

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Citadel of Bourbonnais,the		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41384</p> <p>Based on observation, interview, and record review, the facility failed to provide care with dignity to 2 residents (R38, R70) reviewed for dignity in a sample of 22.</p> <p>Findings include:</p> <p>1. On 09/24/24 at 11:58 am V5 (Certified Nursing Assistant/CNA) was observed in the dining room during lunch time standing over R70 at the foot of R70's wheelchair, while assisting R70 to eat. At 12:05 pm V5 was observed still standing over R70 assisting her with eating, holding R70's bowl while R70 would feed herself and V5 also feeding R70. At 12:06 pm V3 (Assistant Director of Nursing/ADON) was observed taking over for V5. V3 was observed at the foot of R70's wheelchair, holding R70's bowls of food while R70 spoon-fed herself with V3 also spoon feeding R70.</p> <p>R70's 1/19/24 MDS (Minimum Data Set) showed that R70's cognition is severely impaired, and she requires supervision or touch assistance for eating. R70's 8/1/22 care plan showed that she has an ADL (Activity in Daily Living) self-care performance deficit related to diagnoses including functional impairment and dementia with interventions including, R70 is able to feed herself with supervision with set up help from staff. R70's care plan also showed, provide set-up help with meals and fluids only, or Provide cues and supervision with all meals and fluids, or provide assistance as needed for meals and fluids, or requires total care with food and fluid intake.</p> <p>2. On 9/24/24 at 12:02 pm, R38 was observed during lunch setting, at the table with her plate in front of her but she had not received any assistance with set up. R38's meat patty was not cut up and her utensils were wrapped in a napkin above her plate on the table. R38 was observed eating her mashed potatoes with her right-hand fingers and holding the whole meat patty with her left hand eating it whole. At 12:08 pm R38 was observed still eating with her hands, her fingers were in the mashed potatoes and the utensils still wrapped. At 12:09 pm V4 (CNA) was observed while assisting another resident at R38's table, looking at R38 eating with her hands. V4 did not assist R38 at that time, she just left the table after she was done assisting the other resident at the table.</p> <p>On 09/25/24 at 8:34 am during breakfast, V6 (CNA) was observed standing over R38, feeding her.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R38's diagnoses include gastro-esophageal reflux disease, dementia, dysphagia oral, & encephalopathy. R38's 7/3/24 MDS indicated R38's cognition is severely impaired. R38's 7/12/24 MDS under eating showed that R38's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident should be done with supervision or touching assistance. R38's 7/19/24 Care Plan showed R38 has cognitive impairment and dementia, with poor short-term memory, poor reasoning and/or poor judgment. R38 may lose or misplace items, forget how to get places, and may be easily distracted. The interventions include to monitor R38 for snack and hydration needs. Provide cues and prompting and demonstration as needed. R38's care plan also showed that R38 is on a general mechanical soft, thin liquid diet, and she has dysphagia. The interventions include provide set-up help with meals and fluids or provide cues and supervision with all meals and fluids, or provide assistance as needed for meals and fluids, or requires total care with food and fluid intake.</p> <p>On 9/26/24 at 12:35 pm V2 (Director of Nursing) said that staff should not be standing over residents while feeding them, for communication, eye contact, and dignity. V2 said that staff should have provided meal setup for R38. V2 said that if staff sets up R38's meal including cutting her food and setting up her utensils, she will eat with her utensils and not her hands. V2 said, If my loved ones were observed eating with their hands, I would consider it a dignity issue.</p> <p>The facility's Quality of Life - Dignity policy, dated February 2020, showed 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. Residents will be treated with dignity and respect at all times. The policy showed that staff are expected to treat cognitively impaired residents with dignity and sensitivity. The facility's Assistance with Meals policy, dated July 2017, showed that residents shall receive assistance with meals in a manner that meets the individuals needs. Residents who cannot feed themselves will be fed with attention for safety, comfort, and dignity. Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care to residents. This applies to 5 residents (R7, R18, R47, R50, & R66) who were reviewed for activities of daily living in a sample of 22.