STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel Care Center-Kankakee	900 West River Place Kankakee, IL 60901

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 45906 Based on observation, interview, and record review the facility failed to treat all residents with respect and dignity. This applies to 1 resident (R47) reviewed for dignity in a sample of 25. The findings include: On 11/19/24 at 12:34 PM, R47 was observed in the hallway with yogurt spilled down the front of her sweatshirt and dripping down her face. V15 (Housekeeper) and V16 (LPN/Licensed Practical Nurse) walked past R47 and V15 said to R47, Oh my gosh look at your face! V16 (LPN) then whispered something to V15 (Housekeeper) and V15 said, What did I say wrong? People don't wipe it! R47 continued to walk down the hall and turned the corner and V15 and V16 walked down the hall in the opposite direction and did not stop to help clean up R47. On 11/21/24 at 1:08 PM, V2 (DON/Director of Nursing) said since R47 was up and walking around in the hallway, the staff should make sure she looks presentable. V2 said it is a dignity issue that R47 was not assisted and cleaned up when she was seen by staff with yogurt on her face and clothing. V2 said she didn't know why V15 would have made a loud comment in the hallway like that towards R47 and not asked the staff to assist with her hygiene instead. V2 said R47 does not talk a lot and really only says when she is ready to go smoke or ready for a beer. R47's MDS (Minimum Data Set) dated 10/4/24 shows she is moderately cognitively impaired, she has fluctuant inattention, disorganized thinking, and level of consciousness, and she requires substantial assistance with bathing. R47's Care Plan last reviewed 3/29/24 states she is at risk for ADL (Activity of Daily Living) self-care performance deficit related to Huntington's disease. The facility's policy titled, Quality of Life- Dignity last reviewed February 2020 states, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times .3. Some examples of ways which respect for choices and values are exercised include: a. Personal grooming .11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents .12. Staff are expected to treat cognitively impaired residents with dignity and sensitivity .

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 45906 Based on interview and record review, the facility failed to provide the SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice) Form CMS-1005 in writing to all residents who were discharged from Medicare Part A services with benefit days remaining. This applies to 3 residents (R47, R242, R91) reviewed for Advanced Beneficiary Notice and financial liability in a sample of 25. The findings include: V11 (BOM/Business Office Manager) filled out SNF Beneficiary Protection Notification Review Form CMS-20052 for R47 and documented Medicare Part A skilled services start date was 8/16/24 and last covered day of Part A service was 10/4/24. V11 documented the facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. V11 wrote the SNFABN was not provided to the resident/beneficiary because the NOMNC was issued. V11 filled out the SNF Beneficiary Protection Notification Review Form-20052 for R242 and documented Medicare Part A skilled services start date was 2/24/24 and last covered day of Part A service was 5/10/24. V11 documented the facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. V11 wrote the SNFABN was not provided to the resident/beneficiary because the NOMNC was issued. V11 filled out the SNF Beneficiary Protection Notification Review Form-20052 for R91 and documented Medicare Part A skilled services start date was 8/16/24 and last covered day of Part A service was 11/11/24. V11 documented the facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. V11 wrote the SNFABN was not provided to the resident/beneficiary because the NOMNC was issued. On 11/21/24 at 10:26 AM, V11 (BOM/Business Office Manager) said if a resident receives a NOMNC (Notice of Medicare Non Coverage), she does not give them a SNFABN because that was how she was trained. On 11/21/24 at 11:10 AM after reading the facility's policy on ABN, V11 said she should have done ABNs, but she did not. On 11/21/24 at 12:40 PM, V1 (Administrator) said she read the facility's policy on NOMNC and SNFABN and the SNFABNs should have been completed for R47, R242, and R91 but they were not. V1 said V11 (BOM) said she had never completed a SNFABN. