STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145935	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Saint Joseph Village	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a home health referral upon a residents (R1) discharge from the facility. This applies to 1 of 3 residents reviewed for discharge in the sample of 5.The findings include:R1's electronic face sheet printed on 4/21/26 showed R1 has diagnoses including but not limited to fibromyalgia, non-ST elevation myocardial infarction, presence of aortocoronary bypass graft, chronic pain syndrome, muscle wasting & weakness, major depressive disorder, Bell's Palsy, generalized anxiety disorder, and osteoarthritis.R1's care plan dated 6/9/25 showed, Return to community referral. (R1) does not plan to make the community a long term home (R1) will be assisted with the plan to stay in the community until discharge is practical-associates will support (R1's) plan to stay short term, assist with referrals, as needed, to meet goals for discharge.R1's facility discharge assessment dated [DATE] showed, planned discharge, discharge status: home under care of organized home health service organization, active discharge planning is occurring, referral to local contact agency.R1's nurse practitioner notes dated 6/5/25 showed, The patient was seen for follow-up and discharge planning. The social worker stated the patient is most likely going to be discharged home on June 12th, 2025 discharge disposition: despite patient's good participation in subacute rehab and current improvements, patient needs to continue with outpatient home health, PT (physical therapy) and OT (physical therapy) to improve strength, balance, endurance and mobility in order to maintain as much as possible and as long as possible the independence with ADL's (activities of daily living) as well as to decrease the risk of falls.R1's nursing progress notes dated 6/8/25 showed, During inquiry related to 6/11/25 medical appointment, resident reported that she planned to discharge from facility on 6/10/25 as arranged by her son.R1's nurse practitioner note dated 6/9/25 showed, The social worker informed this provider that the patient no longer wants to be in nursing facility and wants to go home today .discharge disposition: despite patient's good participation in subacute rehab and current improvements, patient needs to continue with outpatient home health, PT and OT to improve strength, balance, endurance and mobility in order to maintain as much as possible and as long as possible the independence with ADL's as well as to decrease the risk of falls.R1's social service progress note dated 6/9/25 showed, (R1) requested to discharge today. She will discharge home with in home PT/OT/Nurse/bath aid with (local home health agency). She also plans on cardiac rehab beginning in July.R1's discharge instructions for care dated 6/9/25 showed, discharged to home, cardiac diet, home exercise program, independent in all ADL's, no services contacted, no physician name, appointments scheduled shows f/u 6/11/25.On 4/21/26 at 2:13 PM, V4 (Occupational Therapist/Therapy Director) stated, When a resident desires to discharge, we recommend therapy services to the facility and then the facility would get the orders and do the referrals for the resident. It's pretty routine that we would at least recommend home health if not recommend outpatient therapy. People don't always accept it and don't stay as long as they used to. (R1) arrived to us after a CABG (Coronary Artery Bypass Graft) and was a 1 person assist for transfers, 1 assist for ADL's, and ambulating short distances with a walker. She did great in therapy and by the time she left here she was dressing, toileting, transferring, and ambulating herself to dining (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with a walker due to cardiac precautions. We worked on stairs because she had a few steps to go into her apartment. I recommended cardiac rehab due to her CABG. I did not recommend PT/OT because she wouldn't qualify for both PT/OT and cardiac rehab. I don't know when cardiac rehab was scheduled but I know the referral was in from the cardiologist. We weren't aware of any delay in the cardiac rehab being scheduled. It was a quick discharge, we could have made that referral for PT/OT but I honestly didn't know it was going to be that long before she could get into cardiac rehab. I probably would have made the referral for some PT/OT until she could get into cardiac rehab had I known that it was going to be a few weeks just so she could keep up with her level of functioning and have no deterioration.On 4/22/26 at 8:44 AM, V4 stated, The doctor or nurse practitioner has the final say with the referrals for outside resources upon discharge. If we don't make any recommendations and the provider feels they need something, they will order it and we have no say in it.On 4/22/26 at 9:27 AM, R1 stated, When I left the facility, the social service person told us that they were setting up home health for me for physical therapy and occupational therapy in my home when I discharged . I waited about a week and nobody ever called or showed up, they told me it might take a few days so I waited at least a week if not 2. We called the home health company and they never received a referral so I lost all that time without any therapy and I felt weaker. The home health company didn't seem surprised at all that they didn't receive the referral. I was told I couldn't have both cardiac rehab and therapy services at the same time. I think I started cardiac rehab in the beginning of July.On 4/22/26 at 10:22 AM, V9 (previous social service director) stated she was unable to recall (R1) or her family or any details related to her discharge.On 4/22/26 at 10:58 AM, V12 (home health intake coordinator) stated, We started care for (R1) on 6/23/25 and our care ended on 7/7/25 when she started cardiac rehab. She was getting nursing, physical, and occupational therapy. I do document all accepted and rejected referrals and her name was never received from (facility). I contacted her physician's office on June 18th, 2025 after (R1's son) contacted our office wondering when we were going to start home health for (R1) and I had no idea what he was talking about. I was able to get the order for home health and everything I needed by June 19th and we started care the next week. R1's home health documents dated 6/23/25 