

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145956	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Citadel at Casa Scalabrini		STREET ADDRESS, CITY, STATE, ZIP CODE 480 North Wolf Road Northlake, IL 60164	

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 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** 16746</p> <p>Based on observation, interview and record review, the facility failed to assist residents identified as needing assistance with personal hygiene and grooming. This applies to 6 of 7 residents (R6, R18, R24, R77, R106 and 139) reviewed for ADL (activities of daily living) in the sample of 35.</p> <p>Findings include:</p> <p>1. R18 had multiple diagnoses including incomplete paraplegia, based on the Face sheet.</p> <p>R18's quarterly MDS (minimum data set) dated March 13, 2025 showed that the resident was moderately impaired with cognition and had functional limitation in range of motion to both upper extremities. The same MDS showed that R18 required total assistance from the staff with personal hygiene.</p> <p>On March 18, 2025 at 11:42 AM, R18 was in bed, alert and oriented. R18's fingernails were long and with brown substances under the nails. R18 stated that she needs the assistance of the staff to cut/trim and clean her fingernails.</p> <p>On March 19, 2025 at 9:16 AM, R18 was in bed, alert and oriented. R18's fingernails were long and with brown substances under the nails. R18 stated that she wanted the staff to trim and clean her fingernails. V4 (Assistant Director of Nursing) was present during the observation. V4 acknowledged that R18's fingernails were long and needs cleaning.</p> <p>R18's active care plan last reviewed by the facility on January 15, 2025 showed that the resident has an ADL (activities of daily living) self-care performance deficit related to paraplegia. The same care plan showed multiple interventions including, The resident is dependent for personal hygiene.</p> <p>2. R106 had multiple diagnosis including, dementia with other behavioral disturbance, based on the face sheet.</p> <p>R106's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognitive skills for daily decision making. The same MDS showed that R106 required total assistance from the staff with personal hygiene.</p> <p>On March 18, 2025 at 11:43 AM, R106 was in bed, alert and verbally responsive. R106 had long and curling chin hairs, and her fingernails were long with black substances under the nails. R106 stated that she wanted the staff to remove her facial hair, and to trim and clean her fingernails.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On March 19, 2025 at 9:19 AM, R106 was in bed, alert and verbally responsive. R106 had long and curling chin hairs, and her fingernails were long with black substances under the nails. V4 was present during the observation and acknowledged that the resident had facial hair and her fingernails needed to be trimmed and cleaned by the staff.</p> <p>R106's active care plan initiated on October 15, 2024 showed that the resident has an ADL self-care performance deficit related to dementia. The same care plan showed multiple interventions including, Assist with brushing hair, brushing teeth, shaving, etc. (et cetera).</p> <p>3. R77 had multiple diagnoses including, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dementia with other behavioral disturbance and Alzheimer's disease, based on the face sheet.</p> <p>R77's annual MDS dated [DATE] showed that the resident was severely impaired with cognition and required total assistance from the staff with personal hygiene.</p> <p>On March 18, 2025 at 10:56 AM, R77 was sitting in her wheelchair inside the unit dining room. R77 was alert and verbally responsive. R77 had accumulation of long, chin hair. According to R77, she wanted the staff to shave her facial hair because, she cannot do it herself.</p> <p>R77's active care plan initiated on October 15, 2024 showed that the resident has an ADL self-care performance deficit related to Alzheimer's. The same care plan showed multiple interventions including, Assist with personal hygiene needs.</p> <p>4. R24 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, based on the face sheet.</p> <p>R24's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognitive skills for daily decision making. The same MDS showed that R24 had functional limitation in range of motion to both upper extremities and required total assistance from the staff with personal hygiene.</p> <p>On March 18, 2025 at 11:26 AM, R24 was in bed, alert and verbally responsive. R24 had accumulation of overgrown facial hair. R24 had a left hand splint in place. R24 was asked if he wants the staff to shave him, and he stated, yes.</p> <p>R24's active care plan initiated on October 24, 2024 showed that the resident has an ADL self-care performance deficit related to impaired mobility. The same care plan showed multiple interventions including, providing assistance with shaving.</p> <p>5. R139 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, based on the face sheet.</p> <p>R139's quarterly MDS dated [DATE] showed that the resident was modified independence with cognitive skills for daily decision making. The same MDS showed that R139 had functional limitation in range of motion to one side of his upper extremity and he required total assistance from the staff with personal hygiene.