STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015168	A. BUILDING: _____ B. WING _____	C 08/21/2023

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CITADEL OF NORTHBROOK, THE	3300 MILWAUKEE AVE. NORTHBROOK, IL 60062

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S 000	Initial Comments Complaint Investigation 2396456/IL162809	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed, and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to prevent or identify the origin of how a resident sustained a right hip fracture. This affected one of three residents (R1) reviewed for injury of unknown origin. This failure resulted in R1 complaining of pain to the right leg. R1 was assessed, sent to the local hospital, and diagnosed and treated for complex comminuted periprosthetic fracture.	S9999		

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S9999	Continued From page 2 Findings include: R1 face sheet shows R1 is 99-year-old female, R1 has diagnoses of presence of right artificial hip joint, history of falling, unspecified dementia, lack of coordination. R1 plan of care denotes R1 has difficulty hearing and visual deficits. R1 incident report to the department dated 8/6/2023 denotes in part, location of incident shower room, resident complained of pain on right leg upon assessment, noted right hip swelling and shortening of right leg no bruising or redness noted. NP (Nurse Practitioner) notify and assess resident in order to send resident to hospital for evaluation, resident had no fault or incident noted, grandson notified about resident transfer to hospital, 911 paramedics call for resident transport to hospital. Resident transferred to hospital, admitted to hospital with diagnosis of periprosthetic fracture of proximal femur. Investigation initiated and to follow final report investigation completed after staff interview and medical record review, resident had no recent fall nor incident, no outward injuries nor bruising noted. Resident 99-year-old, frail elderly, medically complex resident with diagnosis of diabetes hypertension acute renal injury anemia hyperkalemia and had history of right hip hemiarthroplasty at the greater trochanter, care plan will be updated when resident returned to facility. Type of injury fracture. R1 incident report titled other, dated 8/6/23, denotes in-part, at around 2:45 pm, CNA called this writer's attention that patient was complaining of right leg pain when CNA was trying to move it in the shower room. Immediately went there, patient was wearing jogger pants, said it was hurting. We transferred her to patient's room into	S9999		

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S9999	Continued From page 3 her bed to take a closer look without her pants. Noted to have pain and swelling on right hip, with shortening of right leg. NP (Nurse Practitioner) informed. NP saw patient and ordered for stat right hip to include right femur bone. PRN (as needed) Tylenol given for pain. All stat called could not provide an ETA (expected time arrival). Supervisor on duty informed. SNOD (Supervisor Nurse on Duty) informed DON (Director of Nursing). Decision was to send patient out to ER for further eval. Supervisor on duty informed that we will send via 911. VS taken. 911 called. Paramedics came and picked up patient around 3:25 pm via stretcher. POA (Power of Attorney) and MD (Medical Doctor) informed. Endorsed to next NOD (Nurse on Duty). Injuries observed at time of incident suspected fracture right trochanter hip. Pain level 4. Mental status orientated to person orientated to place. Predisposing physiological factors fragile skin, incontinent, gait and balance, impaired memory. Predisposing situation factors loss of ability to walk. Notes 8/10/2023, root cause considering residents age medically complex condition history of right hip hemiarthroplasty lack of incidence resident may have hurt herself during act of physical mobility. R1 progress note dated 8/6/23 denotes at around 2:45 pm, CNA called this writer's attention that patient was complaining of Right leg pain when CNA was trying to move it in the shower room. Immediately went there, patient was wearing jogger pants, said it was hurting. We transferred her to patient's room into her bed to take a closer look without her pants. Noted to have pain and swelling on right hip, with shortening of right leg. NP informed. NP saw patient and ordered for stat right hip to include right femur bone. PRN Tylenol given for pain. Radiology company could not	S9999		

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S9999	Continued From page 4	S9999		

provide an ETA. Supervisor on duty informed. SNOD informed DON. Decision was to send patient out to ER for further eval. Supervisor on duty informed that we would send via 911. VS taken. 911 called. Paramedics came and picked up patient around 3:25 pm via stretcher. POA and MD informed. Endorsed to next NOD.

R1 hospital record dated 8/7/23 denotes in-part chief complaint: right hip pain HPI: R1 is a 99-year-old female with PMH (past medical history) of HTN (hypertension), HLD, DM (diabetes mellitus), dementia who presents from SNF (skilled nursing facility) with right hip pain / swelling. It is unclear if she had fallen. Imaging in ER (emergency room) revealed a right hip peri-prosthetic fracture. Xray of pelvis -comminuted displaced impacted overlapped angulated periprosthetic fracture of the proximal femur. Distal tip of the stem of the prosthesis is directed anteriorly. No periosteal reaction. Trabecular pattern unremarkable. Joints: Head of prosthesis remains seated within the acetabular cup which is in stable position. Soft tissues: Unremarkable. Impression: Complex comminuted periprosthetic fracture.

