Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (
7.11.2.1.2.11.1		is a remark to the second and the se	A. BUILDING:	A. BUILDING:			
		L6015168	B. WING		C 01/27/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
CITADEL	CITADEL OF NORTHBROOK, THE 3300 MILWAUKEE AVE.						
0117,022	·	NORTHE	BROOK, IL 60062				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
S 000	Initial Comments		S 000				
	Complaint Investigation	on 2490238/IL168581					
S9999	Final Observations		S9999				
	Statement of Licensu	re Violations:					
	300.610a) 3000.690b) 300.1210b) 300.1210c) 300.1210d)6)						
	Section 300.610 Resi	dent Care Policies					
	procedures governing facility. The written pube formulated by a Roc Committee consisting administrator, the advantage advisory common of nursing and other supplicies shall comply	of at least the					
	Section 300.690 Incid	lents and Accidents					
	any serious incident of this Section, "serious"	all notify the Department of or accident. For purposes of ' means any incident or physical harm or injury to a					
	Section 300.1210 Ge Nursing and Persona	neral Requirements for I Care					
	nent of Public Health	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE		

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

Electronically Signed 02/05/24

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Illinois Department of Public Health

	(2) MULTIPLE CONSTRUCTION . BUILDING:	(X3) DATE SURVEY COMPLETED
IL6015168 B.	. WING	C 01/27/2024
NAME OF PROVIDER OR SUPPLIER CITADEL OF NORTHBROOK, THE STREET ADDRES 3300 MILWAUF NORTHBROOF		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETE DATE
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 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide safe transfer with a full (mechanical) lift per care plan; failed to inform doctor of refusal in using the (mechanical) lift and failed to reassess for safe transfers for 1 (R1) of three residents (R1, R2, R3) reviewed for falls. This failure resulted to R1 sliding on the floor sustaining a fracture of the tibia/fibula.	69999	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	A. Boilbiro.			
		IL6015168	B. WING		01/2	7/2024	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CITADEL	OF NORTHBROOK, THE	3300 MILW	AUKEE AVE.				
CHADLL	OF NORTHBROOK, THE	NORTHBR	OOK, IL 60062	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S9999	Continued From page	2	S9999				
	the facility on 05/06/2 but not limited to: Chr Disease, Emphysema Failure with Hypoxia a Diabetes Mellitus with Nondisplaced Oblique Right Tibia, Venous T Disorder of the Auton Irritable Bowel Syndro Blastomycosis, Urina Neurological Dysfunc Disorder, Major Depre Agoraphobia with Par Compression, Paraple Hypertension, Obesity Gastroesophageal Resophagitis, Visual H Disorder, and Age Repathologic Fracture.	ry Tract Infection, tion of Bladder, Anxiety essive Disorder, nic Disorder, Other Cord egia, Essential y, Obstructive Sleep Apnea, eflux Disease without allucinations, Paranoid					
	Brief Interview for Me documents a score of uses a points system points: 0 to 7 points s impairment. 8 to 12 p	31/2023 under Section C: ntal Status (BIMS) 13. (The BIMS assessment that ranges from 0 to 15 uggests severe cognitive oints suggests moderate 13 to 15 points suggests					
	bed watching television happened on 12/18/2 happened after lunch I haven't been out of the aide was helping at the edge of the bed	4 AM, R1 was observed in on. When asked what 3, R1 stated, "I had a fall. It , I wanted to get my hair cut. oed for about 6 months, V5, to get up. V5 had me sitting d and was standing to pivot d, and I ended up sitting on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING			
	IL6015168	B. WING		C 01/27/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CITADEL OF NORTHBROOK, THE	3300 MILW	AUKEE AVE.			
——————————————————————————————————————	NORTHBR	OOK, IL 60062	2		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
foot was flat and I he foot slowly. V5 then opicked me up and pupoint forward my leg that when I haven't be should have used the hair cut that day. I fratake responsibility for known better but I was There's no one to blace of the hair appointment. She for transfers but R1 refused and had R1 while I called anothe said she is dizzy and the floor. I held on to slid down on the floothat R1 refused to us V3 said that it's okay assist since she was talked to R1 about die (mechanical) lift, V5 about it. V6, CNA, are bed, with 3 person as (mechanical) lift. On 1/26/2024 at 1:24 again. R1 stated she (mechanical) lift. On 1/26/2024 at 1:24 again. R1 stated she (mechanical) lift and offered for her to use used the (mechanical Sit-to-Stand or (mechanical Si	y was under my body and my ard the crack. I pulled out my called another CNA, V6. V6 at me in the chair. From that was numb. In a case like een up for long time, we estit to stand. But I did get my actured my shin. I gotta (sic) r my stupidity, I should have anted to get my hair cut. The came for it." 2 PM, V5, Certified Nursing ed, "On 12/28/23, R1 had a e needs a (mechanical) lift	\$9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6015168	B. WING		C 01/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	
CITADEL	OF NORTHBROOK, THE	3300 MIL	WAUKEE AVE.		
CHADLL	OF NORTHBROOK, THE	NORTHB	ROOK, IL 60062		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
S9999	Progress Noted dated Registered Nurse dod (Certified Nursing Asson Duty) to informed the floor during transf wheelchair. NOD cannoted resident siting the bed". Interview with V3, Re 1/26/2023 at 1:20 pm "I was the nurse in ch V5, Certified Nursing informed me that R1 that she was getting fat the edge of the bed the floor. I was then cobserved R1 on the flassessment, R1 said informed me then that used because R1 refu (mechanical) lift." Wh documentation on R1 that R1 refused to uscreated date of 12/20 the fall, V3 did not result of the said informed me then that R1 require staff assistance for al Plan does not address use the (mechanical)	when I fell and put me back ng the (mechanical) lift." d 12/18/2023 by V3, cuments in part: "CNA sistant) called NOD (Nurse (sic) that pt. (patient) slid to fer (sic) resident to the ne to the resident room position on the floor next to gistered Nurse, on was conducted. V3 stated, large of R1 on 12/18/2023. Assistant called me and slid on the floor. V5 stated R1 ready and had R1 sitting d and R1 started slipping on halled to R1's room and loor. I did a head-to-toe she was not in pain. V3 t (mechanical) lift was not used to sue the en asked why her 's progress notes stating the the (mechanical) lift had a /23, which was 2 days after spond. In revision date of 12/20/23 is (mechanical) lift with (X2) I transfers. The said Care is that R1 was refusing to lift. PM, V2, Director of Nursing	\$9999		
	stated, "When someb (mechanical) lift, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
	IL6015168	B. WING		01	C I/ 27/2024
NAME OF PROVIDER OR SUPPLIER CITADEL OF NORTHBROOK, THE	3300 MII	DDRESS, CITY, STATE	, ZIP CODE		
PREFIX (EACH DEFICIENCY I	MORTHE EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
I called V7, Physician, N pathological, we didn't r following day, he said it co-morbidities, R1 has a pathological in nature, with the state reporting ager fracture is considered at there was no report subsurveying agency about Review of R1's medical documentation regarding place R1 at risk for path On 1/26/2024 at 1:55 P "For R1, we discussed was that R1 was sitting was being assisted and have any per se trauma and showed severe Ostoan contribute to a path absence of trauma. R1' have caused the fracture that there was really no have been informed frowas refusing to use the particular incident, I dor me that she refused to on 12/18/23." On 1/26/2024 at 3:12 P Assistant (CNA) stated, V5. When I got there, R floor. V5 prepared R1 for said R1 slid on the floor and R1 said she has not	racture of the tibia. When V7 said the fracture was report it. I talked to V7 the 's due to her severe osteopenia. If it's we don't send a report to ncy." V2 affirmed that tibial a serious injury. V2 stated omitted to the state this serious injury. records excludes any condition that would hological fractures. M, V7, Physician, stated, the fall, and the discussion on the side of the bed and I slipped and did not really a We reviewed R1's X-ray teopenia and that certainly hological fracture, in the severe osteopenia could be because I was informed trauma to the extremity. I m time to time that R1 body lift, but for this n't recall them informing use the (mechanical) lift M, V6, Certified Nursing "I was in the room with the was already on the	S9999			