</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 March 18, 2025 at 10:40 AM, R139 was sitting in his wheelchair inside the unit dining room. The resident was alert but with confusion. R139 cannot open some of his fingers on his right hand. R139 had accumulation of overgrown facial hair. R139 stated that he wanted to be shaven.</p> <p>R139's active care plan initiated on November 7, 2024 showed that the resident has an ADL self-care performance deficit related to weakness. The same care plan showed multiple interventions including, providing assistance with shaving.</p> <p>On March 21, 2025 at 9:42 AM, V3 (Director of Nursing) stated that it is part of the facility's nursing care and services to assist all residents needing assistance with ADLs including shaving/removal of unwanted facial hair and nail care. According to V3, all residents needing assistance with ADLs should be assisted by the staff to ensure and maintain the residents good hygiene and grooming.</p> <p>36567</p> <p>6. R6's face sheet showed multiple diagnoses including chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, quadriplegia, tracheostomy status, gastrostomy status, anoxic brain damage.</p> <p>R6's quarterly MDS dated [DATE] showed that R6 is dependent on staff for personal hygiene.</p> <p>On March 18, 2025 at 12:05 PM, R6 was lying in bed with presence of tracheostomy tube. Both of R6's hands were contracted and was noted wearing a splint device on right hand. R6's nails on both hands appeared very long with the left hand fingers curled in and fingernails digging into her hands. R6 was non verbal.</p> <p>On March 19, 2025 at 10:07 AM, R6 was lying in bed with both hands contracted and did not have splint devices on. R6's long fingernails were seen digging into her hands. V10 (Certified Nursing Assistance), who came into the room, stated she puts R6's devices on after ADL (activities of daily living) care. V10 was notified of R6's long fingernails.</p> <p>R6's ADL care plan revised on March 6, 2025 showed that R6 has a ADL self-care performance deficit related to quadriplegia. Interventions for personal hygiene included that R6 is dependent with personal hygiene 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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to follow physician orders for a resident to address swelling to hand and failed to assess a resident to assist in positioning of his thumb digit. This applies to 2 of 2 residents (R86, R100) reviewed for quality of care in the sample of 35.</p> <p>Findings include:</p> <p>1. R86's face sheet included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified osteoarthritis, unspecified site, aphasia following cerebral infarction.</p> <p>R86's POS (Physician Order Sheet) showed to apply ace bandage to right hand in the morning, remove at bedtime one time a day for swelling and remove per schedule (revised date September 19, 2024).</p> <p>On March 18, 2025 at 10:13 AM, R86's right hand appeared contracted with fingers closed in a fist. R86 did not have any bandages on her right hand. R86 stated that she is unable to open her fingers, and remarked It hurts. R86 did not have any ace bandage on her right hand during intermittent observations until lunch meal service at 1:05 PM on the same day.</p> <p>On March 19, 2025 at 10:04 AM, R86's right hand was in an ace bandage wrap. R86 stated They put it on when they want to. V10 (Certified Nursing Assistant) who was in the area stated that it is usually put on in the morning.</p> <p>On March 20, 2025 at 09:10 AM, R86 was eating breakfast and did not have an ace bandage on her right hand.</p> <p>On March 20, 2025 at 10:49 AM, R86 was in the dining room and still did not have ace bandage on her right hand and V10 was notified of the same. V10 stated that the night nurse should have put it on in the morning. V10 remarked that it was an agency nurse that worked the overnight shift.</p> <p>R86's care plan revised November 15, 2024 included that R86 has potential for skin breakdown due to limited mobility, incontinence, physical limitations, medical conditions and use of medications. Intervention included to apply ace bandage to right hand as ordered.</p> <p>2. R100's face sheet included diagnoses of hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, neuralgia and neuritis, and repeated falls.</p> <p>R100's Annual MDS (minimum data set) dated February 4, 2025 showed that R100 was cognitively intact and was impaired on one side on upper extremity.</p> <p>(continued on next page)</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>On March 18, 2025 at 10:29 AM, R100 was in the dining room and his right arm appeared contracted with no devices on for support. R100 stated I can use both arms/hands but my right arm is messed up and cannot use it much. I had a stroke many years ago. My thumb has moved down after the stroke. I have some neuropathy on both hands and feet. I used to get therapy when I first came here 5 years ago. Now I go with V26 (Restorative Aide) twice a week when she is here to do puzzles, go on the bicycle and other exercises. She is not here this week as she is on vacation.</p> <p>On March 19, 2025 at 10:05 AM, R100 was in dining room and did not have any devices on right arm that appeared contracted. V10, who was in the area stated He has been like that since he came here. They had nothing to support his arm. V26 does restorative therapy with him.</p> <p>On March 20, 2025 at 09:45 AM, R100's right hand was shown to V4 (Assisted Director of Nursing) and asked if anyone has assessed him to see if he will benefit from any devices. V4 stated that she will have to consult therapy to screen him for the same.