STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145932	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel Care Center-Wilmette	432 Poplar Drive Wilmette, IL 60091

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the residents' controlled medications were properly received and documented on according to facility policy by failing to: 1. Maintain documentation of receiving controlled medications, upon receipt of medication into the facility and maintaining administration information for controlled medications; this deficient practice affected two (R1 and R8) of two residents. This deficient practice affected two (R1 and R8) of two residents reviewed for controlled medication management in the sample of 60 and has the potential to affect all residents prescribed controlled medications in the facility.Findings:R1 is an [AGE] year-old resident, on hospice care, with diagnoses of, but not limited to hemiplegia, unspecified, affecting left, non-dominant side, cerebral palsy, unspecified, and unspecified osteoarthritis, unspecified site.R8 is a [AGE] year-old resident, on hospice care, with diagnoses of, but not limited to other cervical disc degeneration, unspecified cervical region, sciatica, unspecified side, and peripheral vascular disease, unspecified.On 04/06/2026 at 10:50 AM, this surveyor encountered V4 (Registered Nurse) at the second-floor nursing station. V4 has worked as a nurse as needed (PRN/pro re nata) for five years and states they usually work a couple of days per week.At 10:55 AM, V4 accompanied this surveyor to the second-floor medication cart for investigation. V4 stated that this is the sole medication cart for this unit. During the controlled medication observation, it was observed that there were three liquid controlled medications (two located in the controlled box within the cart and one located within the controlled box within the storage refrigerator) that did not have a controlled medication requisition logs present on the unit. V4 was observed looking through the controlled medication logs on the medication cart and went through documents behind the nurse's station to see if it had been misplaced. V4 stated, we don't have it, but we should. This surveyor observed the medication requisition logbook with double signatures (two nurses) every time a count was done despite these medications being excluded from the logbook.The bottle located in the refrigerator belonged to R1 and was labelled Morphine Sulfate Concentrate Oral Solution 100 mg/5 ml and had 6 ml remaining in the bottle, one bottle located in the medication storage refrigerator belonged to R1 and was labelled Morphine Sulfate Concentrate Oral Solution 100 mg/5 ml and had 15 ml remaining, and the second bottle located in the medication storage refrigerator belonged to R8 and was labelled Morphine Sulfate Concentrate Oral Solution 100 mg/5 ml and had 4 ml remaining. Bottles were all stored within their own bag, were dry and did not appear to be leaking. V4 began creating medication requisition logs for each of these medications in front of this surveyor.At 12:30 PM, this surveyor requested copies of the medication requisition logs that V4 was creating earlier in the day, from V4; V4 stated that they began creating the forms and while filling them out, V2 requested the forms to review, in the nursing department. V4 called V2 and requested the forms for this surveyor and brought them once received. The forms were as follows (only two forms for Morphine were given to this surveyor):R8 - Morphine Sulfate Oral Solution 100 mg/5 mlR1 - Morphine Sulfate (no concentration listed)On 04/07/2026 at 8:40 AM, this surveyor spoke to V2 regarding controlled medication policy and protocols in the facility. V2 stated that residents who are not on hospice care receive controlled medications from their (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-house contracted pharmacy; V2 states that these controlled medications come with medication requisition logs. V2 stated that hospice medications come from the hospice contracted pharmacy and states these controlled medications do not come with medication requisition logs. V2 states that the medications are taken in by a nurse and placed in the medication storage refrigerators on the correlating residents' floor; V2 states that a medication requisition log will only be created once medication is taken out for use. This surveyor advised V2 that controlled medications were found in a medication cart and medication storage room and did not have medication requisition logs in the controlled medication logbook on that cart. V2 stated, that's a problem.On 04/07/2026 at 11:30 AM, V2 brought the four controlled medication bottles to the surveyors on site. At this time, the bottles remained in their individual bags but all were wet, sticky, had a rubber/plastic top that was not present the day prior, and medication was leaking out from the tops; this is not the condition these medications were found in on the second floor medication cart or medication storage room while investigating the morning prior with V4 present. V2 stated that the bottles that are not full, must have been leaking because they were not penetrated on the top.At 11:40 AM, record review of the electronic medication administration record revealed that these three Morphine prescriptions (even the ones with medication missing from the bottles) have not been documented as given since the most recent order dates. The most recent physician order for R8's two Morphine prescriptions is 11/05/2026 (only one prescription bottle for Morphine was located on the unit) and the physician order for R1's two Morphine prescriptions was dated 06/28/2025.On 04/08/2026 at 4:30 PM, this surveyor spoke to V16 (hospice contracted pharmacy technician) at the contracted pharmacy of the facility-contracted hospice company. V16 stated that all controlled medications that are sent to a facility, whether for a hospice resident or non-hospice resident, are sent with a medication requisition log to properly track medication administration.On 04/08/2026 at 4:33 PM, this surveyor spoke to a receptionist at the facility-contracted hospice company who verified that the pharmacy used for their hospice residents is the pharmacy that V2 previously mentioned.Facility Policy:04/06/2026 at 11:00 AMThe Controlled Substances facility policy was received from V2 (Director of Nursing).Facility Policy named Controlled Substances, dated December 2025 states in part but not limited to:3. Controlled substances must be counted upon delivery. Both individuals must sign the designated controlled substance record. For controlled substances supplied by palliative or hospice, the nurse will acknowledge delivery, and inventory/accounting will begin upon first use.4. If the count is correct, an individual resident - controlled substance record must be made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record must contain:a. Name of the residentb. Name and strength of medicationc. Quantity receivedd. Number on [NAME]. Name of physicianf. Prescription numberg. Name of issuing pharmacyh. Date and time receivedi. Time of administrationj. Method of administrationk. Signature of person receiving medicationl. Signature of nurse administering medication9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.