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Notices of Non-coverage and Advanced Beneficiary Notices revised October 2024 states, The facility is committed to upholding resident rights and this includes following the guidelines set forth by regulations regarding notices of non-coverage. We want all of our residents and families to be aware of the rights they have under Medicare as well as properly notifying them of what expenses may incur when switching payment sources .SNFABN .The facility will issue the SNFABN prior to Medicare A services ending to inform them that there will potentially be a cost incurred to the resident as a result of the Med A coverage ending. Typically, the facility will make every effort to issue this notice at the same time as the NOMNC . SNFABN- End of covered Stay .If a resident is currently covered under Medicare and coverage is ending and the resident will remain in the SNF, the SNFABN must be provided to the resident notifying them that someone else will need to pay for the SNF stay after Medicare ends. This could be private, Medicaid, or other insurance. This would be in addition to the NOMNC you already provided. The SNFABN does not need to be given if the reason for ending Medicare is due to exhausting their 100 days .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on interview and record review, the facility failed to provide a resident and/or their family/POA (POA/Power of Attorney) in writing for the reason of transfer to the hospital. The facility also failed to notify the ombudsman of the transfer. This applies to 3 of 3 residents (R48, R64, and R78) reviewed for discharge in a sample of 25. The findings include: 1. On [DATE] at 1:38 PM, V1 (Administrator) stated we haven't been giving the residents or their representatives written documentation as for the reason the residents are sent out to the hospital. We call the family when they are transferred. I did not know we had to give the written documentation. The ombudsman should be notified of all discharges, transfers, and hospital admissions. We hadn't notified the ombudsman in the past. R48's Face Sheet showed R48 was admitted to the facility on [DATE]. R48 had multiple diagnoses which included Alzheimer's, asthma, convulsions, syncope and collapse, major depressive disorder, and schizophrenia. R48's Progress Notes showed the following: On [DATE] At 1500 resident was sitting in the dining room with the activities. Quiet with eyes closed but breathing. At 1533 CNA's (CNA/Certified Nursing Assistant) observed that resident was not breathing. They did not see her chest rise or fall and brought her to the nurse's station. Upon assessing no heartbeat heard and no breathing. Resident was placed on the floor and CPR (CPR/Cardiopulmonary Resuscitation) compressions started immediately. CODE blue called. At 1535 pulse and breathing returned. AED (AED/Automated External Defibrillator) pads applied; oxygen applied. 911 called, no shock was advised from AED. 1537 No shock advised from AED. 1537 IV (IV/Intravenous) started to left antecubital. Vitals ,d+[DATE] blood sugar 129. 1539 No shock advised from AED, breathing. 1540 911 arrived. 1544 911 transported resident to (Hospital) ER. 1546 Family notified and MD (MD/Medical Doctor) notified. Report called to (Hospital). Report given to (Nurse). [DATE] 2020 PM Resident is being admitted for observation. DX (DX/Diagnoses): altered mental status, hypothermia, and UTI (UTI/Urinary Tract Infection). R48 returned to the facility on [DATE]. On [DATE] 3:09 PM Resident was sent to ER (ER/emergency room) per nurse practitioner this afternoon due to altered mental status and hypotension. Attempted to call son and sister with no success. Messages left. Spoke with third contact and informed her of send out. [DATE] 11:16 PM resident admitted to 3W, will be seen by neurology tomorrow. On [DATE] at 2:42 PM resident arrived at 1:23 PM via ambulance. Resident is sleepy at this time. Lungs clear, bowel sounds in all 4 quads. Bruise from IV on r arm. No documentation of written notice for reason of transfer or discharge to the hospital given to the resident or POA. No notice sent to the Ombudsman for transfer or discharge to hospital. Facility unable to provide written documentation for either hospital admission. 41384 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On [DATE] at 12:55 PM, R64 and V4 (R64's Brother) denied that the facility provided written documentation of R64's hospital transfer. R64's [DATE] progress note showed that she was transferred to the hospital on [DATE]. R64's electronic health record did not show any documentation that a written notice was given to R64, her representative, or the Ombudsman about her hospital transfer. 3. On [DATE] at 11:16 AM, R78 said that he was sent to the hospital and the facility did not notify him in writing of the transfer. R78's [DATE] progress note showed that he was transferred to the hospital on [DATE]. R78's electronic health record did not show any documentation that a written notice was given to R78, a representative, or the Ombudsman about the hospital transfer. On [DATE] at 02:47 PM, V1 (Administrator) said the facility has not been giving written notification for the reason of transfer/discharge to the hospital to the residents, the resident's representative and a copy of the notice to the Ombudsman because the facility did not know they were supposed to do it.