R1 MDS (Minimum Data Set) dated 5/17/23 denotes in-part section C, BIMS score 6 (cognitively impaired) section G transfers; extensive assistance two plus person physical assist. Bed mobility- extensive assist with two plus person physical assistance. Walk in a room extensive assist of 2 plus person physical assist. Locomotion on and off the unit, extensive assist of one-person physical assist. Dressing extensive assist of one-person physical assist. Eating supervision with one-person physical assist. Toilet use extensive assist of two plus person physical assist. Personal hygiene extensive assist of

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S9999	Continued From page 5 one-person physical assist. Balance during transition and walking; moving from seated to standing; not steady only able to stabilize with staff assist. Surface to surface transfer; not steady only able to stabilize with staff assist. R1 care plan for ADL self-care performance deficit due to decreased mobility pain related to right hip hemiarthroplasty, goal is one will maintain current level of function with ADL 's through the next review date, target date 8/22/23, interventions bed mobility program turn and reposition every room round assist with sideline position support backward pillow monitor for any intolerance monitor for presence of pain intolerance during bed mobility bare mobility the resident requires extensive assistance by 2 staff in turn and repositioning in bed every room round and as necessary transfer the resident require extensive assistance times 2 staff using sit to stand for all transfer. R1 care plan denotes R1 is high risk for falls due to decreased mobility, pain related to right hip hemiarthroplasty, diabetes mellitus and the use of narcotic medication, other medication side effects. Goal is will not sustain injury through the next review date, target date 8/22/2023. Interventions: anticipated and meet the resident needs be sure the resident call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance. Encourage the resident to participate in activity that promote exercise, physical activity for strengthening and improve mobility. Ensure the resident is wearing appropriate shoes non-skid socks when ambulating or mobilizing in wheelchair. Review medication that caused the fall. Scoop mattress.	S9999		

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S9999	Continued From page 6 On 8/19/23 at 2:43pm, V3 (Administrator) said the investigation directed her and V6 (Director of Nursing/DON) to V5 (Certified Nursing Aide/CNA). V3 said V5 was asked to write a statement. V3 said V5 statement was reviewed, and there was not a lot of details, so V5 was asked to come into the facility for an interview. V3 (Administrator) said herself and V6 (DON) interviewed V5 on 8/10/23. V3 said during that interview V5 (CNA) said he got R1 up in the chair, V5 said he transferred R1 using the sit to stand mechanical lift. V3 said V5 said there was no falls, no incidents. V3 (Administrator) said V5 (CNA) stopped responding to the email communications and V5 stopped coming to work. V3 said V5 cannot be reached at the phone number they have on file. V3 said V5 (CNA) was terminated due to no call, no show to work. V5 said she is not aware of R1 having a fall. On 8/20/23, V5 said she did not review facility video surveillance. V5 said she does not know what happened to R1's hip. On 8/21/23 at 8:32am, V6 (DON) said she conducted the investigation for R1. V6 said she did not review video surveillance for her investigation for R1. V6 said she went back 3 days from the date R1 was observed with pain during her investigation. V6 said V5 (CNA) was the staff that worked with R1 prior to R1 being observed with pain and swelling on 8/6/23 in the hip. V6 said all the staff within those 3 days were asked to write a statement. V6 said when reviewing V5 written statement, there was not a lot of details. V6 said V5 was asked to come into the facility for an interview. V6 said V5 told her that he transferred R1 to the wheelchair using a gait belt on the morning of 8/6/23. V6 said V5 had R1 to sit at the bedside before transferring R1. V6	S9999		

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S9999	Continued From page 7	S9999		

said V5 did not say he used the sit to stand to transfer R1. V6 said she only asked about transferring of R1, she did not inquire about bed mobility and dressing R1 that morning. V6 said V5 said he was getting R1 up for the day. V6 said V5 (CNA) statement consistently changed during the interview. V6 said R1 is on the get-up list, that's why V5 was getting her up that morning. V6 said if R1 had a fall outside of her room staff would have heard it or saw it. V6 said R1 cannot get up by herself after a fall, R1 needs assist to get up. V6 said there's no cameras in R1's room. V6 said she do not know what happened to R1 hip. V6 said she reviewed the hospital records and R1 has a bad fracture. V6 said R1 require 2 persons assist with the use of the sit-to-stand mechanical lift. V6 (DON) said V5 should use the sit-to-stand when transferring R1. V6 said it's for safety reason, to prevent injuries, especially in the elderly population. V6 said her root cause analysis was based on that no staff witness R1 falling.

