PRINTED: 07/03/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE O	(X3) DATE SURVEY COMPLETED		
AND PLAN	O CORNECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COINILLEIED
		IL6009179	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE	
CITADEL	OF STERLING,THE	105 EAST	23RD STREET		
OHADEL	OI OTEIXEINO,THE	STERLIN	G, IL 61081		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
	Annual Licensure He	alth Survey			
S9999	Final Observations		S9999		
	Statement of Licensu	re Violations:			
	300.610a) 300.1010h) 300.1210b) 300.1210d)3)				
	Section 300.610 Resi	ident Care Policies			
	procedures governing facility. The written p be formulated by a Rocommittee consisting administrator, the advinedical advisory comof nursing and other spolicies shall comply				
	Section 300.1010 Me	dical Care Policies			
	physician of any accic change in a resident's health, safety or welfa but not limited to, the manifest decubitus ul of five percent or mor The facility shall obta plan of care for the ca	all notify the resident's dent, injury, or significant is condition that threatens the are of a resident, including, presence of incipient or cers or a weight loss or gain the within a period of 30 days. In and record the physician's are or treatment of such ange in condition at the time			
	 ment_of Public Health DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

06/24/24 **Electronically Signed**

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009179	B. WING		06	6/12/2024
	ROVIDER OR SUPPLIER OF STERLING,THE	105 EAS	ADDRESS, CITY, STATE ST 23RD STREET NG, IL 61081	, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 1	S9999			
	b) The facility sh care and services to a practicable physical, I well-being of the residench resident's comp plan. Adequate and p care and personal car resident to meet the t care needs of the resident and personal car esident to meet the total personal car resident to meet the total personal car esident to meet the total personal car esident to meet the total personal car esident to seven day-a-week bath objective observed and personal changes, and determining care required.	all provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing re shall be provided to each otal nursing and personal ident. Subsection (a), general lude, at a minimum, the practiced on a 24-hour, sis: ervations of changes in a nocluding mental and s a means for analyzing and uired and the need for ation and treatment shall be f and recorded in the				
	These requirements v	vere not met as evidenced				
	review the facility faile delay in notifying a di- in residents and failed delay in implementing recommendations for	n, interview, and record ed to ensure there was no etitian of severe weight loss if to ensure there was no if the dietitian's residents with severe ure resulted in the delayed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		IL6009179	B. WING		06	6/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
CITADEL	OF STERLING,THE		T 23RD STREET G, IL 61081			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	weight loss. This app R339, R61) reviewed sample of 18. The findings include: 1. R27's Weights and showed on 9/5/23 R2 and on 10/4/23 weight weight loss of 13.4% R27's Progress Note dietitian recommende supplement twice a dark R27's Progress Notes doctor was notified of recommendations. A fax to R27's physicithe physician was not the dietitian's recommendation R27 to receive a day. R27's Progress Notes doctor agreed with the recommendation. R27's Physician Ordedietitian's recommendation.	ring of residents with severe lies to 3 of 3 residents (R27, for severe weight loss in the divides to 3 of 3 residents (R27, for severe weight loss in the divides to 3 of 3 residents (R27, for severe weight loss in the divides to 3 of 3 residents and the divides to 4 residents and the divides to 5 residents a	S9999			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		IL6009179	B. WING		06	6/12/2024
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CITADEL	OF STERLING,THE		T 23RD STREET NG, IL 61081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	process can take up October 2023, she was the facility's dietitic there was a delay in loss. V6 add that a sis considered a chance on 06/11/24 at 1:25 I said the normal time dietitian of a significal implementation of the is no longer than a ware why there was a weight loss as she was manager in October 20. R339's face sheet include: chronic obstruction of the include: chronic obstruction obstruction of the include: chronic obstruction obstruction of the include: chronic obstruction of the include: chronic obstruction of the include: chronic obstruction of the inc	to one week. V6 said in as transitioning into the role an and was not sure why addressing R27's weight ignificant/severe weight loss ge in the resident's condition. PM, V5 (Dietary Manager) frame for notifying the nt weight loss and the edictitian's recommendation eek. V5 said she was not a delay in addressing R27's as new to the role of dietary 2023. Wed R27 was at risk for is. I lists his diagnoses to ructive pulmonary disease, ilure, dysphagia, unilateral estive heart failure, alcoholog, dementia, and alcohol 9:45 AM, R339 was awake as very thin and stated, he 9 was not sure why and that in the resident of the role of dietary 2023.	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=1ED
	IL6009179		B. WING		06/12/2024	
		120003173			00/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		105 EAST	23RD STREET			
CHADEL	OF STERLING,THE	STERLING	G, IL 61081			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
S9999	Continued From page	Δ. A	S9999			
00000	Continued From page					
	dietitian] WT [weight]	REVIEW/WEIGHT				
	WARNING: Value: 11	10.4#, BMI [body mass				
	index] 20 low for age.	sig [significant] wt. loss x 1				
	month noted. Overall	weight is now slightly more				
	stable x 2 weeks R	EVIEW: res [resident]				
	recently downgraded	diet to mech soft				
	[mechanical soft] for p	oocketing/chewing difficulty.				
	He does have CHF [c	congestive heart failure] and				
	some fluid shifts likely	/ causing weight loss/gain.				
	REC: add house supp	olement/ensure BID [twice				
	daily] for supplement	and weekly weights- monitor				
	on NAR [nutrition risk	assessment]."				
	R339's electronic med	dical record shows, he has				
	not been weighed we	ekly. The last weight record				
	was May 20, 2024.					
	R339's electronic med	dical record does not show,				
	an order for weekly w	eights.				
		s dated May 20, 2024				
	shows, "Call placed to	o son/POA [power of				
	attorney] to inform of	weight loss and poor				
	appetite. Message lef	t to call facility. Referral to				
	dietician. MD [medica	ıl doctor] updated."				
	R339's electronic med	dical record does not show				
	,	erventions in place following				
	his 14 lbs. 12.50% we	eight loss in 14 days.				
	· ·	11:22 AM, V6 Dietitian				
	stated, she was aware of R339's weight loss. V6 said she asked the facility for a re-weigh to					
	_	024 weight was correct. V6				
	•	any interventions in place				
		en re-weighed. V6 said the				
	facility should be follo	wing her recommendations				
	of weekly weights.					
	3. R61's Weights and Vitals Summary report					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CITADEL	OF STERLING,THE		ST 23RD STREET			
	CLIMMADY CT		NG, IL 61081	DDOVIDEDIS DI AN OF	CORRECTION	
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S9999	Continued From page	e 5	S9999			
	and on 6/2/24 weight weight loss of 5.4% in					
	recommended weekly	0 AM, V6 (dietitian) said she y weighs for [R61] because red for weight loss following				
		s entered on 5/21/2024 by n weekly weights and				
	R61's Weights and V 6/11/2024 shows a w 6/2/2024 with no add current (6/11/2024).					
	R61's Care Plan dated 5/16/2024 states, "Weigh me as ordered and notify my nurse, my physician, the dietary manager, and the dietitian of any significant weight loss".					
		PM, V2 Director of Nursing an's frequency of weight ould be followed for				
	intervention dated Se "Policy Statement: T strive to prevent, mor undesirable weight lo interpretation and imp assessment: 2. Wei individual's medical re change of 5% or more					

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	Г		NG, IL 61081						
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