</p> <p>Findings include:</p> <p>1. On 09/24/24 at 12:27 PM, R18 had long jagged nails with brown substances under the nails and dry flaking skin on her legs. R18 said it had been over a month since she had been provided nail care.</p> <p>R18's 7/30/24 MDS (Minimum Data Set) showed that R18's cognition is intact, and personal hygiene showed that R18 needs partial/moderate assistance. R18's 7/16/24 care plan showed that R18 has an ADL self-care performance deficit related to diabetes, depression, and anti-depression medication, with interventions including staff assistance with personal hygiene.</p> <p>2. On 09/24/24 at 12:15 PM, R50 was in her bed and her toenails were long and jagged, and her fingernails were long and jagged and with brown substances under the nails. R50's scalp had an excessive amount of dry flaking skin. R50 said that she would like more showers when she was asked about her personal hygiene. On 09/26/24 at 10:15 AM, R50's right hand fingernails were observed long and with brown substances under the nails.</p> <p>R50's 9/23/24 care plan showed that R50 has an ADL self-care performance deficit related to diagnoses including hemiparesis, anxiety, and weakness. The care plan showed interventions including R50 requires extensive assistance by staff with showering and extensive assistance from staff for personal hygiene. R50's 12/18/23 MDS showed that R50's cognition is moderately impaired, and section GG showed that R50 needs substantial/maximal assistance with personal hygiene.</p> <p>3. On 09/24/24 at 12:40 PM, R66 was observed with long jagged fingernails and with brown substances under nails. R66's 8/15/24 MDS section GG showed that R66 needs substantial/maximal assistance with personal hygiene. R66's 6/14/23 care plan showed R66 has ADL self-care performance deficit related to impaired mobility due to quadriplegia with interventions including R66 requiring extensive assistance by staff with personal hygiene.</p> <p>On 09/26/24 at 12:35 PM V2 (Director of Nursing/DON) said that nailcare should be provided for safety, residents could scratch themselves and or others, and for infection control. V2 said that staff should provide skin care daily or as needed for dignity issues, cleanliness, skin integrity and skin balance.</p> <p>48526</p> <p>4. On 09/24/24 at 2:25 PM, R47 was sitting in a wheelchair reading a newspaper. R47 had long chin hairs and hairs above her lip. R47 stated she wanted the facial hair removed. On 09/25/24 at 4:19 PM R47 was in the hallway going to church services. She continued to have facial hair above her lip and under her chin.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/26/24 at 12:00 PM, V2 (DON) stated female residents should not have facial hair above their lips or below their chin. Facial hair should be removed on shower days, when visible, or when the resident requests. The CNAs (Certified Nursing Assistants) are responsible for removing the residents' facial hair. R47 does not refuse care. My expectation is that the staff do ADL care in a timely manner. It is a dignity issue for female residents to have facial hair.</p> <p>R47's Face Sheet showed R47 had diagnoses of congestive heart failure, dementia, anxiety disorder, adjustment disorder with depressed mood, polyarthritis, right shoulder dislocation, and weakness. R47's MDS dated [DATE] showed R47 had cognitive impairment. The same MDS showed R47 required partial/moderate assistance with personal hygiene. R47's ADL Self-Care performance care plan showed R47 required extensive assistance by staff with personal hygiene.</p> <p>45906</p> <p>5. R7's Face sheet shows an admitted [DATE] and diagnoses of dementia and weakness. R7's MDS dated [DATE] shows severe cognitive impairment and she requires moderate assistance for personal hygiene. R7's Care Plan dated 8/26/24 shows resident has an ADL self-care performance deficit. Intervention shows the resident requires partial assistance by staff with personal hygiene.</p> <p>On 9/24/24 at 2:24 PM, R7's fingernails were noted to be long, about a quarter inch past the tip of her finger and there was a brown/gray substance under every nail. On 9/26/24 at 1:43 PM, V19 (R7's daughter) said she noticed on 9/24/24 that R7's fingernails looked dirty and long, and they still need to be cleaned and trimmed.</p> <p>On 9/26/24 at 12:59 PM, V2 (DON) said resident nail care should be done by CNAs as needed, upon request, and twice a week during bathing. V2 said long, dirty nails are an infection control issue and a harm risk if the resident were to scratch themselves.</p> <p>The facility's policy titled, Activities of Daily Living (ADLs), Supporting last revised March 2022 states, Policy Statement: .