STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000888	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Saint Anne Place	**4405 HIGHCREST ROAD , ROCKFORD, Illinois, 61107**

(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 25110247/2649209	S0000		12/05/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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:	S9999		12/05/2025

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

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S9999	Continued from page 1 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 ensure a thorough assessment was performed for a resident sustaining a fall and failed to identify an acute fracture prior to sustaining a second fall. This failure resulted in R3 sustaining a fall with x-ray results showing a right hip impacted subcapital fracture of right femoral neck without staff identifying and reporting her injury and sustaining a 2nd fall approximately two days later delaying emergency care and services. This applies to 1 of 3 residents (R3) reviewed for quality of care in the sample size 18. R3's face sheet shows diagnoses including Alzheimer's, unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing, unspecified fracture of left pubis, palliative care, anxiety, muscle weakness, unsteadiness on feet, repeated falls and hypertension. R3's Fall Risk Assessment dated 9/19/25 shows she is high risk for falls. R3's Final Incident Report dated 10/10/25 shows on 10/5/25 approximately 12:45 PM, (R3) was observed laying on right side in the dining room. Assessment revealed limited range of motion (ROM) to her right lower extremity…(R3) sent out to the local hospital x-rays shows a right femur fracture. (R3's report does not include her first fall on 10/3/25 and the x-ray results on 10/4/25 showing a right hip fracture). R3's hospital records dated 10/5/25 shows (R3) had multiple ER visits for recurrent falls who presented after a fall unwitnessed fall from her wheelchair. Nurse that assessed her noticed she was crying when moving her lower extremities…reported another fall on 10/2 or 10/3…decreased ROM to right hip about 10	S9999		

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S9999	Continued from page 2 degrees flexion limited by pain…right lower extremity appears shorter and externally rotated…right x-ray shows subcapital femoral neck fracture with varus angulation. R3's X-Ray report dated 10/4/25 shows right hip impacted subcapital fracture of right femoral neck with varus deformity. On 11/24/25 at 10:05 AM, V14 (Registered Nurse/RN) said on 10/3/25, she was R3's nurse when she fell from her bed. After the fall R3 was rubbing her right hip and wincing in pain and could not verbally communicate. R3 said she was working with V21 (Agency RN) who did the fall follow up documentation. V21 had a lighter assignment and has lots of nursing home experience and we were working "together as a team." V14 said V21 has a lot more nursing home experience than her and V21 was helping her assess R3. V14 said she was R3's primary nurse and did not document the fall in the medical record at that time because V21 said she would document R3's fall. V14 said she was asked to put in a nursing note by the facility because there was no documentation regarding her fall on 10/3/25. V14 said she put in note on 10/13/25 (ten days later) because she was told to by management. She could recall R3 having pain to her right hip but does not recall any changes to her right lower extremity. On 11/24/25 at 9:09 AM, V21 (Agency RN) said on 10/3/25, she offered to help V14 (RN) because she was behind and really struggling. V21 said she put in some orders and notified the provider of the fall. V21 said she did not assess R3 following her fall and was not R3's nurse. When a resident falls, nursing should assess the resident including vitals, pain, check range of motion, notify the family, and physician. On 11/25/25 at 7:00 AM, V13 (RN) said she was R3's nurse on third shift after she fell on the previous shift. V13 said when she arrived, R3 was sitting at the nurse's station, she was having "obvious pain" to her right hip. R3 was "guarding" her right hip. When x-ray arrived R3 was transferred to her bed. V13 said she assisted R3 into bed, "I don't remember how" R3 was transferred back to bed but said she had a change in her transfer status but could not recall the details. V13 said she does not remember assessing R3's right leg and she received the x-ray results by fax and remembers there was no evidence of a fracture. "My memory of the night is not good." V13 said after a resident sustains a fall, post fall monitoring includes checking rom (range of motion), pain, and monitoring for any changes. V13 said she should have done an assessment on	S9999		

