and dated minutes	policies and pro Resident Care F ng of at least the dvisory physicia mmittee, and re r services in the ly with the Act ar shall be followe I be reviewed at documented by	provided by the ocedures shall Policy en or the epresentatives facility. The nd this Part. It is presented in operating least annually				
	Section 300.1210 ( Nursing and Persor		ments for				
	a) Comprehent facility, with the part the resident's guard applicable, must de comprehensive car includes measurable transt of Rublic Health.	lian or represent velop and imple e plan for each r	resident and tative, as ment a resident that				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

TITLE (X6) DATE 01/30/24

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6000269		B. WING		01/12/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
CITADEL	. CARE CENTER-KAN	IKAKEE	RIVER PLA EE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
\$9999	and psychosocial nesident's comprehallow the resident to practicable level of provide for dischargestrictive setting by needs. The assess the active participater resident's guardian applicable. (Section b) The facility care and services to practicable physical well-being of the reeach resident's complan. Adequate and care and personal cresident to meet the care needs of the red) Pursuant to nursing care shall infollowing and shall seven-day-a-week  3) Objective or resident's condition emotional changes determining care refurther medical evaluations.	medical, nursing, and mental eeds that are identified in the ensive assessment, which attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act)  shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with inprehensive resident care I properly supervised nursing care shall be provided to each te total nursing and personal esident.  subsection (a), general include, at a minimum, the be practiced on a 24-hour, basis:  observations of changes in a including mental and including mental and including and the need for luation and treatment shall be aff and recorded in the	\$9999			
	These Requirement by:	ts were not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IL6000269		B. WING		01/12/2024		
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S FRIVER PLA	STATE, ZIP CODE	<u>, 01/1</u>	2/2027
CHADEL	. CARE CENTER-KAN	KANKAKI	EE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 2	S9999			
	Based on observation, interview, and record review, the facility failed to assess and address pain before and during wound care to a resident. This failure has caused severe pain for one resident during dressing changes. This applies to 1 of 2 residents (R54) reviewed pain management in a sample of 31.  The Findings include:  R54 is a 74-year-old male admitted on 11/29/23 with cognition intact as per the Minimum Data Set (MDS) dated 12/2/23.  On 1/10/24 at 2:20 PM, observed V5 (Wound Care Nurse) and V7 (Certified Nursing Assistant - CNA/Memory Care Director) begin to provide wound care to R54's coccyx wound without assessing for pain. Observed V5 and V7 using the mattress linen to pull him up on the bed and R54 complaining of pain, saying, "I have too much pain." In response to R54's pain, V5 said to R54, "I know your nurse gave you pain medication."					
	his right side to pro coccyx wound. V5 s unstageable wound again complained of much pain, it's hurti	PM, V5 and V7 turned R54 to vide wound treatment to his sprayed wound cleanser on his d (as per V5) and wiped it. R54 of pain, saying, "Ohhtoo ing." In response to R54's am not touching you now."				
	surveyor's inquiry, f	PM, in response to the R54 stated, "I have pain all 7 out of 10. I was given helping."				
		PM, V5 stated, "R54 was ion, and that's why I didn't ask				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		IL6000269		B. WING		01/	12/2024
	PROVIDER OR SUPPLIER  CARE CENTER-KAN	IKAKEE	900 WES	DRESS, CITY, S F RIVER PLA EE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From partial him for his pain lever sure I should have complained of pain see whether I should complained of pain.  On 01/11/24 at 10:3 I have pain when the me one Norco pill, and DON) stated, "Our assessing residents."  O1/11/24 10:45 AM DON) stated, "Our assessing residents. The wound care nuresident for pain becare and should hat reatment when the during treatment."  O1/11/24 10:15 AM Practitioner) stated before wound care, managed well. If pacause the resident The patient should If the patient complicate, she should he have a pleasant exit in the October 2010 2. Review the resident Administrator) of the A review of the Pair Management Policy documented the sterecognize pain.  Observe the resident.	el before starting stopped treatme. I have to look a ld have stopped during treatmen. B7 AM, R54 state ey do wound care and that doesn't will be started ve stopped the started ve stopped to deny treatment have been assessing of pain during be started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to document: ent's care plan to the started ve stopped to t	nt when he t the policy to when R54 t."  ed, "Every day, re. They give do anything."  Nursing / tice is wound care. assessed the with wound wound ained of pain  e Nurse ent is crucial ould be ed well, it can not and care. ssed for pain. In gwound e the pain to resident."  policy revised to assess for sper  and the 2015) dure to	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6000269	B. WING		01/1	2/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CITADEL	CARE CENTER-KAN	IKAKEE	T RIVER PLA EE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	movement) for physical (non-verbal) signs of 2. Possible Behaves a. Verbal excrying, screaming.	siologic and behavioral of pain.	\$9999			

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