</p> <p>On March 20, 2025 at 02:29 PM, V4 brought a screening evaluation dated March 20, 2025 by V12 (Occupational Therapist) with recommendations for a thumb spica IP (interpharyngeal) free splint.</p> <p>On March 20, 2025 at 2:35 PM, V25 (Restorative Nurse) stated that R100 is under restorative therapy and is very active with therapy. V25 stated that the restorative nurse or aide will refer residents to therapy if they see that a resident has potential for contractures or related concerns.</p> <p>On March 20, 2025 at 2:49 PM, V12 (Occupational Therapist) stated that on evaluation of R100, she recommended a thumb spica IP free splint for optimal positioning of R100's right hand thumb. V12 stated that it looked like R100's right hand CMC (carpal metacarpal) joint has subluxation [a partial dislocation]. V12 stated that this device she recommended will help optimal positioning so that the [displaced] thumb will not bother him and prevent it from getting worse.</p> <p>R100's care plan revised December 27, 2024 included that R100 has potential for decreased range of motion due to impaired mobility. Intervention for the same included to assess resident quarterly and as needed.</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** 16746</p> <p>Based on observation, interview and record review the facility failed to assess and provide splints and devices to residents, to maintain and prevent further reduction in ROM (range of motion). This applies to 2 of 8 residents (R126 and R139) reviewed for range of motion in the sample of 35.</p> <p>Findings include:</p> <p>1. R126 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.</p> <p>R126's quarterly MDS dated [DATE] showed that the resident was cognitively intact. The same MDS showed that R126 had functional limitation in range of motion to one side of his upper extremity.</p> <p>On March 18, 2025 at 11:07 AM, R126 was sitting in his wheelchair inside the unit dining room. R126 was alert, oriented and verbally responsive. R126's left hand was positioned on his lap. R126 cannot move his left arm and hand, and he was not able to open/extend his left hand fingers without the assistance of his right hand. R126 had no device or splint on his left arm and/or left hand.</p> <p>On March 19, 2025 at 9:24 AM, R126 was sitting in his wheelchair inside the unit dining room. R126 was alert, oriented and verbally responsive. R126's left hand was positioned on his lap. R126 was eating his breakfast meal using his right hand. The resident could not move his left arm and hand, and he was not able to open/extend his left hand fingers. R126 had no device or splint on his left arm and/or left hand. V4 (Assistant Director of Nursing) was present during the observation. V4 was asked if R126 needed a device or a splint on his left arm and hand. After this prompting, V4 stated that the facility will request the therapy department for screening to determine if R126 needed any splint/device on the left arm and hand.</p> <p>On March 19, 2025 at 11:20 AM, V12 (OT/Occupational Therapist) stated that she was requested by V4 to screen R126's left arm and hand for possible device/splint. V12 stated that she assessed R126 at around 11:00 AM that day. According to V12, based on R126 screening, the resident cannot actively move his left arm and hand, including wrist and fingers. V12 stated that she recommended for the resident to use a left resting hand splint to keep his wrist in a resting hand position to prevent shortening of the ligaments and tendons, and to prevent contracture of the wrist. V12 added that she also recommended for R126 to use a left upper extremity sling to prevent shoulder dropping and to prevent pain. According to V12, she recommends for R126 to use the left resting hand splint and left upper extremity sling daily when sitting in his chair and should be removed during ADL care to check for skin integrity.</p> <p>2. R139 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, based on the face sheet.</p> <p>R139's quarterly MDS dated [DATE] showed that the resident was modified independence with cognitive skills for daily decision making. The same MDS showed that R139 had functional limitation in range of motion to one side of his upper extremity.</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>On March 18, 2025 at 10:40 AM, R139 was sitting in his wheelchair inside the unit dining room. R139 was alert and verbally responsive. R139 could not open his middle, ring and small fingers on the right hand and according to the resident, he cannot open his right hand. V11 (Certified Nursing Assistant) had to assist the resident in opening his right hand. R139 had no device or splint in place.</p> <p>On March 19, 2025 at 9:26 AM, R139 was sitting in his wheelchair inside the unit dining room. R139 was alert and verbally responsive. R139 could not open his middle, ring and small fingers on the right hand. R139 had no device or splint in place. In the presence of V4, R139 stated that he cannot open his right hand. V4 was asked if R139 needed a device or a splint on his right hand. After this prompting, V4 stated that the facility will request the therapy department for screening to determine if R139 needed any splint/device on the right hand.