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to provide in writing to the residents and/or their POA (POA/Power of Attorney) regarding bed hold and return at the time of discharge to the hospital. This applies to 3 of 3 residents (R48, R64, and R78) reviewed for discharge in a sample of 25. The findings include: 1. On [DATE] at 1:38 PM, V1 (Administrator) Residents or the resident's representatives should have a bed policy given to them when they go out to the hospital. R48's Face Sheet showed R48 was admitted to the facility on [DATE]. R48 had multiple diagnoses which included Alzheimer's, asthma, convulsions, syncope and collapse, major depressive disorder, and schizophrenia. R48's Progress Notes showed the following: On [DATE] At 1500 resident was sitting in the dining room with the activities. Quiet with eyes closed but breathing. At 1533 CNA's (CNA/Certified Nursing Assistant) observed that resident was not breathing. They did not see her chest rise or fall and brought her to the nurse's station. Upon assessing no heartbeat heard and no breathing. Resident was placed on the floor and CPR (CPR/Cardiopulmonary Resuscitation) compressions started immediately. CODE blue called. At 1535 pulse and breathing returned. AED (AED/Automated External Defibrillator) pads applied; oxygen applied. 911 called, no shock was advised from AED. 1537 No shock advised from AED. 1537 IV (IV/Intravenous) started to left antecubital. Vitals ,d+[DATE] blood sugar 129. 1539 No shock advised from AED, breathing. 1540 911 arrived. 1544 911 transported resident to (Hospital) ER. 1546 Family notified and MD (MD/Medical Doctor) notified. Report called to (Hospital). Report given to (Nurse). [DATE] 2020 PM Resident is being admitted for observation. DX (DX/Diagnoses): altered mental status, hypothermia, and UTI (UTI/Urinary Tract Infection). R48 returned to the facility on [DATE]. On [DATE] 3:09 PM Resident was sent to ER (ER/emergency room) per nurse practitioner this afternoon due to altered mental status and hypotension. Attempted to call son and sister with no success. Messages left. Spoke with third contact and informed her of send out. [DATE] 11:16 PM resident admitted to 3W, will be seen by neurology tomorrow. On [DATE] at 2:42 PM resident arrived at 1:23 PM via ambulance. Resident is sleepy at this time. Lungs clear, bowel sounds in all 4 quads. Bruise from IV on r arm. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. 41384 2. On [DATE] at 12:55 PM, R64 and V4 (R64's Brother) were asked if the facility notified them of the facility's bed hold policy before being transferred to the hospital and they denied ever receiving the information. R64's [DATE] progress note showed that she was transferred to the hospital on [DATE]. R64's electronic health record did not show any documentation that the facility provided R64 or V4 with the facility's Bed Hold policy when R64 was sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On [DATE] at 11:16 AM, R78 denied being notified by the facility of their Bed-Hold policy. R78's [DATE] progress note showed that he was transferred to the hospital on [DATE]. R78's electronic health record did not show any documentation that the facility provided R78 with the facility's Bed Hold policy when he was sent to the hospital. On [DATE] at 2:47 PM, V1 (Administrator) said that the facility is supposed to provide the residents and their representatives with the facility's Bed-Hold policy when they are transferred to the hospital. The facility's Bed-Hold and Returns policy ([DATE]) showed that prior to transfers and therapeutic leaves, residents and resident representatives will be informed in writing of bed-hold and return policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review the facility failed to provide personal hygiene for 3 residents (R29, R86, & R64) who are dependent on ADL care (Activities of Daily Living) in a sample of 25. Findings include: 1. On 11/19/24 at 12:25 PM, R29 was observed with her nails long, jagged and with brown substance under the nails and her hair was oily. V5 (R29's niece) was present at that time and said that the staff needs to cut and clean her nails. R29's EHR (Electronic Health Record) showed that she is a [AGE] year old female admitted to the facility on [DATE]. Her 10/18/24 MDS (Minimum Data Set) showed that cognitive skills for daily decision making are severely impaired, and she has long and short term memory problems. Her 10/10/24 MDS section GG showed that she is dependent on staff for personal hygiene. 