

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #2274041/IL147220	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were provided adequate supervision during a community outing. The facility also failed to ensure the staff are knowledgeable about residents at risk for elopement and their individualized supervision needs and complete resident risk assessments and re-assessments timely. This applies to 3 of 7 residents (R1, R2, R3) reviewed for safety and supervision in the sample of 29.</p> <p>Findings include:</p> <p>A computerized web mapping platform documents the distance between the retail store and the farm retail store documents the walking</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
---	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>distance as 0.9 miles.</p> <p>5/26/2022 at 12:11 PM Illinois Route 50 between the retail store and farm retail store did not have a shoulder, sidewalk or crosswalks to safely walk between the stores.</p> <p>On 5/23/2022 at 11:05 AM V9 (Police Officer) stated on 5/19/2022 R1 and R2 were walking on Illinois Route 50 towards farm retail store in Bradley, Illinois; R1 was pushing R2 in a wheelchair after leaving a retail store in Bradley. V10 (Community Bystander) was driving on Route 50 and saw R1 and R2 walking on the road and stopped to assist them. V9 stated they told V10 they lived in a nursing home and R1 asked V10 to take them to her home providing the address of her previous home. V10 instead dropped both R1 and R2 off at the closest nursing facility who contacted the police where V9 responded. V9 stated the facility was unaware R1 and R2 were missing and had not contacted the police.</p> <p>The Bradley Police Incident Report dated 5/19/2022 documents the first police department contact was at 4:33 PM. This report documents V10 picked R1 and R2 up walking on Route 50 impeding traffic by the farm retail store. After placing R1 and R2 in her personal car, V10 then dropped R1 and R2 off at the nearest nursing facility which they did not reside at. This report further documents V10 reporting to the dispatcher both R1 and R2 are confused, one had an obvious stroke and they were unsure which facility they resided at. At 5:08 PM facility staff at their nursing facility were en route to pick up R1 and R2.</p> <p>On 5/23/2022 12:50 PM V4 (Activity Director)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
---	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>stated this was the first community outing since Covid (March 2020). V4 stated she and 2 other Activity Aides (V5, V6) left at approximately 2:30-2:45 PM for a shopping trip to retail store with R1-R7. V4 stated once they arrived at the retail store V4 assisted R5 and R7, V6 assisted R4 and V5 assisted R6 with their shopping. V4 stated R4-R7 needed assistance with shopping due to their physical needs and/or inability to hold their shopping baskets. V4 stated R3 was independent in a scooter and did not need staff supervision or assistance while he shopped. V4 stated R1 was pushing R2 in her wheelchair and they went off to shop unsupervised. V4 stated she thought R1 was oriented, further stating, "I guess not so much- not as much as I thought."</p> <p>V4 stated the Activity Department completes resident shopping trips as community outings. V4 stated she or the accompanying activity staff do not stay with all residents while shopping and her normal protocol is to make arrangements with residents who shop unsupervised once they arrive at the store to meet at the front at a designated time. V4 stated only the residents who cannot push themselves in wheelchairs or get their own stuff are supervised. V4 stated R1-R3 were instructed to meet in the front of the store in an hour which was approximately 3:45-4 PM. V4 stated everyone except R1 and R2 were at the front of the store at the designated time. V4 stated V5 and V6 did a sweep through the store and then alerted V1 (Administrator). V4 stated V4-V6 also had a retail store employee complete an overhead page, spoke with security, and alerted a manager. While all this was being completed, V1 notified V4 that R1 and R2 had been found. V4 arrived at the other nursing facility and picked up R1 and R2 and returned them to their correct facility.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>R1's Admission Record documents R1 admitted on 3/12/2021 with diagnoses to include Alzheimer's Disease, Psychosis wit Delusions and Dementia with Behaviors.</p> <p>R1's Petition for Appointment of Guardian of Person and Estate dated 3/5/2021 document R1 as under the guardianship of the Office of State Guardian.