</p> <p>On March 19, 2025 at 11:27 AM, V12 (OT) stated that she was requested by V4 to screen R139's right hand for possible device. V12 stated that she assessed R139 at around 11:15 AM that day. Stated that based on R139's screening, the resident had moderate contracture on his right middle, ring and small fingers. According to V12, R139 was only able to extend those mentioned fingers minimally with verbalization of pain. V12 stated that she had recommended a right hand roll to prevent further contracture, for positioning and to prevent skin breakdown. V12 added that based on R139's screening, the resident was not able to maintain optimal position on his right arm, so she had recommended a sling for the right upper extremity to prevent shoulder dropping and to prevent development of pain. V12 stated that the two recommended devices (right hand roll and right upper extremity sling) should be applied daily, when R139 is sitting in his chair and should be removed during ADL care to check for skin integrity.</p> <p>On March 21, 2025 at 10:59 AM, V3 (Director of Nursing) stated that for any change in a resident's mobility and/or range of motion, the restorative team should refer the resident to the therapy department immediately to determine the need for any splint and or devices. Once the therapy department had screened and made the recommendation for any splints/devices, it will be applied to the resident to maintain, improve or prevent further decline of the resident's status.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389</p> <p>Based on interview and record review, the facility failed to ensure that therapy recommendations for hands-on transfers were followed to prevent a resident from falling. This failure resulted in R132 falling and sustaining a fracture of the left fibula. This applies to 1 of 1 resident (R132) reviewed for accidents in the sample of 35.</p> <p>Findings include:</p> <p>R132's electronic medical record showed R132 is an [AGE] year old admitted to the facility on [DATE] with medical diagnoses that include cerebral infarction, repeated falls, malignant neoplasm of endometrium and uterus, unilateral primary osteoarthritis of the left knee, aphasia, and apraxia following cerebral infarction. R132's Minimum Data Set (MDS) dated [DATE] showed R132 to be severely cognitively impaired and required partial/moderate assistance for transfers and ambulation.</p> <p>On March 18, 2025 at 11:03 AM, R132 was observed sitting in a wheelchair with a left leg orthotic boot on. R132 stated she fell , but was unable to describe what happened.</p> <p>R132 progress incident note dated December 28 2024, showed the following: R132 verbalized My knee hurts. The assigned Certified Nursing Assistant (CNA) stated she was weighing R132 in the shower room, while standing, her knee buckled and the CNA eased R132 down to the floor/scale on the floor.</p> <p>R132's progress note dated December 29, 2024 showed R132 still complained of pain to her foot, her ankle remained swollen and resident was unable to bend her left ankle, ace wrap was on and acetaminophen was given. The Nurse Practitioner was made aware and new order carried out. Progress note dated December 29, 2024 showed that R132 was sent to the emergency room .</p> <p>R132's hospital after visit summary dated December 29, 2024 showed the diagnosis of closed fracture of the distal end of the left fibula. R132's x-ray of the left ankle dated December 29, 2024 showed an acute nondisplaced oblique fracture within the distal left fibula.</p> <p>On March 19, 2024 at 12:09 PM, V21 (Certified Nursing Assistant/CNA) stated she brought R132 to the shower room in a wheelchair to weigh her. V21 and surveyor went into the shower room and then V21 demonstrated what happened. V21 stated she wheeled R132 to the scale. V21 stated that she had a gait belt on R132 and helped her up and onto the scale. The scale had a short angled ramp on the sides. V21 stated that when R132 stood on the scale, the resident held onto the bar in front of her. V21 stated that she (V21) let go of the gait belt to allow for an accurate weight of R132, at that time (when V21 was not holding onto the gait belt) R132 let go of the bars in front of her and started straightening her pants (V21 demonstrated that resident was pulling her pants up from side to side). V21 stated, then R132 lost her balance and fell on to the scale and she was not able to catch her (R132).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On March 20 2025, at 9:17 AM, V23 (Director of Rehab) stated that R132 had physical therapy from November 22, 2024 until December 19, 2024 with diagnoses of difficulty in walking, abnormal gait, and chronic obstructive pulmonary disease. V23 stated that physical therapy recommended on discharge that R132 required moderate one person assistance for transfers, standing and ambulation. V23 stated moderate assist means staff are holding the gait belt at all times during transfers, standing and ambulation because of the risk for falls. V23 stated R132 was not stable enough to not have hands-on at all times while transferring, standing, and ambulating. V23 stated R132 always had supervision for transfers, standing, and ambulation, and therapy never recommended her to transfer, stand, or ambulate without hands on supervision. V23 stated someone should always be holding the resident and that was the recommendation for R132 upon discharge on December 19, 2024. V23 stated when using that kind of scale, weighing the resident in the chair is the safest way.