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ļ , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6015168	B. WING		01	C / 27/2024	
	ROVIDER OR SUPPLIER OF NORTHBROOK, THE	3300 MIL	DDRESS, CITY, STATE WAUKEE AVE. BROOK, IL 60062	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	the beauty shop." Review of R1's medic documentation that R proper transfer techniallegedly refusing to the Review of medical reducementation that R dangers of refusing to V3, Registered Nurse informed that R1 refulift after R1 slid on the the progress notes with 12/20/2023, which is that R1 refused to use R1's hospital records Complete Minimum 3 Tibia/Fibula, 2 Views IMPRESSION: A minifracture involving distinondisplaced distal fill Facility Policy titled "S Residents" with a revidocuments in part: In order to protect the staff and residents, at this facility uses approdevices to lift and mo POLICY INTERPRET IMPLEMENTATION: 3. Nursing staff, in corehabilitation staff, sh residents' needs for transfer of the care plan. Such a. Resident's preferer	al records excludes any 1 was reassessed for ques since R1 was use the (mechanical) lift. cords also exclude 1 was educated on the 1 use the (mechanical) lift. 1, affirm that she was used to use the (mechanical) 1 floor. V3 documented on 1 th a created date of 2 days after the incident, 2 the (mechanical) lift. I document under Xray Ankle Views, (Right) and Xray (Right): Final Result, 1 mally displaced oblique 1 tibia is noted with 1 cular diaphyseal fracture. I affe Lifting and Movement of 1 ew date of July 2022 I safety and well-being of 1 nd to promote quality care, 1 private techniques and 2 ve residents. I ATION and 2 njunction with the 2 all assess individual 2 ansfer assistance. Staff will 2 ansfer in and lifting needs 3 assessment shall include:	S9999				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND I EAN OF CONNECTION IDENTIFICATION NOWIBER.		A. BUILDING: _		COMPLETED				
ı	IL6015168	B. WING		01/27	7/2024			
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CITADEL OF NORTHBROOK, THE	3300 MILWA	UKEE AVE.						
NORTHBROOK, THE NORTHBROOK, IL 60062								
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE			
S9999 Continued From page 7 c. Resident's size; d. Weight-bearing ability; e. Cognitive status; f. Whether the resident is usustaff. (A)	ually cooperative with	S9999						

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