

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER PA Peterson at the Citadel		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 Parkview Avenue Rockford, IL 61107	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on interview and record review, the facility failed to notify a resident's (R1) representative of a change in condition and need to alter treatment. This applies to 1 of 5 residents reviewed for change in condition in the sample of 5.</p> <p>The findings include:</p> <p>R1's electronic face sheet printed on 6/10/24 showed R1 has diagnoses including but not limited to Parkinsonism, acute respiratory failure, pneumonia, chronic obstructive pulmonary disease, and hallucinations.</p> <p>R1's facility assessment dated [DATE] showed R1 has moderate cognitive impairment and no behaviors.</p> <p>R1's care plan dated 6/6/24 showed, (R1) is noted to have a problem with cognition related to confusion. (R1) has used inappropriate verbal, and physical behaviors with facility personnel and residents at times, pushing walker into staff and residents around him. Patient will at times use foul language towards staff during caregiving, or redirection when behavior is happening. (R1) has been observed to engage in a variety of other behavioral symptoms including refusing care at times or taking medications. Patient becomes verbally aggressive with staff at times after he has wandering episodes, or incontinence</p> <p>R1's nursing progress notes showed, 6/7/24 Resident exited room and came to nurse's station swearing. Staff attempted to redirect by offering snacks/beverages which were all denied. When taking resident back to room he grabbed nurse by the necklace and broke it as he would not let go. (Nurse Practitioner) notified and 2mg Haldol shot ordered and administered with assistance from staff. 6/8/24 CNA's (Certified Nursing Assistants) attempting to change resident pants and pull up in his room because he was wet. Resident initially resisted this but eventually complied. As CNA's were attempting to change his pull up, resident became more aggressive and began kicking, scratching, kicking them and calling CNA's derogatory names. CNA's left room at that point. Writer called (Nurse Practitioner) who ordered to give Haldol 2mg IM (intramuscular), which writer did. DON (Director of Nursing) confirmed that resident family has given consent to her for staff to give resident any medications that nurse practitioner recommends for circumstances like this.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/24 at 12:17PM, V10 (R1's daughter) stated, I was notified of my dad's behaviors on 6/7/24 around 10:00AM. They told me there had been 2 instances and one of them occurred earlier Thursday evening and he had his cane, and he was pushing his wheelchair and trying to run into them. They said they were able to get him to his room and calmed down until around 2:30AM; and he got up again and was sitting in his wheelchair and trying to hit people with his cane. I don't know how but they told me he broke a nurse's necklace. They told me they gave him Haldol and he slept the rest of the night. I was told he did not have any injuries but when I came to see him on 6/8/24 I saw he had a bandage on each forearm. I did ask him what happened, and he wasn't sure. I did tell them they could give him whatever the doctor orders for him in a time like this, but they never even notified me of the first incident when they gave him Haldol until several hours later. I didn't even give consent for him to have Haldol the first time but after they explained everything to me, I was okay with it. Shouldn't they have at least called me to tell me he had this episode? They never even told me he had an additional dose of Haldol on 6/8 and I was here later that day! I would expect for them to at least let me know when he's having these episodes as this is new for him. He used to live with me and would get irritable but nothing like these episodes. This is definitely a change for him that I would like to be notified about.</p> <p>On 6/10/24 at 1:30PM, V2 (Director of Nursing) stated, We did talk to (V10) about (R1), but it was later in the day on 6/7/24 after his first incident. I would expect the nurses to call her to report the change as this was a change in behavior and the need to alter treatment.</p> <p>The facility's undated policy titled, Change in Resident's Condition or Status showed, Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status .</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on interview and record review, the facility failed to protect 2 residents (R2, R3) from physical abuse by another resident. This applies to 2 of 5 residents reviewed for abuse in the sample of 5.</p> <p>The findings include:</p> <p>1. R2's electronic face sheet printed on 6/10/24 showed R2 has diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction, emphysema, alcohol abuse, and repeated falls.</p> <p>R2's facility assessment dated [DATE] showed R2 has no cognitive impairment and no behaviors.</p> <p>R2's nursing progress notes dated 3/13/24 showed, Resident in dining room and told his roommate, (R4), that he was wearing his coat. (R4) walked over to (R2) and punched him in the right side of his face three times, while swearing and calling (R2) names. Staff separated residents. (R2) had a small amount of blood in the bottom of his mouth but was cleaned with water and the bleeding stopped. Administrator notified and both residents separated for the night.</p> <p>R4's facility assessment dated [DATE] showed R4 has moderate cognitive impairment and has verbal behaviors directed towards others.