</p> <p>On March 20, 2025 at 10:58 AM, V22 (Orthopedic Doctor) stated that the cause of R132 injury was the fall that R132 sustained on December 28, 2024. V22 stated that he expects staff to follow therapy recommendations when transferring and ambulating residents in their care. V22 stated the injury could have been prevented, if staff was holding the belt to prevent the fall.</p> <p>R132's Weights and Vital Summary show that R132 weights were done by wheelchair monthly since September 11, 2024.</p> <p>R132's fall risk assessment dated [DATE] showed R132 to be at risk for falls. The same assessment showed that R132 had a balance problem while standing, and the facility's focus intervention was to determine resident's ability to transfer and assist resident with ambulation and transfers utilizing therapy recommendations.</p> <p>R132's Physical Therapy Discharge Summary dated December 19, 2024 showed the following recommendation: Patient requires assistance for safe transfers and toileting.</p> <p>R132's fall risk care plan dated December 5, 2024 showed the intervention to be the following: assist the resident with ambulation and transfers, utilizing therapy recommendations.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to provide gravy for mechanical soft diets and failed to provide the vegetable option as starter for the mechanical soft and pureed diets.</p> <p>This applies to 10 of 10 residents (R35, R52, R80, R90, R91, R93, R94, R103, R116, R136) reviewed for dining in the sample of 35.</p> <p>Findings include:</p> <p>Facility daily spread sheet for Week 3 Tuesday included Garden Fresh Lettuce and Tomato Salad (1 cup) as a starter for General diets, soft cooked hot vegetable for Mechanical soft diets and pureed cooked hot vegetables for Pureed diets. The same spread sheet also included Tender Pork Roast as the main entree and showed to serve ground pork roast with 1 oz/ounce gravy for Mechanical soft diets. Additionally the lunch meal also included carrots and lemon herb potatoes.</p> <p>On March 18, 2025 at 11:20 AM during lunch tray line service, R35, R80, R91, R116, R136 who were on mechanical soft diets and R52, R90, R93, R94, R103 who were on pureed diets did not receive the soft cooked hot vegetables and pureed cooked hot vegetables respectively with the other meal items (pork roast and carrots, lemon herb potatoes) they had received.</p> <p>The ground pork roast on the tray line appeared dry and R35, R80, R91, R116, R136 who were on mechanical soft diets received the same without 1 oz gravy. When asked about the above items not received, V5 (Dietary manager) after inquiring with V6 (Cook), stated that the gravy was not prepared. V5 and V6 also stated that the residents on mechanical soft and pureed diets received carrots as a vegetable and don't receive salads and that only General diets receive the same.</p> <p>On March 20, 2025 at 1:08 PM and 5:10 PM, V18 (Dietitian) stated that the facility should follow the menu spreadsheets and serve foods as shown. V18 added that although the salad is just a starter, she understands that all residents should receive the same foods as the planned meal in their respective consistencies.</p> <p>Recipe for Ground Pork Roast with Gravy included as follows: Portion with #10 scoop [3.25 oz] plus 1 oz gravy to keep moist.</p> <p>Facility diet order listing showed that R35, R80, R91, R116, R136 were on mechanical soft diets and R52, R90, R93, R94, R103 were on pureed diets.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145956	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Citadel at Casa Scalabrini		STREET ADDRESS, CITY, STATE, ZIP CODE 480 North Wolf Road Northlake, IL 60164	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<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** 36567</p> <p>Based on observation, interview and record review, the facility failed to follow sanitary practices in the facility kitchen. This applies to 172 residents that received foods prepared in the facility kitchen.</p> <p>Findings include:</p> <p>Facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated March 18, 2025 showed that the facility census was 176 residents. Facility provided information that there were 4 residents on NPO (nothing by mouth) status.</p> <p>On March 18, 2025 at 9:11 AM, during initial tour of the kitchen in the presence of V5 (Dietary Manager) the following observations were made:</p> <p>In the dry storage area, 2 dented cans at the seams were stored on horizontal shelving along with other cans. These cans were labeled Traditional Refried Beans (7 lbs/pounds) and Vegetarian Baked Beans (7 lbs, 3 oz/ounces).</p> <p>In a walk-in Cooler, there were also multiple cans stored on a slanted shelving and also showed a dented can labeled Sauerkraut (6 lbs, 8 oz). V5 stated that the dented cans in both the dry storage and cooler may have fallen off the rack and were placed back on the shelving. There were also multiple cans with no delivery date: 3 cans labeled Natural Apple Sauce (6 lbs, 10 oz per can), 2 cans labeled Mandarin Oranges (6 lbs, 10 oz), and 1 can labeled [NAME] pudding (7 lbs). V5 stated that the delivery date may have been overlooked. In the same walk-in cooler, there were multiple crates (about 18) of individual 8 oz cartons of milk, several 5 lb tubs of cottage cheese and several blocks of cream cheese. The refrigerator thermometer showed 54 degrees Fahrenheit. V5 stated that he was just made aware that morning that the cooler was out of order and as soon as an employee [NAME] up, he was planning to shift all the items stored in this cooler to another cooler.