</p> <p>On 5/23/2022 at 12:10 PM R1 stated when asked about the trip to retail store on 5/19/2022, "As far as I can tell the bus stopped and we went into retail store. I was with that lady, yes (R2). We bought what we wanted and went back to the bus. The bus was there and we got on. Went to, wait, a heavy set girl who was congenial. I was not in my best shape. Somehow we got to farm retail store on the bus and I got into a car." R1 then stated another resident in addition to R2 was with them. R1 provided a first name of an unidentified resident and continued stating the third unidentified resident sat in the front seat of the car. R1 stated, "There were 3 of us in the car with the lady. That's what it seems like, but I may be wrong. I walked a little. I was with (R2) in the front seat of the car. I didn't pass anyone on the road that I recall. I was in the car with staff. I went to my house on (provided address of her old house). I was taken by whomever was driving the car. I have a friend a few doors down and she has my car. I don't like it (car) to be sitting outside when I am not home. I drove my car back to my house. I cannot put my finger on how I got here- it is vague."</p> <p>R1's Minimum Data Set dated 3/17/2022 documents R1 with moderate cognitive impairments.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>R1's Elopement Risk Assessment dated 2/20/2022, shows R1 was at risk for elopement. R1's elopement risk assessment score was 7.0. The elopement risk assessment tool shows a score greater than 5.0 means the resident is at risk for elopement.</p> <p>R1's Community Skills Assessment dated 3/15/2022 documents R1 as not capable of unsupervised pass privileges.</p> <p>R1's Follow-Up Question Report for Behavior Monitoring and Interventions from the EMR (Electronic Medical Record) 4/26-5/25/2022 documents R1 with 3 incidents of exit seeking and elopement behaviors.</p> <p>R1's Psychiatric Physician Note dated 1/26/2022 documents R1 as alert and oriented 2-3 with periods of confusion and this note documents R1 is noted to refuse care and wander halls.</p> <p>On 5/23/2022 at 11:50 AM V7 (Nurse) stated R1 is forgetful, has poor judgement and resides on the alarmed dementia unit. V7 stated R1 does not leave the dementia unit unsupervised.</p> <p>On 5/24/2022 at 10:15 AM V14 (Nursing Assistant) stated R1 wanders and will go to the door and try to leave. V14 stated R1 is a resident that can make you think she is more oriented than she is and that's where mistakes come in.</p> <p>R2's Admission Record documents R2 admitted to the facility on 8/31/2016 with diagnoses to include repeated falls, Diabetes and Hemiplegia and Hemiparesis due to a Stroke.</p> <p>R2 declined all attempts to be interviewed on</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
---	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 6 5/23-24/2022.</p> <p>On 5/23/2022 at 11:50 AM V7 (Nurse) stated R2 can be quite withdrawn and has right hemiplegia but can propel herself in the building in her wheelchair. V7 stated R2 cannot transfer herself independently but can stand pivot to transfer with one staff. V7 stated R2 has judgement issues, gets confused and has had some recent hypoglycemic episodes (low blood sugar levels). V7 stated R2 requires staff supervision.</p> <p>R2's Minimum Data Set dated 4/30/2022 documents R2 with intact cognition and requiring extensive assist of one staff for transfers and ADL care.</p> <p>R2's Elopement Risk Assessment dated 8/31/2016 documents a score of 3/not at risk.</p> <p>R2's Community Skills Assessment dated 9/3/2016 documents R2 as not capable of unsupervised pass privileges.</p> <p>5/25/2022 at 10:40 AM V13 (Social Services) stated assessments for elopement risk and community skills are done every year at minimum. V13 stated there were some problems with the computer program triggering some assessments as due and they were missed.</p> <p>R2's Psychiatric Physician Note dated 4/19/2022 documents R2 as irritable and requiring cueing, withdrawn and difficult to engage during this assessment. R2 is documented as alert and oriented to time and person but forgetful.</p> <p>R2's Care Plan dated 4/1/2022 documents R2 at risk for falls for reasons including right hemiparesis, impulsiveness, impaired safety</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>awareness, impaired balance, forgets limits, and refusing assistance when staff attempt to provide it.</p> <p>On 5/23/2022 at 1:30 PM R3 sat in wheelchair and was interviewable with word finding issues. R3 stated he was on the shopping trip and was allowed to shop by himself using the store scooter. R3 stated he met back at the front of the store but the "2 ladies" did not come back and the staff had to go looking for them.</p> <p>R3's Minimum Data Set dated 4/20/2022 documents R3 with moderate cognitive impairments.