</p> <p>R4's care plan dated 1/18/21 (revised 3/20/24) showed, (R4) has a behavior problem related to Alzheimer's disease, dementia with behaviors. Patient will at times yell, swear, and call other residents or staff personnel names. Aggressive behavior towards other residents of physical nature related to space, objects, food, and clothing.</p> <p>The facility's IDPH (Illinois Department of Public Health) Incident Report Form dated 3/12/24 showed, R4 and R2 are roommates and reside on dementia unit. R4 was wearing R2's coat. R2 noticed this when he was eating dinner in the dining room and yelled at R4 for wearing his coat. R4 then hit R2. Staff immediately intervened. Staff offered R4 his own coat and R4 removed R2's coat when asked and did not seem to recall the incident. R2 was provided a room change. R2 was also counseled to reach out to staff for any issues with roommates or any conflicts as opposed to yelling at people .</p> <p>On 6/7/24 at 12:38PM, R2 stated, R4 and I used to share a room together and he was always stealing my stuff. I don't even have dementia, so I have no idea why I was even put on the dementia unit. We had been in altercations before but nothing too bad until he hit me. I finally moved rooms after he hit me. All I said to him was that he was wearing my coat because he took it from me. Then he came over to me and punched me in the face. I feel safe now that I got to move off of that unit but that just made me feel crazy being up there.</p> <p>2) R3's electronic face sheet printed on 6/7/24 showed R3 has diagnoses including but not limited to dementia without behaviors, muscle weakness, osteoarthritis, major depressive disorder, and adult failure to thrive.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's facility assessment dated [DATE] showed R3 has moderate cognitive impairment and has no behaviors.</p> <p>On 6/7/24 at 12:56PM, R3 stated, There was a man that's not here anymore. He hit me in the face and the arm. My arm and face were black and blue, and my face was bruised over my right eye. I don't feel safe here because of the way people are. This happened a month or so ago, maybe more. I can't really tell you anything else because my memory isn't that great, but I would know him if I saw him again.</p> <p>R3's nursing progress notes dated 3/14/24 showed, CNA (Certified Nursing Assistant) was responding to call light and observed a peer walking out of her room. Upon answering call light, resident noted to have an abrasion to left side of eye and bruised chin. Resident stated, Peer was laying in roommate's bed alone, I asked what he wanted, and he put his fist up and punched me. Nurse on duty assessed resident from head to toe .resident also noted to have bruise to right chin, and bruise to right arm .</p> <p>The facility's IDPH Incident Report Form dated 3/13/24 showed, R3 stated she yelled at R5 stating, Go away, what are you doing over here. R5 walked over and hit her. R3 stated she alerted staff. R5 was sent out for a psychiatric evaluation R3 remains at baseline participating in facility activities and states she feels safe in the facility. Abrasion to eyebrow is resolving.</p> <p>On 6/7/24 at 2:45PM, V6 (Licensed Practical Nurse) stated, I don't really know what happened between (R3) and (R5). I was doing my medication pass and asked the CNA where (R5) was because he had a lot of behavioral issues and I wanted to keep an eye on him. I was told he was in his room, so I continued my medication pass. I guess (R5) came out of (R3's) room when the CNA was answering the call light and (R3) had a laceration to her right eye and a bruise on her arm. (R5) had prior issues of being aggressive with staff and residents. We had to keep a close eye on him.</p> <p>On 6/7/24 at 3:22PM, V2 (Director of Nursing) stated, Both of these instances are definitely considered resident to resident abuse. It is our policy in this facility to do everything we can to prevent any abuse from occurring. (R5) definitely had more psychiatric issues than we could handle here so we sent him for a psychiatric evaluation, and he has not returned to our facility. I'm not sure why (R2) was on the dementia unit to begin with, maybe that was the only male bed we had available at that time. I really can't speak to that, but he is now out of the dementia unit and seems much happier with his current roommate.</p> <p>The facility's policy titled, Abuse and Neglect-Clinical Protocol dated 12/2009 showed, a. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on interview and record review, the facility failed to monitor, document, and respond to behaviors for 1 of 5 residents (R1) reviewed for behavior management in the sample of 5.</p> <p>The findings include:</p> <p>R1's electronic face sheet printed on 6/10/24 showed R1 has diagnoses including but not limited to Parkinsonism, hallucinations, pneumonia, and acute respiratory failure.</p> <p>R1's facility assessment dated [DATE] showed R1 has moderate cognitive impairment and has no behaviors.</p> <p>R1's care plan dated 4/17/24 showed, Resident has a diagnosis of hallucinations. Administer medications as ordered. No further interventions were listed in R1's care plan.</p> <p>R1's care plan dated 4/18/24 showed, The resident has a mood problem related to anxiety. Administer medications as ordered. No further interventions were listed in R1's care plan.</p> <p>R1's behavior and mood task documentation were reviewed for the past 30 days and showed no documentation until 6/8/24 of any behaviors for R1.