On 8/19/23 at 1:35pm, V1 (CNA- Certified Nursing Aide) said when she came on duty on 8/6/23 (morning) she saw R1 up in the wheelchair at the nurse station. V1 said she thought that was strange because R1 is not on the get-up list. V1 said multiple staff was shocked to see R1 up so early. V1 said R1 was escorted to the dining room to have breakfast. After breakfast, R1 had activities. After activities, it was soon time for lunch. V1 said after lunch, she went to toilet R1. V1 said she took R1 to the restroom, she went and got the sit to stand lift. V1 said she asked the Aide to assist her with R1. V1 said she lifted R1 leg to remove the leg rest, and R1 complain of pain. V1 said she went to get the nurse immediately so that the nurse can check R1. V1 said her and the nurse took R1 back to her room,

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S9999	Continued From page 8 put R1 in the bed. V1 said they took R1 joggers off and R1 had big swelling to the right hip. V1 said that was her first-time toileting R1 that day (after lunch). V1 said R1 was in pain. V1 said she checked R1 brief once or twice and R1 was dry. On 8/19/23 at 2:49pm, V2 (Nurse) said she was summons to the shower room when R1 had pain. V2 said she did not ask R1 what happened because R1 has dementia. V2 said she's not familiar with R1, she doesn't know if R1 would have been able to tell her what happened. V2 said R1 was taken to her room, placed on the bed for better observation. V2 said R1's right leg was noted with swelling. V2 said she gave R1 Tylenol for pain. V2 said she notified the NP and NP gave orders for Xray, but the Xray company did not give ETA, so R1 was sent to hospital for further evaluation. V2 said she did not get report that R1 had a fall from previous shift, she did not get report of incident from previous shift. On 8.19.23 at 12:20pm, V7 (Physician) said the facility notified him of R1's hip fracture, R1 was sent out to the hospital. V7 said the facility does not know what happened to R1's hip. V7 said the facility said no one reported any falls for R1. V7 made aware of allegation of R1 allegedly being dropped. V7 said that would makes sense if that's what happened but the facility doesn't know what happened. V7 said a fracture is a result of trauma. V7 said a fracture could develop spontaneously, but he has not seen that happen, it rare. V7 said R1 has a history of hemiarthroplasty. V7 made aware R1's diagnosis at the hospital of complex comminuted periprosthetic fracture. V7 said periprosthetic fracture is a fracture around the prosthesis. V7 said the surgeon would be better to ask if fracture is acute or chronic.	S9999		

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S9999	Continued From page 9 R1 hospital record dated 8/7/23 denotes in-part chief complaint: right hip pain HPI: R1 is a 99-year-old female with PMH (past medical history) of HTN (hypertension), HLD, DM (diabetes mellitus), dementia who presents from SNF (skilled nursing facility) with right hip pain / swelling. It is unclear if she had fallen. Imaging in ER (emergency room) revealed a right hip peri-prosthetic fracture. Xray of pelvis -comminuted displaced impacted overlapped angulated periprosthetic fracture of the proximal femur. Distal tip of the stem of the prosthesis is directed anteriorly. No periosteal reaction. Trabecular pattern unremarkable. Joints: Head of prosthesis remains seated within the acetabular cup which is in stable position. Soft tissues: Unremarkable. Impression: Complex comminuted periprosthetic fracture. First policy facility presented on 8/21/23, (3 pages) no date noted titled abuse prevention abuse denotes residents have a right to be free from abuse neglect exploitation misappropriation of property or mistreatment this includes but is not limited to corporal punishment involuntary seclusion and any physical or chemical restraint not required to treat the residence medical symptoms. The purpose of this policy and the abuse prevention program is to describe the process for identification, assessment, and protection of residents from abuse neglect misappropriation of property and exploitation this will be accomplished by conducting pre-employment screening orientating training employees, established environment for residents' sensitivity, resident security, and prevention of mistreatment. Immediately protecting residents involved in identifying reports of property possible abuse neglect exploitation	S9999		

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S9999	Continued From page 10	S9999		

misappropriation property. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means abuse is also the willful infliction of injury unreasonable confinement intimidation or punishment with resulting physical harm pain or mental anguish to a resident. Injury of unknown sources are injuries for which both the following conditions are met one the source of the injury was not observed any person the source of injury could not be explained by the resident and to the injury is suspicious because of the extent or location of the injury the number of injuries observed at one particular point in time or the incidence of injuries over time. Serious bodily injury is defined as an injury involving extreme physical pain substantial risk of death protracted loss or impairment of the function of organ or mental faculty or requiring medical intervention such as surgery hospitalization or physical rehabilitation.

The second policy (3 pages) with last review date March 2019 denotes in-part abuse and neglect policy rather than have the right to be free from abuse neglect exploitation misappropriation of property or mistreatment this includes but is not limited to corporal punishment involuntary seclusion and any physical or chemical restraint not required to treat the residence medical symptoms.

The facility third policy presented 8/21/23 title abuse and neglect (5 pages) with last revised date of July 2017 denotes in part the purpose of this policy and the abuse prevention program is to describe the process for identification assessment and protection of the residents from abuse neglect misappropriation of property and exploitation this would be accomplished by

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S9999	Continued From page 11 identify occurrences and patterns of potential mistreatment immediately protecting residents involved in identified reports of proper possible abuse neglect exploitation mistreatment and misappropriation of property implementing systems to promptly and aggressively investigate all reports and allegations of abuse neglect exploitation misappropriation of property and mistreatment and making all the necessary changes to prevent future occurrences. The residents' rights for people in the long-term care denote as a long-term care resident in Illinois, you are guaranteed certain rights, protection, and privileges according to state and federal laws. (A)	S9999		