</p> <p>In another walk-in Cooler there appeared to be patches of black fuzzy substance under water pipes that was located above the shelving that stored prepped items [that were covered loosely with saran wrap or foil] including salad, diced tomatoes, hot dogs, eggs and containers of condiments. When asked what the black patches were, V5 stated it looks like mold.</p> <p>In the walk-in Freezer, there was a cardboard box of beef patties that were open to air. V5 stated that the weekend cook may have not closed the box. At the far end of the freezer there were icicles dripping onto a partially opened box containing frozen Manicotti.</p> <p>In the kitchen there were several cutting boards on a shelf that were stored both horizontally and vertically inside a large flat sheet pan which contained marked unknown congealed debris.</p> <p>In the kitchen, V6 (Cook), was preparing the lunch meal and was wearing a cap over his head but noted to have facial hair/beard which was about an inch long. When asked, V6 stated that he does not wear a beard cover as he keeps his beard trimmed.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Citadel at Casa Scalabrini		STREET ADDRESS, CITY, STATE, ZIP CODE 480 North Wolf Road Northlake, IL 60164	
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>On March 18, 2025 at 11:16 AM, the food temperatures were monitored at the tray line by V6. The mashed potatoes showed 82 degrees Fahrenheit and V6 was not sure what temperature foods at holding should be. V5 who was in the area stated that the food temperatures should be above 140 degrees Fahrenheit and removed the mashed potatoes from the tray line and directed V6 to reheat the same. In about 15 minutes later, V6 brought the mashed potatoes back to the tray line, stating that he reheated the item to 158 degrees Fahrenheit. When asked, neither V5 nor V6 knew what degree the reheating temperature was recommended. V5 then looked up the information and came back and reported that the reheating temperature should be 165 degrees Fahrenheit. V5 was notified that the correct reheating temperatures should be followed in order to serve the mashed potato.</p> <p>On March 18, 2025 at 11:20 AM and 11:36 AM, V7 (dietary aide) was seen eating a banana in the kitchen and V8 (dietary aide) was seen washing dishes with her coffee cup and personal lotion placed on a rack that stored clean dishes. V9 (dietary aide) was also seen at tray line assisting with serving the deserts and was not wearing gloves. V5 stated that employees should not eat and drink and store personal items in the kitchen.</p> <p>On March 18, 2025 at 11:53 AM, the walk in cooler seen earlier with individuals cartons of milk was checked again and noted to be 58 degrees Fahrenheit. The cartons of milk remained in the cooler and V5 stated that he has not got a chance to move the milk crates to another cooler.</p> <p>On March 19, 2025 at 12:28 PM, V13 (cook) was at the stove stirring a big container of pasta with a spoon with his right hand. V13 then spooned some pasta onto his left palm and tasted it. V13 was wearing a cap and his hair was hanging loose down to the nape of his neck. V13 also had a thick mustache and was wearing a beard cover that was looped on to his ears and tucked under his chin. V5 was notified of the same and V5 called out to V13 You can't taste with your fingers. Its unsanitary. Put some gloves on.</p> <p>On March 20, 2025 at 1:08 PM, V18 (Dietitian) stated that dietary employees should eat in a designated separate area and not in the kitchen for sanitary purposes. V18 added that the cutting boards should be stored in a clean surface.</p> <p>Facility Dietary Policy and Procedure Manual (2017) for Hair restraints/jewelry/nail polish showed that hairnets will be worn at all times in the kitchen. [NAME] guards or masks will be worn as indicated.</p> <p>Facility Dietary Policy and Procedure Manual (2018) for Storage of dry goods/foods and First in First Out showed that dented cans are stored in a designated area to be returned to vendors. Cans are removed from cartons and stored behind already shelved products. Products with the earliest expiration date are stored in front of products with later dates so that the older food is used first .</p> <p>Facility Dietary Policy and Procedure Manual (2018) for Storage of Refrigerated foods included: Policy- refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Procedure- Refrigerated foods are stored at 41 degrees Fahrenheit or below</p> <p>Facility Dietary Policy and Procedure Manual (2018) for Storage of Frozen Foods included that opened products that may not have been properly sealed and dated are discarded.</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>Facility Dietary Policy and Procedure Manual (2018) temperature monitoring form for Critical Control Points Food Temperatures included that holding temperature for hot foods should not be less than 135 degrees Fahrenheit.</p> <p>Facility Dietary Policy and Procedure Manual (2018) for Reheating showed that foods will be reheated rapidly to an internal temperature of 165 degrees Fahrenheit for 15 seconds.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855</p> <p>Based on interview and record review, the facility failed to include in their arbitration agreement the required language indicating that signing the Arbitration Agreement was not a condition for their admission to the facility.