STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145536	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel of Bourbonnais,the	20 Briarcliff Lane Bourbonnais, IL 60914

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, interview, and record review, the facility failed to ensure that a resident who requires maximum assistance with bed mobility was turned safely during provision of care. This failure resulted in R1 rolling out of bed and landing with his face on the floor, sustaining a laceration to his left forehead. R1 was sent to the emergency room and received 12 stitches on his forehead. This applies to 1 of 3 residents (R1) reviewed for fall incidents in the sample of 3.The findings include: R1 had multiple diagnoses including, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified anxiety disorder and personal history of traumatic brain injury, based on the face sheet.R1's annual MDS (Minimum Data Set) dated September 30, 2025, showed R1 was severely impaired with cognitive skills for daily decision making. The MDS showed that R1 had functional limitation to both lower extremities. The same MDS showed that R1 required total assistance from the staff with toileting hygiene and lower body dressing and required substantial/maximum assistance from the staff with bed mobility- from lying on his back to rolling to the left and right sides and returning to back lying position in bed.R1's progress notes dated October 3, 2025, at 6:26 PM, created by V3 (Licensed Practical Nurse/LPN) showed, At [1:20 PM] notified by [CNA/Certified Nursing Assistant) that resident was on the floor. Upon entering room, observed resident lying face down between bed and wall. Blood observed on floor under head. Applied pressure to laceration noted on forehead. Immediately called 911. Resident was unable to state what happened. CNA stated that during brief change [patient] suddenly swung his legs over the side and rolled out of bed. She was unable to catch him. NP (Nurse Practitioner) notified. The same progress notes showed that R1 was sent to the hospital at 1:25 PM.R1's progress notes dated October 3, 2025, at 11:23 PM, showed that the resident returned from the hospital at 8:40 PM. It was documented that, He is alert and oriented x 2, disoriented to time per usual. He was c/o (complaining of) a headache. PRN (as needed) pain medication administered. The same progress notes showed that R1 received 12 stiches to his forehead laceration while in the emergency department and R1's head was wrapped in gauze.R1's hospital notes dated October 3, 2025, showed, [Patient] to [emergency department] after suicidal attempt. [Patient] deliberately threw himself to ground striking his forehead. [Patient] arrived with laceration to left forehead.On October 4, 2025, at 12:38 PM, R1 was in bed, awake and verbally responsive. R1 had a bandage around his head. R1 was asked why he had a bandage on his head and the resident responded that he rolled out of bed, fell on the floor and sustained an open wound on his head. R1 was asked how he rolled out of bed, the resident stated, I don't know I slipped out of bed. When asked if anyone was present when he fell out of the bed, R1 responded that he was in the room by himself.On October 4, 2025, at 1:23 PM, V3 (LPN) stated that on October 3, 2025, between 12:00 and 1:00 PM, while on her break she was informed by V4 (CNA) that R1 fell out of bed. She was informed by V4 that while turning R1 towards the left side to change the resident's disposable brief, R1 swung his leg over the bed and rolled out of bed. V3 stated that when she went to R1's room to assess the resident, R1 was on the floor, on the left side of the bed, between the bed and the wall, away from the door. V3 stated that R1 was lying on his stomach with his head turned to his (R1) left side, facing towards the door. According to V3, there was a pool of blood on the floor, by the resident's head area and she was not able to assess where the bleeding was coming from. V3 stated that the staff did not move R1 due to fear of further injury and that 911 was immediately called because the resident was on anticoagulant medication. V3 stated that while R1 was on the floor, the resident remained alert and when asked how he was doing, R1 moaned and responded that his face hurt. V3 stated that after calling 911, the emergency personnel came to the facility within five minutes, transferred R1 from the floor to the stretcher and transported the resident to the hospital.On October 4, 2025, at 1:54 PM, V4 (CNA) stated that on October 3, 2025, between 12:00 and 1:00 PM, she was changing R1's disposable brief while the resident was in bed. V4 stated that she was providing the care by herself and that R1 was able to assist with turning, by moving/turning his leg towards the direction of where he was being turned. According to V4, while R1 was in the middle of the bed, she turned the resident on his (R1) left side, towards the wall, away from her (V4). V4 stated that while turning R1 on his left side, away from her (V4), the resident swung his right leg over the edge of the bed and R1 rolled out, then fell on his face on the floor. V4 stated that R1 was bleeding somewhere on the head, but she was not sure of the exact site, because there was so much blood on the floor. V4 stated that she immediately called V3 (LPN) to inform of the fall. V4 stated that R1 was not moved while on the floor until 911 personnel came and transported the resident to the hospital. According to V4, before providing care to R1 on October 3, 2025