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. Policy Interpretation and Implementation: .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41384</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to properly position 1 resident to maximize her eating abilities. This applies to (R50) who was reviewed for quality of life in a sample of 22.</p> <p>Findings include:</p> <p>On 09/24/24 from 11:58 AM to 12:09 pm, R70 was observed in the dining room during lunch, laying on her back in her adaptive wheelchair. The chair was in an upright position but R70's back and buttocks were on the seat of the chair. At 11:58 AM V5 (Certified Nursing Assistant/CNA) was observed assisting and feeding R70 in this position, at 12:06 PM, V3 (Assistant Director of Nursing) was observed assisting and feeding R70 in this position. At 12:09 PM V6 (CNA) was observed assisting and feeding R70 in this position.</p> <p>R70's 1/19/24 MDS (Minimum Data Set) Section C showed that R70's cognition is severely impaired and Section GG eating, showed that R70 needs supervision or touch assistance while eating. R70's 8/1/22 care plan showed that R70 has an ADL (activities in daily living) self-care performance deficit related to functional impairment related to non-rheumatic aortic valve stenosis and dementia with interventions including Eating: R70 requires supervision help from staff. R70's 5/8/24 care plan showed R70 is on a general diet with puree consistency and thin liquids with interventions including provide set-up help with meals and fluids, provide cues and supervision with all meals and fluids, provide assistance as needed for meals and fluids, and or requires total care with food and fluid intake.</p> <p>On 09/26/24 at 12:35 PM, V2 (Director of Nursing) said that staff should have repositioned R70 for aspiration precaution.</p> <p>The facility's Assistance with Meals policy dated July 2017 showed that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526</p> <p>Based on observation, interview, and record review, the facility failed to offer restorative strengthening exercises as recommended from physical therapy to a resident with weakness to both lower extremities who was discharged from skilled therapy. This applies to 1 of 1 resident (R88) reviewed for restorative nursing in a sample of 22.</p> <p>The findings include:</p> <p>On 09/24/24 at 12:18 PM, R88 was in bed. R88 stated he had been living in the facility for two months. R88 said he does not receive therapy, and no one comes in to help him exercise his legs. R88 stated I can't use my left leg. R88 stated he asked for help with exercises, and no one assisted him. R88 stated when he was admitted to the facility, her received therapy for his hands and arms, but not his lower extremities. On 09/26/24 at 4:00 PM, R88 stated he has never worked with restorative nursing for exercising. R88 stated no one has come in to work on arm exercises or riding a bike with me. I would not refuse restorative nursing. I want exercises for my leg.</p> <p>On 09/26/24 at 9:07 AM, V15 (Physical Therapy Aide/Director of Rehab) stated R88 received physical and occupational therapy from 06/17/24-07/09/24. V15 stated R88 told him he had deficits with his left leg. When R88 was discharged from skilled therapy on 07/09/24, V15 stated he gave a referral to V9 (Restorative Aide) for strengthening to both upper and lower extremities for range of motion as tolerated. V15 stated we give the restorative referrals to the restorative aide, and she communicates with the restorative nurse. This is the normal process where the restorative aide gives the referrals to the restorative nurse.</p> <p>On 09/26/24 at 9:24 AM, V17 (Licensed Practical Nurse/Restorative Nurse) stated R88 is receiving bed mobility and lower body dressing restorative programs that only the CNAs (CNA/Certified Nursing Assistant) provide. V17 stated she never received a referral from therapy. On 09/26/24 at 11:49 AM, V17 stated she does not remember receiving a therapy discharge notice restorative referral from the restorative aide. V17 stated prior to today, R88 was not receiving a strengthening program. V17 stated residents with weakness should be receiving restorative exercises. The referrals from therapy should be upheld and carried out. The resident could have a decline and get a contracture. It is my responsibility to make sure residents have the appropriate restorative programs and to follow up on therapy recommendations. I create the programs and do care plans for restorative programs. The resident does not have an active program for exercises. We did not follow through with the recommendations from therapy.