</p> <p>This applies to 51 of 176 residents (R14, R16, R23, R29, R30, R36, R39, R40, R41, R46, R50, R52, R55, R56, R58, R59, R62, R89, R101, R112, R121, R123, R126, R129, R133, R136, R138, R140, R141, R148, R153, R154, R157, R158, R160, R161, R162, R163, R164, R165, R167, R169, R171, R172, R173, R174, R329, R330, R331, R332 and R334) residing in the facility reviewed for Arbitration Agreement.</p> <p>Findings include:</p> <p>On March 18, 2025, at 4:55 PM, V2 (Assistant Administrator) stated that all residents admitted to the facility are offered arbitration. It is up to the resident or their responsible party to sign the agreement. Currently out of 176 in-house residents, 51 residents/responsible party had signed the arbitration agreement. V2 stated they have the right to decline because signing this agreement is not a requirement for their admission to the facility. V2 was asked to provide their policy and procedure on Arbitration. V2 stated they did not have a policy on Arbitration.</p> <p>On March 19, 2025, at 1:31 PM, R161 stated she did not remember signing an Arbitration Agreement during admission, only remembered signing for her medications. R171 said due to his career he was aware what arbitration was but did not remembering signing an agreement.</p> <p>On March 20, 2025, at 10:07 AM, R148 stated she did not remember signing an arbitration agreement on admission. She was not sure what arbitration was.</p> <p>On March 20, 2025, at 10:11 AM, V17 (Corporate Admissions) stated that the facility had recently updated their arbitration agreement based on what they had learned from previous surveys. V17 stated that the updated/current arbitration agreement which was effective as of March 4, 2025 included the required language indicating that signing the arbitration agreement was not a condition for their admission to the facility. According to V17, prior to March 4, 2025, this language was not included in the agreement. V17 added that those residents in the facility that had signed an arbitration agreement prior to March 4, 2025, were not asked to sign the new contract because they don't need to. It is implied that those residents can remain in the facility.</p> <p>R41's EMR (Electronic Medical Record) showed R41 was admitted to the facility on [DATE]. R41 signed the Arbitration Agreement on February 12, 2025. R41's Arbitration Agreement did not have the verbiage to show that signing the agreement was not a condition of R41's admission to the facility.</p> <p>R148's EMR showed R148 was admitted to the facility on [DATE]. R148 signed the Arbitration Agreement on October 22, 2024. R148's Arbitration Agreement did not have the verbiage to show that signing the was agreement was not a condition of R148's admission to the facility.</p> <p>(continued on next page)</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R161's EMR showed R161 was admitted to the facility on [DATE]. R161 signed the Arbitration Agreement on November 25, 2024. R161's Arbitration Agreement did not have the verbiage to show that signing the agreement was not a condition of R161's admission to the facility.</p> <p>R171's EMR showed R171 was admitted to the facility on [DATE]. R171 signed the Arbitration Agreement on February 18, 2025. R171's Arbitration Agreement did not have the verbiage to show that signing the agreement was not a condition of R171's admission to the facility.</p> <p>Review of the facility's list of current residents who had signed and/or had their responsible parties signed the arbitration agreement before the updated/current agreement made on March 4, 2025, included R14, R16, R23, R29, R30, R36, R39, R40, R46, R50, R52, R55, R56, R58, R59, R62, R89, R101, R112, R121, R123, R126, R129, R133, R136, R138, R140, R141, R153, R154, R157, R158, R160, R162, R163, R164, R165, R167, R169, R172, R173, R174, R329, R330, R331, R332 and R334. The above mentioned resident arbitration agreements did not include the required language indicating that signing the Arbitration Agreement was not a condition for their admission to the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303</p> <p>Based on observation, interview, and record review, the facility failed to follow their Water Management Plan for Legionella. The facility also failed to follow their policy for EBP (Enhance Barrier Precautions). This applies to all 176 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated March 18, 2025, showed the facility's census was 176 residents.</p> <p>On March 19, 2025, at 10:31 AM, V15 (Maintenance Director) said for the facility's Water Management Plan for Legionella, V15 tests the facility's water temperature in resident rooms and shower rooms. V15 continued to say the water temperatures in the kitchen and laundry are tested daily. V15 said the maintenance department does not test the water for chlorine levels.</p> <p>On March 19, 2025, at 10: 38 AM, V14 (Regional Maintenance Director) said a water company comes to the facility about every month and tests the water for chemicals. V14 said that is the only chemical tests performed on the facility's water.</p> <p>The water company's Water Analysis Report did not show the water company was testing for chlorine levels in the facility's water.</p> <p>On March 20, 2025, at 10:49 AM, V14 said the facility's Water Management Plan for Legionella shows the facility's water should have chlorine levels tested weekly. V14 said the facility is not testing the water for chlorine levels. V14 said he will have to order chlorine testing kits so V15 can start testing the facility's water for chlorine levels.