</p> <p>R3's Elopement Risk Assessment dated 11/12/2021 documents a score of 2/not at risk.</p> <p>R3's Community Skills Assessment dated 11/15/2021 documents R3 as not capable of unsupervised pass privileges.</p> <p>2. On 5/24/2022 12:00 PM V1 (Administrator) provided lists of residents residing in the facility identified as elopement risks and elopement risk with personal body alarms. V1 identified R9-R14 as at risk for elopement with a personal body alarm and R1 and R15-R28 identified as at risk for elopement requiring no body alarm.</p> <p>On 5/24/2022 at 12:00 PM V1 stated, this was R1's first outing since admission to the facility. V1 stated the process for all outings is all residents are to be supervised and with staff. V1 confirmed R1 is on the alarmed dementia unit because she needs supervision. V1 was unaware of R1 having recent documented exit seeking behaviors. V1 stated the facility process to assess for elopement and supervision needs is</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>done through risk assessments and Interdisciplinary Team (IDT) discussions. V1 stated the facility use the elopement risk assessment to determine if they are at risk in combination with observed and reported behaviors. From there the IDT discusses each resident and individualizes their supervision needs and determines if a wander guard is warranted. V1 stated any resident exhibiting new exit seeking behavior is re-assessed.</p> <p>5/25/2022 10:40 V13 (Social Services) stated staff communication for individual supervision needs and elopement risk is done through verbal communication and staff can also reference the computerized assessments. V13 also stated the nurses are aware of residents elopement risk and supervision needs. V13 stated she did not know R1 was documented as making attempts to exit seek and if she had been aware she would have re-assessed R1.</p> <p>5/24/2022 at 3:08 PM V1 stated all staff are trained to supervise residents and should be aware of the residents elopement risk and supervision needs. V1 stated it is V4's responsibility to train her staff in the Activity Department on elopement and supervision policies.</p> <p>5/25/2022 9:15 AM V4 stated she prepares the list of residents at the facility at risk for elopement and wearing a personal body alarm. V4 stated the nurses inform her of which residents wear a personal body alarm and she places them on the list. V4 stated she is unaware of any other residents at risk for elopement or the facility process to determine who is at risk.</p> <p>The following staff were not able to identify the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
---	---

(X4) ID PREFIX 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 9</p> <p>facility process to assess elopement risk, supervision needs and were not able to identify specific residents who were assessed as an elopement risk (without personal body alarms) as determined by the IDT:</p> <p>5/25/2022 8:35 AM V7 (Nurse), 8:40 AM V18 (Nursing Assistant), 8:45 AM V16 (Nursing Assistant), 8:50 AM V17 (Nurse), 8:55 AM V8 (Nurse), 9:00 AM V14 (Nursing Assistant) and on 5/24/2022 at 12:35 PM V15 (Nurse).</p> <p>On 5/25/2022 at 1:04 PM V12 (Medical Director) stated R1 and R2 have dementia and poor safety judgement. V12 confirmed R2's blood sugars have not been stable. V12 stated R1 and R2 could have gotten lost and were found walking on a busy road that they had to cross. V12 stated all the residents at the nursing home should be supervised on outings further stating, "They were not safe on that road and something could have happened, thankfully nothing did."</p> <p>The facility policy Off-Premise Activities dated 5/2021 documents off-premise activities are monitored for safety.</p> <p>The facility policy Safety and Supervision of Residents dated 7/2017 documents resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety shows 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring and reporting process. Individualized, Resident-Centered Approach to Safety shows 2. The IDT shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for those</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CITADEL CARE CENTER-KANKAKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE KANKAKEE, IL 60901
--	---

(X4) ID PREFIX 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) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environments, including adequate supervision. 4. Implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff. System Approach to Safety shows 1. The facility-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual's resident's assessed needs and identified hazards in the environment.</p> <p>(A)</p>	S9999		