</p> <p>On 09/26/24 at 11:41 AM V9 (Restorative Aide), stated when a resident is discharged from therapy and referred to restorative, we get a copy of the therapy discharge notice restorative referral. I keep a copy and I give one to V17. V9 stated she gave a copy of the referral to V17 in July.</p> <p>On 09/26/24 at 2:07 PM V2 (Director of Nursing) stated it is the responsibility of the restorative nurse to create the programs and care plans for all residents. It is the restorative nurse's responsibility to follow the recommendations received from the therapy department. On 09/26/24 at 4:20 PM, V2 verified R88 does not have a care plan for refusing care.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R88's Face Sheet showed R88 had diagnoses of diabetes, acute respiratory failure with hypoxia, alcoholic cirrhosis of liver, peripheral vascular disease, acute kidney failure, and metabolic encephalopathy. R88's MDS (MDS/Minimum Data Set) dated 06/2024 showed R88 was cognitively intact. R88's Therapy Discharge Notice Restorative Referral dated 07/09/24 showed R88 was discharged from physical and occupational therapy on 07/09/24. The same form showed the equipment needed was two-pound dumbbells, and two-pound ankle weights. The form also showed: recommend strengthening to both upper and lower extremities in available pain free ROM (ROM/Range of Motion) as tolerated. R88's Physical Therapy Evaluation & Plan of Treatment assessment dated [DATE] showed R88's strength to his right and left lower extremities were impaired. R88's Physical Therapy Discharge Summary with discontinue date 07/09/24 showed R88 was referred to restorative for strengthening and mobility. R88's Restorative: Assessment/Side Rail/Restraint dated 06/18/24 was reviewed on 09/25/24, it showed R88 was high risk for developing contractures. The same assessment showed no active restorative program for ROM or exercises. 09/25/24 R88 had no active restorative nursing care plan for ROM or exercises.</p> <p>The facility's Restorative Nursing Services Policy revised 07/2021 showed: Policy Statement- Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Policy Interpretation and Implementation 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies). 2. Residents may be started on a restorative nursing program upon admission, during stay or when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. 4. The resident or representative will be included in determining goals and the plan of care. 5. Restorative goals may include but are not limited to supporting and assisting the resident in: b) developing, maintaining, or strengthening his/her physiological and psychological resources.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003</p> <p>Based on observation, interview and record review, the facility failed to implement dietary supplements recommended by the dietician. This applies to 1 of 2 residents (R31) reviewed for nutrition in a sample of 22.</p> <p>Findings include:</p> <p>R31 was readmitted to the facility on [DATE] with diagnoses that includes cerebral infarction, type 2 diabetes, muscle wasting and atrophy, hematuria, wedge compression fracture of lumbar vertebra, anemia, acute kidney failure, congestive heart failure, hypothyroidism, hypertension, and hyperlipidemia. R31's MDS (Minimum Data Set) dated 8/14/24 shows he is cognitively intact. R31 was assessed to have a greater than 5% weight loss in six months. The dietary oral /dehydration/nutritional assessment completed by V25 (Clinical Nurse Manager) states R31 was not on a therapeutic nutrition supplement. R31's care plan dated 8/26/24 states on 8/15/24 R31 to receive (nutritional supplement) cc (Cubic Centimeters) noon and PM meals. Registered dietician to evaluate and make recommendations as indicated.</p> <p>On 09/26/24 at 11:20 AM, V20 (Culinary Director) stated she generates meal tickets form the communication she receives from the nursing department. Supplements that come from the kitchen will be included on the communication.</p> <p>On 09/26/24 at 12:44 PM, R31 stated he never got nutrition supplements.</p> <p>On 09/26/24 at 12:04 PM, V24 (Dietician) stated she made recommendations on 8/15/24 for R31's significant weight changes. V24 stated she recommended a high calorie no sugar supplement at noon and PM meals for 30 days. V24 stated she provided her recommendation form to the facility before she left on 8/15/24.</p> <p>On 09/26/24 at 01:50 PM, V25 (Clinical Nurse Manager) stated the dietician discontinued the previous order but did not reenter the new order with her recommended changes. The dietician recommended no sugar added (nutritional supplement) 120 cc for 30 days. V25 stated R31 had a 7.7% weight loss over a two-month period. The weight loss was a concern which is why R31 should have had the nutrition supplement. V25 stated she receives V24's recommendations and updates the care plan and dietary to send the supplements on the meal tray.