STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145731	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel at Saint Benedict	6930 West Touhy Avenue Niles, IL 60714

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate and sufficient supervision for a cognitively impaired resident (R45) with a history of falls, reviewed out of a sample of 39 residents. This failure resulted in R45 falling from her wheelchair and hitting her face against the floor, resulting in an injury of abrasions to her forehead. The facility also failed to properly assess R45 for injury and failed to send her to the hospital for evaluation after the incident. Findings include: R45 is a [AGE] year-old cognitively impaired female resident, with medical diagnosis including but not limited to dementia; cognitive communication deficit; unsteadiness on feet; abnormal posture; pain in left hip; and spinal stenosis, cervical region. R45's high risk for falls care plan, dated 05/06/2025, does not address constant close supervision, based oh her history of falls. R45's Fall Risk Assessment, dated 05/26/2055 indicates no falls in the past three months. Per R45's electronic health record, she had a fall on 04/29/2025. R45's MDS, dated [DATE], Section C, Cognitive Patterns, indicates R45 is severely impaired in cognitive skills for daily decision making. R45's MDS, dated [DATE], Section GG, Functional Abilities, indicates R45 is only capable of providing less than half the effort to stand from a sitting position in a wheelchair. On 05/27/2025 at 12:44 PM, this Surveyor observed R45 sitting in a wheelchair, about ten feet from the nurse's station; with what appeared to be a reddish, moist, bloody abrasion on her forehead, about two inches in diameter. On 05/27/2025 at 1:59 PM, R45 told this Surveyor that she fell and her head still hurt. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/29/2025 at 10:36 AM, during interview of V18 (CNA) this Surveyor was informed that on 05/26/2025, at about 7:30 PM, V18 was working in another room, about three rooms from the end of the hall, caring for a resident, and was about to leave the room holding linens and trash, when she heard a loud thud, which sounded like something hitting something else, hard. V18 said she, then, looked outside the room and saw R45 by the nurse's station, lying face down on the ground. V18 said she immediately dropped the linens and trash, looked for V20 (Agency Nurse), saw him with his med cart right, and ran towards R45, with V20 running just behind her. V18 said that once she got to R45, she saw R45's wheelchair by the wall, in front of the nurse's station, and R45 lying face down, about four steps from her wheelchair. V18 said it was standard procedure for staff to be with residents that were fall risks by the nurse's station, but noticed the nurse's station empty. V18 said she believed R45 was the only resident stationed at the nurse's station at that time. V18 said R45's assigned CNA, V14, was at another hall caring for another resident when R45 fell. V18 said that, at the count of three, she and V20 slowly log rolled R45 over in order to assess her. V18 said V20 stayed with R45, while she went to get a facility nurse on the first floor for help. V18 said she, then, spoke to V2 (Director of Nursing) over the phone, then passed V20 the phone, so he could speak to her. V18 said there was blood on R45's forehead, so she got a towel, soaked it in water, placed it on her forehead, then placed an ice pack, and let the nurses handle the matter, while she returned to her residents. V18 said R45 required constant monitoring. On 05/27/2025 at 1:52 PM, during interview of V14 on 05/26/2025 at about 7:30 PM, V14 stated that she was in a room at another hall caring for a resident when R45 fell. V14 said no one was at the nurse's station at that time because everyone was doing things. V14 said V18 told her she heard the fall from down the other hall, and that two nurses assessed R45 after she fell. On 05/29/25 at 1:13 PM, during interview of V20 on 05/26/2025 at about 7:30 PM, V20 stated that he was at the nurse's station charting while observing R45, when he noticed R45 standing up. V20 said he asked R45 to please sit down, but could not get to her in time before she fell because she was too far. V20 said he assessed R45, noticed a little redness on the forehead, iced her forehead, and, per V19 (Medical Director), initiated neuro checks, and continued to monitor her. V20 said R45 fell kind of face down and rolled over, and had a little bit of blood on her forehead, which he cleaned with saline water and a gauze cloth, and placed icing on her forehead. V20 said he told V19 that R45 had hit her head on the floor, she had no loss of consciousness, her vitals were stable, and was bleeding, but was not on blood thinners. On 05/28/2025 at 11:35 AM, during interview V2 said R45's care plan called for close observation and physical and occupational therapy for strengthening and balance, since R45 liked to just get up. V2 said that on 05/26/2025 at about 7:30 PM, R45 was in direct view of one of the staff. V2 said she was told that when R45 fell, V20 was at the nurse's station standing with his cart preparing his medications. V2 said staff called her after R45 fell. V2 said she asked V20 if he was able to visualize R45, and he replied that he was at the nurse's station and that she fell. V2 said she did not ask V20 how he was able to see R45 fall while preparing his meds. V2 said V18 heard R45 fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/29/2025 at 12:39 PM, V2 said she believed R45's fall may have been caused by either R45 trying to self-transfer or it was behavioral in nature; and if it was behavioral, they would have to create a care plan for it. V2 said if R45 had been sent to the hospital, and an injury, such as a subdural hematoma, a fracture, or a laceration requiring sutures had been discovered, then the facility would have sent an initial report to the State; but since R45 was not sent, they did not notify the State. When this Surveyor asked V2 how she determined R45 had no fracture from the fall without x-rays, V2 said V19 did not order x-rays for R45 after speaking to V20, only neuro checks and monitoring. V2 said she did not know if V20 completed an SBAR. V2 said she did not believe V20's fall risk assessment for R45 was accurate because she was a high fall risk, yet V20 had graded her an 8, when the previous reports were 12 and 13. V2 said the lower the number was on the assessment, the lower the risk was for falls. V2 said the staff knew who the people were that needed closer observations, and were kept nearby. V2 said R45 was within visual proximity of staff, pretty much all the time. When asked by this Surveyor what distance was no longer an effective distance for staff to supervise a fall risk resident, V2 said, I can't be down the hall and say I have a visual and successfully intervene. On 05/28/2025 at 11:35 AM, V3 (Restorative Nurse/Fall Coordinator/LPN) said that, according to a supervisor that told her, on 05/26/2025 at about 7:30 PM, R45 stood up, lost her balance, and fell to the floor, hitting her forehead on the floor at the nurse's station, within view of V20, who was preparing medications at the time. V3 said R45 was a high fall risk according to her assessments. V3 said R45's only injury after her fall was an abrasion to her forehead; so, she was not sent to the emergency room by the doctor. V3 said there were no fall precautions from R45's care plan implemented at the time of her fall, other than being within view of the nurse. V3 said R45 had a previous fall on 04/29/2025. On 05/29/2025 at 11:46 AM, V3 said major injuries could be discovered by either being visible to the facility staff or by the resident being hospitalized and major injuries discovered there. V3 said that V20 told V19 that R45 only had scrapes; so, no x-rays were ordered, just 72-hour neuro checks. When the Surveyor asked V3 what the best procedure to prevent a fall for R45 was, V3 said, I'll get back to you on that. On 05/28/2025 at 1:15 PM, during interview V16 (CNA) stated R45 had dementia and would suddenly stand up from her wheelchair. V16 said R45 was typically calm, but sometimes would think she was at home and needed to do stuff. V16 said she was sitting next to R45 by the nurse's station because that is what V2 and her nurse would tell her she had to always do, and that she was well aware. V16 said even if it was a single resident on a wheelchair stationed by the nurse's station, that resident would have to be supervised by having staff sit alongside them or being near them and keeping an eye out for them. A progress note from 05/26/2025 at 9:54 PM by V20 states, Patient was in wheelchair and stood up and then lost balance and fell, hit forehead on ground, and some minor scrape occurred on middle of forehead. Neuro checks started. MD and DON informed. POA notified.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to administer medications per physician's orders for two of five (R24, R61) residents observed during the medication pass in the final sample of 26. There were 29 opportunities with 4 errors resulting in a 13.79% medication error rate. Findings include: R24 is a [AGE] year-old admitted to the facility on [DATE] with diagnosis including but not limited to Heart Failure; Gastro-Esophageal Reflux Disease Without Esophagitis; Hereditary And Idiopathic Neuropathy; Hypertensive Heart Disease With Heart Failure; Personal History Of Covid-19; Presence Of Intraocular Lens; Ocular Hypertension, Right Eye; Nonexudative Age-Related Macular Degeneration, Bilateral; Personal History Of Other Malignant Neoplasm Of Rectum, Rectosigmoid Junction, And Anus; Polyneuropathy; Unspecified Atrial Fibrillation; Anemia In Neoplastic Disease; Essential (Primary) Hypertension; and Major Depressive Disorder. R61 is a [AGE] year-old admitted to the facility on [DATE] with diagnosis including but not limited to Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety; Asthma; Other Lack Of Coordination; Other Reduced Mobility; Protein-Calorie Malnutrition; Acute On Chronic Diastolic (Congestive) Heart Failure; Essential (Primary) Hypertension; Paroxysmal Atrial Fibrillation; Major Depressive Disorder; Hyperlipidemia; Gastro-Esophageal Reflux Disease Without Esophagitis; Retention Of Urine; and Adjustment Insomnia. 1. On 05/27/25 at 11:23 AM Surveyor observed V10 (Licensed Practical Nurse) administering medications to R24. V10 (LPN) administered: 1. Ferrous Sulf (Sulfate) Tab (tablet) (Iron) 325 MG (milligrams) EC (enteric coated) Give 1 tablet by mouth two times a day related to Anemia in Neoplastic Disease due at 9:00 AM and 5:00 PM. 2. Furosemide (Diuretic) 20 MG TABS Give 1 tablet by mouth two times a day related to Heart Failure due at 9:00 AM and 5:00 PM. 2. On 05/27/25 at 11:35 AM Surveyor observed V10 (Licensed Practical Nurse) administering medications to R61. V10 (LPN) administered: Carvedilol (Antihypertensive) Tablet 12.5 MG Give 1 tablet by mouth two times a day for Hypertension due at 9:00 AM and 5:00 PM. Furosemide Tablet 40 MG Give 1 tablet by mouth two times a day for stroke due at 9:00 AM and 5:00 PM On 05/27/25 at 11:45 AM V10 (Licensed Practical Nurse) said, It took me a long time to give medications to one previous resident. Also, R24 likes to take his medications later. I also have to check all residents' vital signs and I have 30 residents in my assignment. There is no documentation in R24's and R61's electronic medical chart to show delayed medication administration or physician notification. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/29/25 at 12:32 PM V2 (Director of Nursing) said, It is important to administer medications within scheduled time because medications treat residents' conditions/diseases in a timely fashion. There are parameters and time limits when medications have to administered, especially medications scheduled to be administered multiple times a day. Medications work effectively when they're administered within timely manner. I think, based on the pharmacy policy, the time frame is two hours before and two hours after the schedule time. R24's physical order dated 07/29/2024 reads in part, Ferrous Sulfate Tab 325 MG EC Give 1 tablet by mouth two times a day related to Anemia in Neoplastic Disease. R24's physical order dated 01/17/2025 reads in part, Furosemide 20MG TABS Give 1 tablet by mouth two times a day related to Heart Failure, Unspecified. R61's physical order dated 01/28/2025 reads in part, Carvedilol Tablet 12.5 MG Give 1 tablet by mouth two times a day for Hypertension. R61's physical order dated 01/28/2025 reads in part, Furosemide Tablet 40 MG Give 1 tablet by mouth two times a day for stroke. The facility Administering Medications policy last reviewed 11/2020 reads in part, Medications shall be administered in a safe and timely manner, and as prescriber. Medications must be administered in accordance with the orders, including any required time frame that is indicated specifically in the order by the physician. The pharmacy UnitedRX Policy and Procedure Manual 2024 read sin part, 5.1: DRUG ADMINISTRATION - GENERAL GUIDELINES. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. If a dose of regularly scheduled medication is withheld, refused, or given at other time than the scheduled time, the MAR should reflect documentation as to the reason medication could not be administered.

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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. Based on observation, interviews and record reviews, the facility failed to follow policy related to use of three-compartment sink; failed to maintain normal range of chemical concentration in the sanitizer buckets; and failed to properly label and date leftover foods in the refrigerator. These deficiencies potentially affect the 86 residents receiving foods in the kitchen. Findings include: Per census report, facility has 88 residents currently residing in the facility. Two residents are currently on NPO (nothing by mouth). On 05/27/25 at 9:55 AM during initial brief tour in the kitchen, the following leftover food items placed in a bowl covered with plastic, unlabeled, were observed stored in the walk-in refrigerator: drained pineapple - dated 05/21; apple sauce - dated 05/24; dried peas - undated; peaches - dated 05/21; cream of mushroom - dated 05/21. There was also a sandwich with lettuce and tomato unlabeled and undated, which was observed inside reach - in cooler. Subsequently, red sanitizer buckets were also checked. V4 (Account Manager Food Services) stated that red buckets are used to wipe counters after food preparation. Normal chemical solution range between 200-400 ppm (parts per million) per sanitizer chart. Facility was using ammonium chloride as chemical sanitizer. V4 used a sanitizer strip and dipped into the sanitizing solution in red bucket number one. The strip read 0-100 ppm per color chart in the strip dispenser. Bucket number two was also tested using a new sanitizer strip, giving a reading of 100 ppm. On 05/27/25 at 11:45 AM during a follow up visit in the kitchen, the three-compartment sink was observed with soiled pots, pans, utensils and kitchen wares stored in the first, second and third sinks. The three-compartment sink was not filled with water. V5 (Dietary Aide) was observed scrubbing and washing pots and pans in the sink. V5 removed food debris from the pots and pans by scrubbing then rinsing and washing it with water directly from the gray hose. Afterwards, the pots and pans were placed inside the dish machine. V5 stated, We don't fill the sanitizer sink with water. We use the gray hose and use the water directly to rinse the pots and pans. Sometimes I use the third sink if I have time. But today, I just came in and I just used the dish machine. It was observed that the gray hose is connected to detergent. The sanitizer hose is not connected to the gray hose. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/28/25 at 1:32 PM, V6 (Dietary Manager) was interviewed regarding left over foods. V6 replied, If the food items are not in their original packages, they are left over foods. The left over foods are good for three days. If food items are in their original package, then they are good for 7 days. All food items should be labeled and dated. Left over foods with no dates should be thrown out. V6 was also asked regarding red sanitizer buckets and three compartment sink. V6 stated, Red sanitizer buckets are used to disinfect surface of the work area to prevent cross contamination, kills germs and bacteria. By using the 3- compartment sink, the third sink should be filled with water and sanitizer, and this is where we get the sanitizing solution for the red buckets. Upon testing the water, it should give the correct amount of chemical concentration - we are using quat, should be between 200-400 ppm. Also, the 3-compartment sink should be used all the time to clean and wash pots and pans, to prevent cross contamination. The first sink is filled with soap and water, the second sink is filled with water and the third sink is filled with sanitizer. The 3-compartment sink is what we will be using everyday but right now, it does not hold the water in the second and third sinks. The plugs are loose unable to hold the water for long time. It had been a couple of weeks since it stopped working. The first sink was fixed a week ago. The work order had been requested. Facility presented work order request #2481 dated 03/31/25 showing 3 compartment sink plugs were ordered. There was no work order request to fix the three-compartment sink. There was also no work order receipt that the first sink was fixed a week ago. Facility's policy titled Food Storage, undated, documented in part but not limited to the following: Policy: Sufficient storage facilities will be provided to keep food safe, wholesome, and appetizing. Food will be stores in an area that is clean, dry and free from contaminants. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Procedure: 12. Refrigerated food storage: f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. Facility's policy titled Food Safety and Sanitation, dated 2014 stated in part but not limited to the following: Refrigerated Storage: All leftovers should be labeled and dated. Leftover food should be used or discarded within 72 hours of preparation. Facility's policy titled Cleaning Instructions: Cloths, Pads, Mop and Buckets, undated, documented in part but not limited to the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: Cleaning tools will be maintained in clean, fresh, odor-free condition. Procedure: a. Cleaning cloths should be kept in a container of clean sanitizing solution between uses. b. The sanitizing solution will be tested periodically to assure that it maintains the correct concentration. Facility's policy titled Cleaning Instructions: Counter Space, undated, stated in part but not limited to the following: Policy: Counter space will be cleaned and sanitized prior to and following food preparation and meal service, and as needed. Procedure: 2. To sanitize: f. Store cleaning cloths in sanitizing solution between uses. Facility's policy titled Food and Nutrition Services Sanitation and Food Safety dated 2017 stated in part but not limited to the following: A test strip is used to accurately determine the concentration of the sanitizing solution. The strip is dipped into the sanitizing solution and held for the seconds specified on the test kit. Once removed from the sanitizing solution, the strip is compared to the color on the chart. If the color is not within the correct range, adjustment is made until the sanitizing solution is the correct concentration. Facility's policy titled Manual Sanitizing in Three-Compartment Sink dated 2021 documented in part but not limited to the following: Policy: A sink with three-compartments is used for manually washing, rinsing and sanitizing utensils and equipment that can be submerged. It may also be used for tableware. Procedure: Manufacturer's instructions on the wall poster above the three-compartment sink are followed. Food soil is scraped off utensils or equipment into a waste receptacle before being placed in the first sink. Utensils or equipment are washed in the first sink with a pad or brush in a solution of soap, detergent or other cleaning agent. The temperature of the washing solution is no less than 110F or the temperature specified on the cleaning agent manufacturer's label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Utensils or equipment are thoroughly rinsed in water in the second sink. After washing and rinsing utensils and equipment are sanitized in the third sink by immersion in either: Hot water (at least 171F for thirty seconds) or Chemical sanitizing solution used according to manufacturer's instructions. The most common chemical sanitizers are chlorine, iodine and quaternary ammonia. In determining the correct concentration of the sanitizing solution and the length of immersion time, manufacturer's instructions are followed. Testing procedures for Quaternary Sanitizer: 1. Make sure you select the correct test paper for the sanitizer being used. 2. Testing must be done in sanitizer solution that is clean, fresh and at room temperature. 3. Make sure there is no foam on the solution surface before testing. 4. Tear off a 1 1/2 - 2-inch strip of test paper. 5. Hold the test strip in the solution for 10 seconds. 6. Do not move the test paper around, as this will give a false high concentration reading. 7. Remove test strip from solution. 8. Hold test strip up against the color chart on the side of the test strip container. Always refer to the color range on the QT-10 test kit for accurate color matching of strips. 9. The correct reading must be 200-400 ppm. If the solution test does not meet the 200-400 ppm requirements, test again. Take corrective action if the reading remains out of range. 10. Record the solution concentration reading on the appropriate log.