</p> <p>The facility does not have documentation to show chlorine levels were tested weekly.</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 - Many</p>	<p>The facility's Water Management Plan for Legionella dated October 18, 2024, showed . Cold Water Distribution. Potential Related hazards: Potential growth of microorganisms which could be propagated and transmitted via cold water distribution piping system and aerosolized via sinks. Risk Factors: Medium Risk: Based on the potential variable chlorine present in the cold-water supply, the potential for microbiological growth is reduced compared to a hot water system. The factors for microbiological growth in conjunction with the potential for water to be aerosolized present a medium risk at this processing step. In addition, distribution piping materials vary based on the various building ages and construction practices . Hot Water Distribution. Potential Related Hazards: Microbial growth in the potable water distribution system which could be transmitted by sink faucets and showers. Scalding potential. Target water distribution temperature at the fixture is 110 degrees Fahrenheit. Risk Factors: High Risk: The hot water system is extensive and complex. In addition, many tenant may manage individual hot water heaters. There is potential for 15 to 20 degree Fahrenheit temperature drops after the hot water supply leaves the Hot Water Heaters which can bring the water into prime temperature ranges for microbiological growth. Along with these favorable temperatures for microbiological growth, there is potential for free chlorine residuals to dissipate and leave the hot water system with level of control. The factors for growth in conjunction with the potential for water to be aerosolized present a high risk at this processing step . Cold Water Distribution: Manual and electric faucets/showers and hoses/water hammer arrestors/pipes, valves, and fittings/aerators/faucet flow restrictors. Monitoring methods: 'Free' Chlorine Test. Frequency to Check: Weekly . Hot Water Distribution: Manual and electric faucets/showers and hoses/water hammer arrestors/pipes, valves, and fittings/aerators/faucet flow restrictors. Monitoring methods: 'Free' Chlorine Test. Frequency to Check: Weekly .</p> <p>2. The EMR (Electronic Medical Record) showed R151 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, chronic kidney disease, Alzheimer's disease, and dysphagia.</p> <p>R151's Order Summary Report dated March 20, 2025, showed an order dated March 18, 2025, for Resident on Enhanced Barrier Precautions due to wounds.</p> <p>R151's care plan showed, Resident requires Enhanced Barrier Precautions, Wounds requiring a dressing. The care plan continued to show multiple interventions dated March 18, 2025, including Staff wear gloves and gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs and assisting with toileting. Gown and glove one use only and for only one resident. Staff will wear gloves and gowns for device care or use of central lines, urinary catheters, feeding tubes, tracheostomy, colostomy/ileostomy or any wound care. Gown and glove one use only and for only one resident.</p> <p>On March 18, 2025, at 10:13 AM, V19 (RN/Registered Nurse) entered R151's room. V19 was not wearing a gown. At 10:20 AM, V19 exited R151's room and said she changed R151's wound dressing.</p> <p>On March 19, 2025, at 4:12 PM, V20 (CNA/Certified Nursing Assistant) was in R151's room and was providing care to R151. V20 was not wearing a gown. At 4:16 PM, V20 said she had been changing R151's soiled incontinence brief, repositioning R151 in bed, and adjusting R151's linens.</p> <p>On March 20, 2025, at 1:55 PM, V3 (DON/Director of Nursing) said residents require EBP when they have wounds. V3 continued to say V19 and V20 should have been wearing gowns while providing care to R151.</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 - Many</p>	<p>On March 20, 2025, at 1:57 PM, V16 (Infection Preventionist) said R151's EBP sign was placed outside of his room on March 18, 2025. V16 continued to say R151 should have been on EBP on March 12, 2025, when R151's wound was assessed to be an open wound.</p> <p>The facility's policy titled Enhanced Barrier Protection dated May 2022, showed Introduction: This precaution is for use in long term care facilities to prevent the spread of novel or MDRO (Multidrug-Resistant Organism) infections. Procedure: Everyone must clean their hands before entering and when leaving a room. Healthcare providers must don a gown and gloves prior to entering a room and doff after leaving the room for high contact resident care activities. Healthcare workers do not wear the same gown or gloves for care of more than one person. High contact activities include: Direct ADL (Activity of Daily Living) care- dressing, bathing, providing hygiene, transferring, changing linens, changing briefs or assisting with toileting; Device care or use such as: central line, urinary catheter, feeding tube, tracheostomy, and other indwelling devices; Wound care and any skin opening requiring a dressing; Care of residents that are MDRO colonized . Post clear signage on the door or wall outside of the resident room indicating the type of precautions and requires PPE (Personal Protective Equipment). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves .</p>		