</p> <p>On 09/25/24 at 03:38 PM, R31 did not have any physician ordered diet in the EMR (Electronic Medical Record). R31's EMR showed his diet orders were discontinued on 8/15/24. No nutritional supplement order was in place for R31 as of 8/15/24.</p> <p>The facility policy Diet and Nutrition dated December 2021 states each resident is provided with a nourishing palatable well-balanced diet that meets his or her daily nutritional and special dietary needs.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>48526</p> <p>Based on observation, interview, and record review, the facility failed to post the current date's staffing for the Daily Nursing Department Staffing Report. This applies to all 90 residents in the facility.</p> <p>The findings include:</p> <p>On 09/24/24 at 9:30 AM upon entrance for the annual licensure and certification survey, the Daily Nursing Department Staffing Report sheet was dated for 09/23/24.</p> <p>On 09/26/24 at 1:25 PM V1 (Administrator) stated the Scheduler is responsible for making sure the daily nursing staffing report is visible and up to date. The Scheduler changes the staffing sheet every day. V1 stated it needs to be visible to residents, visitors, and staff, so they will know the staffing for the day.</p> <p>On 09/26/24 at 1:29 PM, V18 (Scheduler) stated it is my responsibility to make sure the daily staffing is posted every day. It was not changed on Tuesday 09/24/24 because it was my first day back to work from vacation, and I got sidetracked. V18 stated it is important that the staffing is posted to make sure we are fully staffed, and if anything happens, we know how many staff is in the building.</p> <p>The facility's Posting Direct Care Daily Staffing Numbers Policy (revised 07/2022) showed: Policy Statement- Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation: 1. The number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to resident and visitors) and in a clear and readable format daily. 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include: b. The date for which the information is posted.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003</p> <p>Based on observation, interview, and record review, the facility failed to maintain the facility's kitchen in a manner to prevent foodborne illness. This applies to all 90 residents in the facility receiving dietary services.</p> <p>Findings include:</p> <p>On [DATE] at 03:14 PM, V20 (Culinary Director) confirmed all 90 residents residing in the facility receive meals form dietary services.</p> <p>1. On [DATE] at 11:01 AM, one red sanitization bucket in use tested at 100 ppm (Parts Per Million).</p> <p>On [DATE] at 10:23 AM, V20 (Culinary Director) stated the quat sanitizer for the red sanitization bucket should test between 300 and 400 ppm.</p> <p>On [DATE] at 11:15 AM, V20 stated the red sanitization bucket use quat for sanitization concentration range should be between 150 to 400 ppm. V20 states they don't document the actual reading; they just place a check mark that the sanitizer concentration is in range.</p> <p>On [DATE] at 03:14 PM, V20 stated the pots and pans log is where they document the testing for the red sanitization buckets.</p> <p>The facility did not provide a policy specific to the red sanitization buckets.</p> <p>2. On [DATE] at 11:01 AM, The dishwasher rinse water tested the sanitizer at 10 ppm. V20 stated the dishwasher disinfects by chemical. V20 stated the temperature booster broke down, so the chemical use has been a new process for approximately three weeks. V20 also stated the facility tests the dishwasher and logs for the temperature. There were no logs documenting the sanitizer ppm.</p> <p>On [DATE] at 11:15 AM, V20 stated the dishwasher uses chlorine to disinfect the dishes and the sanitization concentration should the between 50 to 100 ppm.</p> <p>V20 stated maintenance checks the dishwasher and discovered there was a leak in the supply tubing for the sanitizer. V20 stated it important to make sure the disinfectants are in range to make sure the dishes are sanitized. V20 stated if they aren't disinfected the residents can develop a food borne illness. V20 stated the Dishwasher is responsible for making sure it the sanitization is in range.</p> <p>The Dish machine low temperature log states record wash temperature and sanitizer ppm. The acceptable range of sanitizer is 50 to 100 ppm.</p> <p>3. On [DATE] at 10:23 AM, the dry storage contained:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Citadel of Bourbonnais,the		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Two cans of mandarin oranges 6lb (pound) 10oz (ounce) which were dented.