Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	1L6000277	B WING		06/02/2017
NAME OF PROVIDER OR SUPP			TATE, ZIP CODE	
CITADEL CARE CENTER	ELGIN 180 SOU'	TH STATE ST - 60123	REET	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
S 000 Initial Commen	ts	S 000	9	
Complaint Inve	stigation			
1773205/IL943	50			
S9999 Final Observat	ons	S9999		
Statement of L	censure Violations			
300.1210b) 300.1210d)1) 300.1210d)2) 300.3220f) 300.3240a)				
Section 300.12 Nursing and Pe	10 General Requirements for ersonal Care			
and services to practicable phy well-being of th each resident's plan. Adequate care and perso	shall provide the necessary care attain or maintain the highest sical, mental, and psychological e resident, in accordance with comprehensive resident care and properly supervised nursing nal care shall be provided to each et the total nursing and personal he resident.			
care shall inclu and shall be proseven-day-a-we 1) Medica hypodermic, into be properly address	tions, including oral, rectal, ravenous and intramuscular, shall		Attachment Statement of Licensure	55
administered a	s ordered by the physician.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 06/15/17

STATE FORM

TVI011

If continuation sheet 1 of 6

PRINTED: 07/27/2017 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6000277 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **180 SOUTH STATE STREET** CITADEL CARE CENTER-ELGIN **ELGIN. IL 60123** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure all hospital discharge medication

The findings include:

residents.

R1's electronic clinical record showed R1 was admitted to the facility on April 24, 2017 with

orders are followed and provided to residents.

This failure resulted in R1 not receiving 8 of 16 medications for 3 weeks (from April 25, 2017) through May 15, 2017 - 21 days). These medications includes anticoagulant,

antiarrhythmic and diuretic medications. On May 15, 2017 R1 developed severe congestion and shortness of breath and was admitted to hospital intensive care unit with diagnoses including sepsis, pneumonia and congestive heart failure.

This applies to 1 of 3 residents (R1) reviewed for medication administration in the sample of 6

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6000277 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **180 SOUTH STATE STREET** CITADEL CARE CENTER-ELGIN ELGIN. IL 60123 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 2 S9999 diagnoses to include cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, dysphagia following non-traumatic intra cerebral hemorrhage, congestive heart failure and atrial fibrillation. R1's hospital discharge medication list dated April 24, 2017 includes 3 pages (marked as page 1, 2 and 3) of medication orders that includes 16 scheduled medications and 4 medications as needed (prn). All of these medications were transcribed to the Physician Order Sheet and to R1's Medication Administration Record (MAR). On April 25, 2017 R1's Physician Order Sheet showed 8 of these hospital discharged medications were discontinued. These medications are as follows: 1. Amiodarone HCL 200 mg, give one tablet by mouth one time a day - for Atrial fibrillation. 2. Eliquis (Anticoagulant) 5 mg give one tablet per mouth Twice a Day - for stroke and deep vein thrombosis. 3. Lasix (Diuretic) 20 mg one tablet Twice a Day for diastolic heart failure. 4. Atorvastatin Calcium 40 mg one tablet by mouth at bedtime for hyperlipidemia. 5. Cyanocobalamin 500 mcg give one tablet for anemia. 6. Ferrous Gluconate give one tablet Twice a Day for anemia. 7. Vitamin D3 50000 unit one capsule every Saturday for Vitamin D deficiency and, 8. Albuterol Sulfate Nebulization (2.5 mg/3 ml) 0.083% 3mg/ml inhale orally via nebulizer every 6 hours as needed for shortness of breath. On May 30, 2017 at 1:30 PM, the Administrative

staff (E1 (Administrator), E2 (Director of Nursing)

Illinois Department of Public Health

_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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		ELGIN, IL				,
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S9999	Continued From pa	Continued From page 3				
	they are aware of the they investigated it. admitting nurse commedication list, not list/instruction form, the next day (April 2)	Director of Nursing) stated nese medication errors and They explained that the sied from the "active" hospital from the discharge medication Then a nurse (E6) came in 25, 2017) and discontinued cations without consulting the				6
	electronic clinical re	mentation found in R1's cord or presented as to why were discontinued or that the was notified.	×			
	"The Director of Nu to me (on April 25, 2 Nursing and Assistate doing chart audit are used the active meanot from the dischate to correct it. E2 gaves hospital-discharged	t 12:20 PM, E6 (Nurse) stated, rsing (E2) brought R1's chart 2017) and said we (Director of ant Director of Nursing) were ad realized the admitting nurse dication list from the hospital, rge list. E2 told me two times e me two pages of the orders and the stuff didn't see I discontinued it."	Na .			
		errors were not found until Z2 reviewed R1's chart on May after admission).				
	"R1 was very congestethoscope. I can I was gurgling so lou	11:20 AM, E8 (Nurse) stated, ested. I do not need to use a near him from the hallway, he d, so I asked the Nurse come and evaluate him."				
	progress notes and I was asked by the	12:40 PM Z2 reviewed her explained, "On May 15, 2017 nurse (E8) to evaluate R1 due less of breath, congestion,				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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CITADEL CARE CENTER-ELGIN	180 SOUT ELGIN, IL	H STATE ST	REET		
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES (UST BE PRECEDED BY FULL EIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
my first consult to R1 records from the hosp medications prescribe not carried over. Thes important to be contin history of atrial fibrillat extremities, congestiv was so congested. No could have triggered s The Amiodarone HCL medication), the Lasix (anticoagulant) - these needed those medica the Director of Nursing Z2 also stated, "Wher very congested and hi edematous/swollen. H Congestive Heart Fail Lasix was ordered as diuretics his Congeste exacerbated." On June 1, 2017 at 3: (Attending Physician) getting a call from any these medications to I practice is to approve discharge orders. In h and he is very high ris medications could affe On June 1, 2017 at 11 Admission Director pr physical and emergen currently in the hospita comatose and has dia	versus aspiration. That was so I reviewed his medical pital and found that some ed from the hospital were se medications are nued. R1 has a pacemaker, tion, swollen lower we heart failure at that day he ot giving the medications something so I re-ordered it. (antiarrhythmic x (diuretic), and the Eliquis se are all important and he ations. I reported this error to ag." I evaluated him he was his lower extremities were He was diagnosed with a result of R1's missing the ed Heart Failure 102 PM via phone, Z3 a stated, "I never recall y facility staff asking about be discontinued. My a or follow all hospital his case, R1 is very fragile sk; discontinuing those feet him adversely." 1:30 AM, the facility resented hospital history and ney record and stated, R1 is	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: COMPLETED

L6000277 B. WING COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

180 SOUTH STATE STREET
ELGIN, IL 60123

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
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