2. On 11/19/24 at 12:41 PM, R64 was with V4 (R64's Brother) and her hair was observed oily, and she had an excessive amount of hair on her chin and upper lip. The hair was about 1 to 1 1/2 inches long. R64 said that it bothers her and that it makes her feel bad and then she began crying. V4 said that it has been over a month since the staff has shaved his sister. R64's EHR showed that she is a [AGE] year old female admitted to the facility on [DATE]. R64's 11/14/24 care plan showed that she has an ADL self-care performance deficit related to Parkinson's with interventions including needing assistance with bathing and showering, & nail hygiene. R64's 8/23/24 MDS section C showed that her cognition is moderately impaired, and she needs substantial/maximal assistance with personal hygiene. 3. On 11/19/24 at 10:42 AM, R86 was observed with a brown substance under his nails. R86 said that he provides his own nail care when the staff gives him the necessary supplies. R86's EHR showed that he is a [AGE] year old male admitted to the facility on [DATE]. R86's MDS section C showed that his cognition is moderately impaired, and section GG showed that he needs partial/moderate assistance with personal hygiene. R86's 9/12/24 care plan showed that R86 has an ADL self-care performance deficit related to decrease in grooming skills with interventions including staff assistance required for personal hygiene and oral care setup. On 11/21/24 at 10:11 AM, V1 (Administrator) said that her expectations are that staff provide nail care, remove residents' facial hair, and wash residents' hair for the resident's dignity. The facility's Activities of Daily Living (ADLs), Supporting policy (Revised date March 2018) showed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). The policy also showed that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44387 Based on observation, interview, and record review, the facility failed to ensure anti-contracture devices were applied to resident as ordered. This applies to 1 of 2 residents (R16) reviewed for anti-contracture devices in a sample of 25. The findings include: On 11/19/24 at 11:51 AM, R16 was observed in the dining room, sitting in her high back wheelchair participating in activities with other residents. R16 's right hand was in fist form laying on her abdomen. When asked if R16 wears an anti-contracture device, R16 smiled, did not respond. On 11/20/24 at 11:07 AM, R16 was observed in the dining room, siting in high back wheelchair, right hand still in fist form, no splint. Review of R16's Electronic Medical Record shows that R16 has the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness and muscle wasting and atrophy. R16's Minimum Data Set (MDS) of 10/3/24 shows that R16's cognition is severely impaired. R16's Physician order shows to have right hand palm protector, to wear at all times and take off for care. On 11/20/24 at 2:02 PM, V14 (Restorative Nurse Manager) provided list of residents that use anti-contracture devices; R16 was on the list. V14 said that R16 uses a right-hand palm protector because her right hand is contracted after she had a stroke. V14 said the palm protector is applied during the day and taken off at night. V14 said that R16 is compliant with wearing the palm protector. At 2:06 PM, V14 and surveyor observed R16 in dining room, R16's right hand still in fist form, R16 did not have right hand palm protector. At 2:07 PM, V14 found R16's palm protector in her bedroom dresser. The facility's Assistive Devices and Equipment policy (revised July 2017) states that devices and equipment that assist with resident mobility, safety and independence are provided for residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44387 Based on observation, interview, and record review, the facility failed to properly position indwelling catheter drainage bag during wound care dressing change. This applies of 1 of 2 residents (R22) reviewed for indwelling catheter in a sample of 25. The findings include: On 11/20/24 at 9:58 AM, V9 (Wound Care Nurse Manager) and V10 (Memory Care Coordinator) provided wound care treatment to R22. At 10:09 AM, V9 unhooked R22's catheter drainage bag from the right side of the bed and placed the bag on R22's bed, while V10 turned R22 to her left side so that V9 could access R22's sacral wound. V9 completed R22's sacral wound dressing change, left the drainage bag on the bed. After the dressing change, V9 and V10 repositioned R22 in bed, and R22's catheter bag was under R22's leg. At 10:25 AM, V9 and V10 left R22's room, the catheter bag was still on the bed. At 11:00 AM, R22's catheter bag was still on the bed under R22's leg. Review of R22's Electronic Medical Record shows that R22 