</p> <p>One can of pork & beans 7lb, dented.</p> <p>One can of refried beans 7lb dented.</p> <p>Buttermilk biscuit mix 5lbs that expired on ,d+[DATE].</p> <p>Chicken flavor base 9lb with a written expiration date of ,d+[DATE].</p> <p>One box of Vanilla wafer cookies 11 oz, open to air.</p> <p>On [DATE] at 11:15 AM, V20 stated using dented cans can led to food borne illness or botulism. We want to make sure they are intact, so they are safe for consumption.</p> <p>The facility Food Safety and Sanitization policy date 2014 states dented cans should be stored away from other foods to prevent being served. Label foods with delivery date and discard date. Monitor logs that include dishwasher temperatures and monitor chemical sanitizers on a regular basis.</p> <p>The undated facility Food Storage: Dry Goods policy states all packaged food items will be kept properly sealed.</p> <p>4. On [DATE] at 10:45 AM, the walk-in freezer contained:</p> <p>One 20 lb. box of French bread sticks, open to air.</p> <p>On 10 lb. box of turkey [NAME], open to air.</p> <p>A tray of apple slices with partially uncovered plastic wrap with freezer burn with a written expiration date of , d+[DATE].</p> <p>On [DATE] at 10:54 AM, the reach-in cooler contained:</p> <p>A bag of shredded yellow cheese with no label or expiration date.</p> <p>Three 24 oz bottles of chocolate syrup with best by date of [DATE].</p> <p>On [DATE] at 11:14 AM, the central nourishment room contained:</p> <p>Thickened lemon-flavored drink 216 oz carton that expired on ,d+[DATE].</p> <p>Whole milk 236 ml (Milliliters) carton expired on [DATE].</p> <p>A crusty foil take-out pan with spaghetti and meatballs without a name or date.</p> <p>A small brown bag with two hard cornbread muffins without a name or date.</p> <p>Open Imitation crab 8oz in a zippered bag without a name or date.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 11:15 AM, V20 stated Food should be discarded after it is expired because eating outdated food can cause illness. Food that is open to air can get dust and is susceptible to pest if there is an issue or anything could get in it to contaminate the ingredients.</p> <p>The undated facility Food Storage: Cold Foods policy states a written record of daily temperatures will be recorded. All food will be stored wrapped or in covered containers, labeled and dated arranged in a manner to prevent cross contamination.</p> <p>5. On [DATE] at 11:30AM, a unit refrigerator contained excessive ice build-up in the freezer. Ice was built up inside the refrigerator on the back. The inside of the refrigerator had brown spills and splatters coating the inside. Three drinking mugs had a thick orange gel like substance with no label, name, or date. The September refrigerator temperature log had temperature logged for four days ,d+[DATE], ,d+[DATE], ,d+[DATE] and ,d+[DATE].</p> <p>On [DATE] at 11:40 AM, the refrigerator in the main dining kitchenette had a bag with an expiration date of ,d+[DATE]. The bag contained three 23.9 oz open bottles of pizza sauce and an opened 5lb bag of mozzarella. V23 (Short Order Cook's) bun and mustache were not covered by his hair nets.</p> <p>On [DATE] at 11:24 AM, V3 (Assistant Director of Nursing) stated housekeeping is responsible for the temperature logs and making sure outdated expired foods are tossed out. Whoever puts the food in the refrigerator is responsible for making sure it is labeled with the resident's name and the date.</p> <p>On [DATE] at 09:58 AM, V1 (Administrator) stated housekeeping is responsible for cleaning out the refrigerator. Staff should know if they put food in the refrigerator, it should be labeled with a name and date.</p> <p>The facility policy Foods Brought by Family/Visitors dated [DATE] states containers will be labeled with the resident's name, the item, and the use by date. The Nursing staff will discard perishable foods on or before the use by date.</p> <p>6. On [DATE] at 11:34 AM, V21 (Licensed Practical Nurse) was in the main kitchen without hair covering.</p> <p>On [DATE] at 11:36 AM, V22 (Kitchen Staff) was in the kitchen with a hairnet on the top of her head and long lengths of hair to her shoulders, uncovered.</p> <p>The facility Food Safety and Sanitization policy date 2014 showed Hair restraints must be worn at all times while around food production areas.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41384</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control practices for enhanced barrier precautions, hand hygiene, and urinary drainage bag management. This applies to 3 residents (R7, R22, R65) reviewed for infection control in a sample of 22.