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S9999	Continued from page 3 R3 and documented her findings in the medical record. V14's nurses note late entry date 10/13/25 (10 days later) documents on 10/3/25...(R3) at foot of bed right hip in contact with floor. Assisted back to bed with CNA…(R3) indicating via gesture that hip is painful… V21's nurses note dated 10/3/25 at 8:14 PM, documents order received for x-ray of right hip and leg related to fall in resident bedroom… V13's nurses note dated 10/4/25 at 6:33 AM, documents (R3) continue to have guarding leg and hip. STAT (urgently) X-ray performed, and report shows no recent fracture or dislocation. X-ray results placed in V19's (Nurse Practitioner) folder for review. The next nurses note dated 10/5/25 at 1:39 PM, shows (R3) had an unwitnessed fall in the dining room…(R3) observed laying on her right side…has limited ROM (range of motion) bilateral lower extremities, crying out when bilateral lower extremities are moved…sent to the local hospital. R3's electronic medical record shows from 10/3/25 to 10/5/25 there was no assessment of her right lower extremity until her 2nd fall on 10/5/25. R3's Pain Assessment Record dated 10/3/25 to 10/5/25 shows pain score of 4 to 8 recorded. R3's hospital records dated 10/5/25 shows (R3) had multiple ER visits for recurrent falls who presented after a fall unwitnessed fall from her wheelchair. Nurse that assessed her noticed she was crying when moving her lower extremities…reported another fall on 10/2 or 10/3…decreased ROM to right hip about 10 degrees flexion limited by pain…right lower extremity appears shorter and externally rotated…right x-ray shows subcapital femoral neck fracture with varus angulation. On 11/24/25 at 2:25 PM, V19 (NP) said she was not aware of R3's hip fracture on 10/4/25. She would expect staff to notify her of the x-rays results and assess residents after a fall to monitor for injuries. On 11/24/25 at 11:13 AM, V16 (Nurse Manager) said she is the fall coordinator, when a resident falls nursing should assess the resident and document in the progress notes. Post fall monitoring should occur every shift for 72 hours to monitor for changes and document their assessment. R3 was a high risk for falls with frequent falls. R3 had a fall on 10/3/25 in her room, she is not	S9999		

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S9999	Continued from page 4 sure what happened with her fall because the nurse did not document the fall at the time. V2 (DON/Director of Nurses) spoke to the nurse about her assessment and her lack of documentation and follows up on the falls with injury. V16 said R3 had a 2nd fall two days later 10/5/25 with an injury. Staff should send out a resident to the ER right away if the x-ray results show a fracture and report it the physician. Imaging usually calls the facility to report fractures. She is not sure why R3 was not sent after her x-ray results showed a right femur fracture on 10/4/25. On 11/24/25 at 12:47 PM, V2 (DON) said she was not aware of R3's right femur fracture on 10/4/25 until she started printing out the documents today. V2 confirmed R3's x-ray dated 10/4/25 shows a right femur fracture and V13 documented there was no fracture. When she pulled the hospital report she assumed the fracture was from the 2nd fall. V2 said she was aware of R3's fall on 10/3/25 and was made aware V14 did not document R3's fall assessment. V2 said staff should document and assess a resident after falling, with post fall monitoring for 72 hours, monitor for changes and notify the x-ray reports. "We have a problem" with nursing not assessing, monitoring or reporting x-results. The facility's Fall Clinical Protocol Policy dated 2008 states, "Assessment and Recognition as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling…in addition, the nurse shall assess and document/report the following: vitals, recent injury especially fracture or head injury, musculoskeletal function, observing for changes in normal range of motion, weight bearing., etc.…, pain….monitoring and follow up…the staff with the physicians guidance, will follow up any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. The facilities Notification of Change Guidance Policy dated 2024 states, "It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or the resident representative…and are reported to and consulted with the attending physician….an accident involving the resident, which results in injury and has the potential for requiring physician intervention. "A"	S9999		