has the following diagnoses of osteomyelitis of vertebra, sacral and sacrococcygeal region, pressure ulcer of sacral region stage 4, and neuromuscular dysfunction of bladder. R22's Minimum Data Set (MDS) of 10/14/24 shows that R22's cognition is severely impaired. R22's has a physician order for indwelling catheter. R22's care plan (initiated 10/9/24) shows that R22 has indwelling catheter due to sacral wound and neurogenic muscular dysfunction, with intervention to position catheter bag and tubing below the level of the bladder. On 11/20/24 at 11:15 AM, V2 (Director of Nursing/DON) was informed of the catheter bag. V2 saw R22's catheter drainage bag on the bed. V2 said it should not be on the bed, it should be below the resident's bladder so the urine can flow properly and to prevent backflow of urine. The facility's Catheter Care, Urinary policy (revised July 2020) states that the urinary catheter drainage bag must be held or positioned lower than bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the urinary bladder.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to remove expired food items, reseal opened food items, and maintain temperature of freezer to keep foods solid. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated [DATE] documents that the total census was 88 residents. On [DATE] at 11:33 AM, V12 (Dietary Manager) said all residents eat from the facility kitchen; there are no NPO (Nothing by Mouth) residents. On [DATE] starting at 11:04 AM, the facility kitchen was toured in the presence of V12 (Dietary Manager) and the following was found: Dry Storage: 1. ,d+[DATE] quart cartons of cultured reduced fat buttermilk dated best if used by [DATE]. Expired. 2. 1 quart of French vanilla coffee creamer dated best by [DATE]. Expired. 3. 8 ounce container of sour cream best by [DATE]. Expired. Reach in freezer in dry storage room: 4. An opened, not sealed traditional pie crust that is broken with some freezer burn. Reach in freezer in kitchen: 5. Opened, unsealed bag of beef franks in cardboard box that are soft, not frozen solid. V12 said the staff was just cleaning the freezer so the temperature might have dropped. V12 then checked the temperature of the beef franks and they were 27.2 degrees Fahrenheit. On [DATE] at 1:01 PM, V12 (Dietary Manager) said expired foods should be removed from storage immediately on the expiration date so the expired food is not served to the residents with the potential to make them sick. V12 said all opened food items should be resealed before frozen to prevent freezer burn and maintain the quality of the food. V12 said the freezer should be maintained at 0 degrees Fahrenheit or below and food items should be frozen solid to maintain food quality and prevent food from being thawed and refrozen multiple times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel Care Center-Kankakee	900 West River Place Kankakee, IL 60901

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled, Refrigerated Food last revised 2017 states, Refrigerated Potentially Hazardous Foods (PHF) or Time/Temperature Controlled (TCS) foods are labeled with the date received and if not opened, are discarded by the manufacturer's expiration date. If opened, the cold food item is labeled with the date opened and the date by which to discard or use by . The facility's policy titled, Storage of Frozen Foods last revised 2017 states, Policy: Frozen foods are maintained at a temperature level that keeps frozen foods solid. Procedure: . If taken out of the original container, food is tightly wrapped .Frozen food that is not solidly frozen is evaluated for the possibility of being discarded .Opened products that have not been properly sealed and dated are discarded .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel Care Center-Kankakee	900 West River Place Kankakee, IL 60901

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41384 Based on interview and record review, the facility failed to maintain a QAA (Quality Assessment and Assurance) committee consisting at a minimum of the director of nursing services, the Medical Director or his/her designee, at least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and the infection preventionist. This has a potential to affect all the residents in the facility. The findings include: On 11/21/24 at 09:23 AM, V1 (Administrator) said the Medical Director has not been to any QAA meetings in over a year. A review of all the facility's QAA attendance sheets for the last year, January - March 2024, April - June 2024, & July - September 2024 showed that the facility's Medical Director had not signed the attendance sheets. A review of the facility's 11/19/24 - 11/22/24 Long-Term Care Facility Application for Medicare and Medicaid showed a census of 88 residents.