</p> <p>The findings include:</p> <p>45906</p> <p>1. On 9/24/24 at 2:24 PM, an enhanced barrier precaution sign was seen on the door to R7's room. V7 (Certified Nursing Assistant/CNA) was then seen emptying R7's indwelling catheter drainage bag wearing only gloves, no gown. R7's urine was noted to be dark brown with thick sediment seen in the tubing. After V7 finished emptying R7's indwelling urinary catheter drainage bag, V7 clipped the urinary drainage bag onto R7's bed with the bottom of the drainage bag resting on the floor. The floor in the room was noted to be sticky by R7's bed when walking on it.</p> <p>R7's POS (Physician Order Sheet) shows an order for enhanced barrier precautions related to urinary catheter. The POS shows an order dated 8/26/24 for referral to Infectious Disease doctor for salmonella in the urine. R7's MDS (Minimum Data Set) dated 8/14/24 shows R7 has an indwelling urinary catheter.</p> <p>On 9/25/24 at 11:35 AM, V3 (Infection Preventionist/Assistant Director of Nursing) said gown and gloves are required in enhanced barrier precaution rooms for direct contact care, including emptying an indwelling urinary catheter drainage bag. V3 said the staff should be wearing gown and gloves to prevent the transmission of bacteria between the staff and the resident. V3 said if the resident has a history of an MDRO (Multi-Drug Resistant Organism) there is greater risk of bacteria transmission. V3 said enhanced barrier precautions are put in place to help protect both the staff member and resident from the spread of infection. On 9/26/24 at 12:59 PM, V2 said a urinary catheter drainage bag should never be resting on the floor because of the risk of contamination of the floor in the room and/or the resident's urine. V2 said there is risk for bacteria from the urine to be carried around the building on staff shoes and/or the risk of urinary tract infection for the resident if bacteria get inside the drainage bag from the floor. V2 said gown and gloves are required for enhanced barrier precautions when emptying a urinary catheter drainage bag to protect both the staff member and resident from contaminants. V2 said we have residents with histories of MDROs in the urine and the risk for those residents is greater because they already have a history of those infections.</p> <p>R7's Care Plan dated 8/26/24 shows the resident has risk for infection and is on enhanced barrier precautions related to urinary catheter. Interventions include wear gowns and gloves during direct high contact resident care such as urinary catheter care. Care Plan initiated on 8/26/24 shows resident has a urinary tract infection related to salmonella in urine and is on contact precautions and antibiotic treatment until 9/9/24.</p> <p>The facility's displayed Enhanced Barrier Precaution sign states, providers and staff must also wear gloves and gown for the following high contact resident care activities: .device care or use: .urinary catheter .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled, Enhanced Barrier Protection last revised 3/24 states, Introduction: This precaution is for use in long term care facilities to prevent the spread of novel or MDRO infections. Multidrug resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Facility will consider EBP (when contact precautions do not otherwise apply) for residents with any of the following: .indwelling medical devices .history of MDRO . Procedure: .Healthcare providers must don a gown and gloves prior to providing direct care .High contact activities include: .Device care or use such as: .urinary catheter .</p> <p>The facility's policy titled Indwelling Catheter, Urinary last reviewed July 2020 states, Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control .2.b. Be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>2. On 09/24/24 at 11:47 AM, in the dining room during lunch, V4 (CNA) was observed placing R12's plate on the table and then went to R48, who was sitting at R12's table, and adjusted R48's legs, feet, and R48's footrests on her wheelchair. V4 then went back to the kitchen window, without cleaning her hands, and picked up R65's lunch plates. V4 setup R65's meal including opening up R65's napkin for his utensils and cut up his meat. V4 did this with ungloved, unclean hands. After providing meal setup for R65, V4 did not clean her hands and went back to the kitchen window and got R22's lunch plates and brought them to her, still with ungloved, uncleaned hands.</p> <p>On 09/26/24 at 12:35 PM, V2 (Director of Nursing) said that staff should clean their hands after touching a resident, after going from an area of dirty to clean and always before touching food, for infection control.</p> <p>The facility's Handwashing/Hand Hygiene policy dated August 2022 showed that the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p>		