</p> <p>R1's nursing progress notes showed, 6/6/24 Resident came out of room using wheelchair for a walker and was calm at first. When he came near others, he attempted to run his chair into them. Staff intervened immediately. Resident not redirectable as he took his cane and attempted hitting staff. Resident did go into his room and shut the door. 6/7/24 Resident exited room and came to nurse's station swearing. Staff attempted to redirect by offering snacks/beverages which were all denied. When taking resident back to room he grabbed nurse by the necklace and broke it as he would not let go. (Nurse Practitioner) notified and 2mg Haldol shot ordered and administered with assistance from staff. 6/8/24 CNA's (Certified Nursing Assistants) attempting to change resident pants and pull up in his room because he was wet. Resident initially resisted this but eventually complied. As CNA's were attempting to change his pull up, resident became more aggressive and began kicking, scratching, kicking them and calling CNA's derogatory names. CNA's left room at that point. Writer called (Nurse Practitioner) who ordered to give Haldol 2mg IM (intramuscular), which writer did.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/7/24 at 2:45PM, V6 (Licensed Practical Nurse) stated, (R1) had some behaviors last night into this morning. First, he came out of his room, walking with his wheelchair past the nurse's station then I heard him say, I'm going to beat your a**. I got him to sit at the nurse's station, but he wouldn't take his medication. There were other family members visiting other residents and he tried hitting them with his wheelchair. I approached him and he grabbed my chain around my neck and wouldn't let go. Then he went into his room and slammed the door. Around 2:30AM he came out and I had the nurse practitioner give me an order for Haldol. I don't really remember what happened or why I asked for the order, but I know he started coming after the staff. I remember we almost fell to the ground when he came after me. I did let the nurse practitioner know and she wanted me to give him Seroquel, but he wouldn't take it, so I called another nurse practitioner who gave me the Haldol order. There wasn't anything else that happened, and I'm not used to (R1) having any behaviors so I didn't know what else to do with him.</p> <p>On 6/7/24 at 3:03PM, V7 (Certified Nursing Assistant-CNA) stated, (V6) called me upstairs because (R1) was being combative and she needed to give him an injection and I was the only male working. I was trying to get him not to move when she was giving him the injection so I held his hands down so he wouldn't move but as soon as he felt the needle, he started elbowing us with the needle in his arm. I had to hold his hands and arms down so she could give him the injection but as soon as it was done, I let him go. I don't know about anything else that happened or why he needed the injection, I was just doing what she told me to do.</p> <p>On 6/7/24 at 3:11PM, V8 (Certified Nursing Assistant) stated, When I came out of the utility room around 4AM, (R1) had a hold of (V6's) necklace, she was trying to get away from him and I intervened. They did fall to the ground, and he got a skin tear to his arm. We got him into the room and calm and he was sitting on the bed. I asked him if he needed anything, and he said no. (V6) then came in and she gave him a shot of Haldol while I held one of his hands down and (V7) held the other hand down. We let him go as soon as the shot was given.</p> <p>On 6/7/24 at 3:22PM, V2 (Director of Nursing) stated, (R1) has been having a lot of behaviors lately and gets agitated and doesn't want assistance from staff. It was reported to me that last night he went after a nurse, she redirected him, and he went to his room. A few hours later, he had another episode around 2AM and he broke the nurse's necklace, and she gave him Haldol. I was not aware of anything else that occurred or him being injured. I would expect staff to intervene if resident was a danger to themselves or others but there seems to be something missing with this case. Staff have been trained to redirect as much as possible, provide a quiet environment, and not egg the resident's on when they are agitated. Perhaps, holding him down and going into his personal space agitated him even more. It was not reported to me that (R1) fell to the ground or got injured in this situation.</p> <p>On 6/7/24 at 4:16PM, V9 (CNA in training) stated, I have been waiting for someone to call me about this. I was sitting in the common area studying and I heard a bunch of commotion by (R1's) door. (V6) was yelling at (R1) to let go of her. When I got up and looked around the corner, (R1) was on his knee on the ground and it looked like (V6 and V8) were helping him off the ground. I'm a CNA in training so I'm not even trying to get involved with anything they were doing with him. I was told when I got on shift to leave him alone because he was agitated. I didn't like that because he was on my assignment, so I felt like I wasn't taking care of him. He spent hours in his room with the door shut and I was told not to open it. When this incident occurred, I left to go on my break because I didn't want to get in trouble for something before, I even get my certification. I know (R1) did have a cut on his arm after this incident, but I don't know how he got it.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled, Behavioral Assessment, Intervention and monitoring dated December 2016 showed, 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, at a minimum: a. A description of the behavioral symptom, including frequency, intensity, duration, outcomes, location, environment, precipitating factor of situations. B. targeted and individualized interventions for the behavioral and/or psychosocial symptoms .9. Non-pharmacologic approaches will be utilized to the extent possible to avoid reduce the use of antipsychotic medications to manage behavioral symptoms .</p>		