showed R1 enrolled in home health services and received nursing, physical therapy, and occupational therapy from 6/23/25-7/7/25.On 4/22/26 at 1:15 PM, V13 (Social Services) stated, I have been working as social services since November 2025. If resident requests to discharge from the facility, I talk to therapy to see how they are doing, talk to nurse practitioner to see if discharge order can be obtained, and then talk to family to see if home health, DME (durable medical equipment), or therapy services are wanted. We have 2 home health agencies that we typically deal with. We fax the referral order and then they reach out to us if further information is needed. They will also reach out to us when they have received the referral so we know things are set up. I try to call if I don't hear anything but I don't always remember. A weekend is a little more difficult to get home health set up. I tell the resident and family that I can get the referral sent but home health won't reach out until the following week because there typically isn't anyone in the office.The facility's policy titled, Transfer or Discharge-Resident-Initiated dated October 2022 showed, Residents may initiate a transfer or discharge from the facility.Documentation: 1. For resident-initiated discharges, the medical record contains: c. documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received an ordered low sodium diet. This applies to 1 of 3 residents (R1) reviewed for special dietary needs in the sample of 5. The findings include:R1's Face Sheet showed diagnoses to include heart bypass surgery, myocardial infarction (heart attack), and hypertension (high blood pressure).R1's 5/28/25 Brief Interview for Mental Status score showed she was cognitively intact with a score of 15 out of 15.On 4/21/26 at 9:35 AM, V1 (Administrator) stated the facility had changed ownership after R1 was discharged from the facility (R1 was discharged to home with family on 6/9/25). V1 stated records prior to 10/1/25 went with the previous owners and they were not returning calls. R1's entire medical was requested. On 4/21/26 at 9:50 AM, V1 stated she may have a staff member that has access to the previous electronic health record.On 4/21/26 at 11:45 AM, V1 provided a paper copy of R1's Electronic Medical Record. R1's hospital Discharge Packet (printed 5/27/25, R1's admission date to the facility was 5/28/25) showed an order for a Heart Healthy DASH diet (Dietary Approaches to Stop Hypertension) and No Added Salt Diet. The orders showed, The hospital diet order may be substituted with your facilities equivalent diet description. The discharge packet showed R1 had been admitted to the hospital on [DATE] with a heart attack and then on 5/20/25 underwent coronary bypass graft surgery (heart bypass surgery).The National Institutes of Health website (NIH, Official United States Government Website titled DASH Eating Plan (Last Updated 2/25/26) showed a DASH diet is a .flexible and balanced eating plan that helps create a heart-healthy eating style for life. The DASH eating plan requires no special foods and instead provides daily and weekly nutritional goals. This plan recommends: Eating vegetables, fruits, and whole grains. Including fat-free or low-fat dairy products, fish, poultry, beans, nuts, and vegetable oils. Limiting foods that are high in saturated fat, such as fatty meats, full-fat dairy products, and tropical oils such as coconut, palm kernel, and palm oils. Limiting sugar-sweetened beverages and sweet (sic). Sodium 2,300mg (milligrams)* The plan continued, *1,500 milligrams (mg) sodium lowers blood pressure even further than 2,300 mg sodium daily. The website showed, When following the DASH eating plan, it is important to choose foods that are.lower in sodium.The Mayo Clinic Website titled, DASH diet: Guide to recommended servings (Dated 5/25/23) showed, The DASH diet also limits salt, also called sodium, to between 1,500 and 2,300 milligrams a day.R1's Physician's Orders showed an order for No added salt diet which was started on 5/28/25. The orders then showed a third change on 6/6/25 (9 days after R1 was admitted to the facility) when the diet was altered to DIET: 2-3g (grams, 2,000 to 3,000 milligrams) Sodium; Thin Liquids.On 4/22/26 at 9:26 AM, R1 said I was supposed to be on low sodium and low fat diet. I took a picture of it; the first meal I was served was a big glob of pulled pork with barbecue sauce and fat all through it. It was salty and that was what they served me. I sent the picture to my kids, and I said, ?Can you believe this?' I ate less than half. I knew I wasn't supposed to eat it.On 4/21/26 at 2:22 PM, V7 (Registered Dietitian) stated, at the time of R1's admission, there were two dietary options for sodium restriction; a no added salt diet and a 2 to 3 gram salt diet. V7 stated the no added salt diet is a regular diet with no salt packet provided to the residents. V7 stated, in long-term care, a 2-3 gram salt diet is a low sodium diet. V7 stated the regular menu would exceed 3 grams of salt on most days. V7 stated the 2-3 gram salt diet is more restrictive than the no added salt diet. V7 stated she was not certain what the sodium restrictions were for a DASH diet; however, the facility did not have a DASH diet. V7 stated, she was notified by staff the day following R1's admission that R1 had been served pulled pork the night of her admission and R1's Son was not happy. V7 said, she did go through the menu with R1 and help her make better choices. (Interview concluded at 2:45 PM at the request of V7, who cited a previously scheduled appointment.)On 4/22/26 at 10:28 AM, V7 was shown the hospital discharge orders. V7 stated she would expect staff to enter a no added salt diet because (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that is what was ordered, and the facility did not have a DASH diet option. V7 stated, The DASH diet is more for when they go home. V7 stated, upon further review of the hospital discharge orders, it is possible the intended order from the hospital was for R1 to be on a DASH diet in addition to a no added salt diet and the No Added Salt diet was not to the exclusion of the DASH diet. V7 stated, if a DASH diet recommendation is less than 3 grams, then the facility's 2-3 gram sodium diet most closely aligns with the DASH diet's sodium restriction. V7 stated the purpose of sodium restriction is to minimize swelling and reduce blood pressure.