STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056788	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF BOURBONNAIS,THE	**20 BRIARCLIFF LANE , BOURBONNAIS, Illinois, 60914**

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2579679/2634736	S0000		10/16/2025
S9999	Final Observations Statement of Licensure Violations: 300.1210b)4)5) 300.1210c) 300.1210d)6) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be	S9999		10/17/2025

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

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S9999	Continued from page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident who requires maximum assistance with bed mobility was turned safely during provision of care. This failure resulted in R1 rolling out of bed and landing with his face on the floor, sustaining a laceration to his left forehead. R1 was sent to the emergency room and received 12 stitches on his forehead. This applies to 1 of 3 residents (R1) reviewed for fall incidents in the sample of 3. The findings include: R1 had multiple diagnoses including, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified anxiety disorder and personal history of traumatic brain injury, based on the face sheet. R1's annual MDS (Minimum Data Set) dated September 30, 2025, showed R1 was severely impaired with cognitive skills for daily decision making. The MDS showed that R1 had functional limitation to both lower extremities. The same MDS showed that R1 required total assistance from the staff with toileting hygiene and lower body dressing and required substantial/maximum assistance from the staff with bed mobility- from lying on his back to rolling to the left and right sides and returning to back lying position in bed. R1's progress notes dated October 3, 2025, at 6:26 PM, created by V3 (Licensed Practical Nurse/LPN) showed, "At [1:20 PM] notified by [CNA/Certified Nursing Assistant) that resident was on the floor. Upon entering room, observed resident lying face down	S9999		

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S9999	Continued from page 2 between bed and wall. Blood observed on floor under head. Applied pressure to laceration noted on forehead. Immediately called 911. Resident was unable to state what happened. CNA stated that during brief change [patient] suddenly swung his legs over the side and rolled out of bed. She was unable to catch him. NP (Nurse Practitioner) notified." The same progress notes showed that R1 was sent to the hospital at 1:25 PM. R1's progress notes dated October 3, 2025, at 11:23 PM, showed that the resident returned from the hospital at 8:40 PM. It was documented that, "He is alert and oriented x 2, disoriented to time per usual. He was c/o (complaining of) a headache. PRN (as needed) pain medication administered." The same progress notes showed that R1 received 12 stiches to his forehead laceration while in the emergency department and R1's head was wrapped in gauze. R1's hospital notes dated October 3, 2025, showed, "[Patient] to [emergency department] after suicidal attempt. [Patient] deliberately threw himself to ground striking his forehead. [Patient] arrived with laceration to left forehead." On October 4, 2025, at 12:38 PM, R1 was in bed, awake and verbally responsive. R1 had a bandage around his head. R1 was asked why he had a bandage on his head and the resident responded that he rolled out of bed, fell on the floor and sustained an open wound on his head. R1 was asked how he rolled out of bed, the resident stated, "I don't know I slipped out of bed." When asked if anyone was present when he fell out of the bed, R1 responded that he was in the room by himself. On October 4, 2025, at 1:23 PM, V3 (LPN) stated that on October 3, 2025, between 12:00 and 1:00 PM, while on her break she was informed by V4 (CNA) that R1 fell out of bed. She was informed by V4 that while turning R1 towards the left side to change the resident's disposable brief, R1 swung his leg over the bed and rolled out of bed. V3 stated that when she went to R1's room to assess the resident, R1 was on the floor, on the left side of the bed, between the bed and the wall, away from the door. V3 stated that R1 was lying on his stomach with his head turned to his (R1) left side, facing towards the door. According to V3, there was a pool of blood on the floor, by the resident's head area and she was not able to assess where the bleeding was coming from. V3 stated that the staff did not move R1 due to fear of further injury and that 911 was immediately called because the resident was on anticoagulant medication. V3 stated that while R1 was on the floor, the resident remained alert and when	S9999		

