

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/02/2025
NAME OF PROVIDER OR SUPPLIER  The Citadel at Saint Joseph Village		STREET ADDRESS, CITY, STATE, ZIP CODE  659 East Jefferson Street Freeport, IL 61032	

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	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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure a resident (R1), with a urinary catheter in place, was dressed in a manner to prevent a resident injury, failed to ensure facility staff safely managed and positioned a resident's (R2) urinary catheter as the resident ambulated, and failed to ensure a resident (R3) was showered in a manner to prevent a resident fall. This failure resulted in R1 being sent to a local hospital after her skin was lacerated by a plastic clip connected to her urinary catheter as she was being dressed by facility staff. R1 required nine sutures to repair her laceration. These failures apply to 3 of 3 residents (R1, R2, R3) reviewed for resident safety and supervision in the sample of 3. The findings include: 1. R1's hospital discharge records showed R1 was discharged to the facility on 7/28/25 for rehabilitation after being hospitalized for right leg cellulitis, lymphedema, pneumonia, and urinary retention. R1 was discharged with a urinary catheter in place due to her urinary retention. R1 was cognitively intact. A facility incident report dated 7/31/25 showed R1 sustained a laceration to her right lower leg as V4 Certified Nursing Assistant (CNA) was attempting to put pants on R1, V4 started to pull the catheter system through the resident's leggings and noticed bleeding. The nurse assessed the resident's laceration and applied a dressing. The wound care nurse and the nurse practitioner then evaluated the laceration and the resident was sent to the ER (emergency room) where she received 9 sutures to the anterior right lower leg. R1's hospital discharge instructions dated 7/31/25 showed R1 was discharged, back to the facility, with a diagnosis of a leg laceration that required nine sutures to repair. R1's skin evaluation form dated 7/31/25 showed R1's sutured, right leg laceration measured 4 cm (centimeters) x 1.5 cm. R1's facility records showed R1 was discharged home on 8/18/25. On 9/2/25 at 8:37 AM, R1 was interviewed via telephone about the 7/31/25 incident. R1 stated on 7/31/25, V4 CNA had just finished helping her shower. R1 was seated in a chair in the shower room. V4 CNA was the only staff present at the time of the incident. R1 stated V4 partially put R1's pants on, up to R1's knees. R1 stated as V4 was pulling R1's urinary catheter bag and catheter tubing through the right leg of R1's pants, that plastic clip (attached to the catheter bag) scraped against my leg and cut me. I told her to stop. She was hurting me. That is when we saw the blood. On 9/2/25 at 9:47 AM, V4 CNA stated, on 7/31/25, she was trying to pull (R1's) catheter up the right leg of (R1's) pants when either the ties or the plastic clip (both attached to the urinary catheter system to hang the catheter bag in place) cut R1's right leg. V4 stated she should have put R1's catheter bag and tubing through R1's pant legs first, prior to pulling up R1's pants, to avoid any contact between R1's skin and her catheter. On 9/2/25 at 10:48 AM, V8 Nurse Practitioner (NP) stated on 7/31/25 she was told the plastic clip attached to R1's urinary catheter cut R1's leg as V4 CNA was putting on R1's pants. V8 stated R1's injury could have been prevented had they put something around the plastic clip to protect (R1's) skin when getting her dressed. V8 stated facility staff could have used a leg bag (urinary catheter drainage bag that attaches directly to a resident's upper leg) to avoid having to pull a catheter bag through R1's pant leg. V8 stated facility staff need to make sure they are protecting a resident's skin especially if the resident's skin is fragile. 2. R2's current care plan showed R2 had diagnoses including encephalopathy, lung cancer, and neuromuscular dysfunction of her bladder. R2's plan showed R2 was at risk for falls as she had a history of falls in the facility. R2 was confused. R2 had a urinary catheter in place to drain her urine. The plan showed facility staff were to ensure R2's catheter bag and tubing were secured in place to avoid any tension on or the pulling of R2's urinary catheter tubing. On 9/2/25 at 9:20 AM, R2 was seated in a high back wheelchair in the facility's therapy room. R2's urinary drainage bag hung from underneath the seat of R2's wheelchair. R2's urinary catheter tubing was noted sticking out of R2's pants, down by her left ankle. At 9:25 AM, V6 Physical Therapy Assistant (PTA) assisted R2 to a standing position with the use of a walker. R2's urinary catheter bag remained attached to R2's wheelchair located behind R2. R2 took a step and began walking with V6 at her side. As R2 took a step with her left leg, R2's urinary catheter tubing was pulled taut and began pulling R2's left leg slightly back as the catheter tubing and drainage bag remained attached R2's wheelchair. At that time, V7 Occupational Therapy Assistant (OTA) began pushing R2's wheelchair behind R2 as she walked, however, every time R2 took a step with her left leg, R2's catheter tubing was pulled taut as the catheter drainage bag continued to hang off R2's wheelchair, behind R2 as she attempted to ambulate. On 9/2/25 at 12:26 PM, V2 Director of Nursing (DON) stated for a resident that has a urinary catheter in place, the standard urinary drainage bag should be changed to a leg bag drainage system to help promote mobility while in therapy and to help avoid any pulling</p>		