

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 08/20/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on interview and record review the facility failed to clarify conflicting admitting orders for a resident who was readmitted to the facility after hospitalization to ensure necessary care and services were provided. This applies to 1 of 3 (R1) reviewed for quality of care in the sample of 4.</p> <p>The findings include:</p> <p>R1's face sheet shows he is a [AGE] year old male readmitted to the facility on [DATE] with diagnoses including critical illness myopathy, sepsis, unspecified protein calorie malnutrition, end stage renal disease, dependence on renal dialysis, chronic congestive heart failure, pneumonia, personal history of malignant neoplasm of prostate, history of venous thrombosis and embolism, multiple myeloma not having achieved remission, heart disease, presence of cardiac pacemaker, gastrostomy status and dysphagia.</p> <p>R1's Hospital After Visit Summary dated 8/3/24 shows he was hospitalized from 7/17/24 to 8/3/24, diagnosis: multifocal pneumonia likely due to aspiration. R1's medications list shows orders for his medications to be administered by mouth and through the g-tube including Acetaminophen 325 mg (milligrams) take 3 tablets by mouth three times a day, Ambien 5 mg take by mouth nightly, omeprazole take 40 mg by mouth every evening, guaifenesin 100 mg/5 ml take 10 ml by mouth every 6 hours, atorvastatin 10 mg daily, calcitriol 1 MCG/ML solution take 0.5 ml per g-tube daily.</p> <p>R1's Hospital Records dated 8/2/24 documents plan: dysphagia: (R1) unable to tolerate secretions at this time, very weak. Status post PEG tube placement on 7/31/24. Tolerating tube feedings, swallow study once stronger at rehab facility .continue current tube feedings order for Nepro @ 45 ml (milliliters)/hr (hour) with 185 ml free water flush every 4 hours. DIET order NPO.</p> <p>R1's Physician Order Sheets dated August 3, 2024, shows he is a full code, orders for NPO (nothing by mouth), medications ordered shows to be given by mouth. The P.O.S. does not show orders to administer his gastric tube feeding orders.</p> <p>R1's nurses note dated 8/3/24 documents he arrived at the facility at 2:00 PM. At 5:46 PM, R1's admission note documents R1 unaware and disoriented x4, complaints of pain with turning. NPO medications need to go through peg tube on continuous tube feeding.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/19/24 at 10:52 AM, V3 (Licensed Practical Nurse-LPN) said she was R1's nurse when he was admitted to the facility. He did not look stable; he was fatigued and weak and looked as he was staring off into space. R1 was NPO and had a g-tube. She called the hospital to confirm if he was able to have anything by mouth and they said no. She entered the order for NPO but did not change the route of the medications. NPO means nothing by mouth, nursing should crush the medications and give through the peg-tube. V4 reported to her she had given R1's pills by mouth because that is what the order said. V3 said R1's tube feedings were not entered in the orders, and he did not receive his tube feedings.</p> <p>On 8/19/24 at 11:26 AM, V4 (LPN) said she was R1's nurse on 8/3/24. She administered R1's medications by mouth with yogurt. She said he had a peg tube but was taking his pills by mouth. There was no order for NPO, she did not see the order, the orders said to give the medications by mouth, I did the best I could. He didn't get much for medications one or two meds. Nothing happened.</p> <p>On 8/19/24 at 1:00 PM, V2 (Director of Nursing) said R1 was recently hospitalized and returned to the facility on [DATE]. He returned with a peg tube. If a resident is NPO and medications are ordered to be given nursing should clarify which route to administer the medications. If nursing is unclear about orders, they should call the physician to clarify the orders. V2 confirmed R1's tube feedings orders were not transcribed into his EMR (electronic medical record).</p> <p>On 8/20/24 at 3:32 PM, V13 (Nurse Practitioner) said staff should clarify orders if the orders are not clear. If a resident is NPO, he would expect the resident to be seen by speech to evaluate their swallowing ability.</p> <p>On 8/20/24 at 9:28 AM, V12 (R1's wife) said she went to the facility the evening on 8/3/24 after he was admitted. R1 was tired and quiet she thought it was because of him being transferred that day. R1 did not have the tube feeding infusing when she went to visit. R1 did not pass the swallow study while at the hospital and they placed a peg tube for his nutrition. While R1 was in the hospital he was NPO and receiving his medications thru the tube. She returned to the facility in the morning and R1 still did not have his nutritional feedings on.</p> <p>R1's Medication Administration Record Dated August 2024 shows orders administered on 8/3/24 at 8:00 PM included Ambien 5 mg by mouth at bedtime, omeprazole 40 mg by mouth at bedtime, guaifenesin 10 ml by mouth every 6 hours given at 8:00 PM and 2:00 AM. R1's M.A.R. does not shows orders for his tube feedings infusing.</p> <p>The facility's Medication and Treatment Orders Policy dated 2014 states, if an order is determined to be incomplete, illegible, or unclear, the licensed personal must clarify the order with transferring institution and/or the prescribing provider.</p>		