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S9999	Continued from page 3 asked how he was doing, R1 moaned and responded that his face hurt. V3 stated that after calling 911, the emergency personnel came to the facility within five minutes, transferred R1 from the floor to the stretcher and transported the resident to the hospital. On October 4, 2025, at 1:54 PM, V4 (CNA) stated that on October 3, 2025, between 12:00 and 1:00 PM, she was changing R1's disposable brief while the resident was in bed. V4 stated that she was providing the care by herself and that R1 was able to assist with turning, by moving/turning his leg towards the direction of where he was being turned. According to V4, while R1 was in the middle of the bed, she turned the resident on his (R1) left side, towards the wall, away from her (V4). V4 stated that while turning R1 on his left side, away from her (V4), the resident swung his right leg over the edge of the bed and R1 rolled out, then fell on his face on the floor. V4 stated that R1 was bleeding somewhere on the head, but she was not sure of the exact site, because there was so much blood on the floor. V4 stated that she immediately called V3 (LPN) to inform of the fall. V4 stated that R1 was not moved while on the floor until 911 personnel came and transported the resident to the hospital. According to V4, before providing care to R1 on October 3, 2025, she raised the height of the resident's bed for easy access. R1 was calm and cooperative during the care. R1 was using an air mattress that was plugged on the wall's electrical socket. V4 stated that R1's air mattress was flat (not scooped and/or no side bolsters) and there were no bedrails attached to the bedframe, nor was there any other device to prevent R1 from rolling out of bed away from her during the turning procedure. V4 stated that because R1 was naked during the provision of care, she (V4) had no other means to grab on to R1 and prevent the fall either. R1's care plan last revised on July 12, 2025, showed that the resident has an ADL (activities of daily living) self-care performance deficit. The said ADL care plan showed multiple interventions including, "Bed mobility: The resident required extensive assistance by staff to turn and reposition in bed" and "Side rails: Resident uses 2 quarter side rails in bed for turning and repositioning. Instruct resident to grab onto side rail and gently pull self to side lying position. Two quarter bed rails up to aide in mobility." Both above-mentioned interventions were initiated on December 28, 2024, and were the active plan of care when R1 had the fall incident on October 3, 2025. On October 7, 2025, at 9:32 AM, V2 (Director of Nursing) stated that all residents at the facility are	S9999		

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S9999	Continued from page 4 expected to be safe during provision of their care by the staff and that no resident should roll out of bed and fall, sustaining injury while being turned by the staff. V2 stated that two quarter side rails should be present in R1's bed for turning and repositioning of the resident to aide in bed mobility as part of R1's plan of care. According to V2, "I do agree that if the bilateral quarter side rails were present, it would have potentially stopped the resident from rolling out of bed and sustaining the injury." On October 7, 2025, at 9:56 AM, V5 (Nurse Practitioner) stated she was aware that R1 was sent to the hospital via 911 after a fall with injury on October 3, 2025. V5 stated that she had read the emergency department notes dated October 3, 2025, documenting that R1 had suicidal attempt by deliberately throwing himself to the ground. According to V5, she sees R1 at the facility once a month. R1 was cognitively impaired and not a reliable historian. R1 had history of traumatic brain injury which she believes leads to some form of probable dementia. V5 stated that he had seen resident at the facility after the fall incident, and he denied suicidal attempt/ideation. V5 further stated that there was no psychiatric evaluation done at the hospital on October 3, 2025, which is a routine evaluation at the emergency department. This led her (V5) to believe that the emergency department does not believe the suicidal attempt was true. During the same interview, V5 stated that residents at the facility should be safe during the provision of their care by the staff. V5 stated that she expects the staff to provide all necessary safety measures to ensure that resident does not roll out of bed and sustain injury during provision of care. According to V5, the facility should implement their own plan of care for R1, including providing the two quarter side rails for turning and/or repositioning the resident to aide in bed mobility. Additionally, V5 stated that if the plan of care to have the two quarter side rails was implemented, it could have potentially prevented R1 from rolling out of bed and sustaining lacerations on his forehead requiring 12 stitches. "B"	S9999		