STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145751	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA Peterson at the Citadel	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20042 Based on observation, interview, and record review the facility failed to ensure daily dressing changes were completed as ordered, and failed to ensure as needed dressing changes were completed when a dressing was loose for 2 of 3 residents (R3 & R4) reviewed for dressings in the sample of 8. The findings include: 1. On 9/10/24 at 3:18 PM, V7 (Registered Nurse/RN-Wound Nurse) went into R4's room with the surveyor to do a check on R4's right calf skin tear and dressing. R4's dressing was coming off around some of the edges and was wrinkled up on one side. V7 stated R4's dressing was coming undone and was dated 9/8/24. V7 removed R4's dressing and she had a small skin tear to the calf area of her right leg. V7 stated dressings should be done as ordered and documented on the TAR (Treatment Administration Record). The Physician Orders dated 9/11/24 for R4 showed an order entered on 9/4/24, skin tear right posterior leg - cleanse with wound cleanser. Pat dry. Apply skin prep peri wound. Apply xeroform to wound bed. Cover with a transparent film dressing. Complete treatment three times per week and as needed for soilage or looseness. The TAR (Treatment Administration Record) dated September 2024 for R4 showed, skin tear right posterior leg - cleanse with wound cleanser. Pat dry. Apply skin prep peri wound. Apply xeroform to wound bed. Cover with a transparent film dressing. Complete treatment three times per week and as needed for soilage or looseness. R4's TAR did not show any as needed dressing changes completed for her on 9/10/24 or 9/11/24 until the wound nurse was notified by the surveyor of R4's loose dressing. On 9/11/24 at 11:36 AM, V2 (Director of Nursing/DON) stated dressing changes are on the residents' TARs. There would be an order for dressing changes. Dressing changes need to be done as ordered. The Face Sheet dated 9/11/24 for R4 showed diagnoses including chronic kidney disease, moderate protein calorie malnutrition, chronic obstructive pulmonary disease, osteomyelitis of vertebra, muscle weakness, dysphagia, unsteadiness on feet, anemia, anxiety, adult failure to thrive, and hypertension. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Care Plan dated 8/16/24 showed R4 has the potential/actual impairment to skin integrity related to localized swelling, mass and lump, to lower bilateral limbs. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. R4's care plan did not have any information related to her skin tears and treatments. The facility's Dressings Non-Sterile (Aseptic) policy (no date) showed, Purpose: The purpose of this procedure is to provide guidelines for application of non-sterile dressings. Verify there is a physician's order for this procedure. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. Check treatment record. Assemble equipment and supplies. Documentation: If the resident is non-adherent with treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. 2. On 9/10/24 at 3:30 PM, R3 was sitting in his bed watching television. R3 stated he has a dressing on his right elbow from a fall that he had at home before coming to the facility for his fractures. R3 stated his elbow dressing gets changed but it is not done every day. The Physician Orders for R3 dated September 2024 showed, cleanse skin tear to right elbow with wound wash, cover with xeroform, thick pad, and secure with kerlix. Change daily and as needed for strikethrough drainage. The TAR (Treatment Administration Record) for R3 for September 2024 showed, skin tear right elbow - cleanse with normal saline, pat dry. Apply xeroform to wound bed. Cover with bordered gauze dressing. Change daily and as needed for looseness or soilage. R3's TAR showed on 9/1/24, 9/4/24, and 9/5/24 his dressing was not changed. On 9/11/24 at 11:36 AM, V2 (DON) stated dressing changes are on the residents' TARs. There would be an order for dressing changes. If there is a blank spot on the TAR, then the nurse did not sign it out and we can't assume that the dressing was done. Dressing changes need to be done as ordered. The Face Sheet dated 9/11/24 for R3 showed diagnoses including acute kidney failure, alcoholic cirrhosis of the liver, ascites, muscle weakness, anemia, coagulation defect, osteoporosis, and ulnar fracture. The facility's Dressings Non-Sterile (Aseptic) policy (no date) showed, Purpose: The purpose of this procedure is to provide guidelines for application of non-sterile dressings. Verify there is a physician's order for this procedure. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. Check treatment record. Assemble equipment and supplies. Documentation: If the resident is non-adherent with treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on interview and record review the facility failed to give a resident an as needed nebulizer treatment when he was wheezing for 1 of 3 residents (R1) reviewed for medications and respiratory treatments in the sample of 8. The findings include: On [DATE] R1 could not be observed at the facility; R1 died on [DATE]. The Admission Summary dated [DATE] at 5:46 PM for R1 showed, Wife called back at 5:26 PM and gave verbal consent to treat patient. Patient lung sounds clear with light wheezing bilaterally, patient unaware & disoriented x 4 (person, place, time, & situation) On [DATE] at 8:33 AM, V2 (Director of Nursing/DON) stated, if R1 was wheezing she would have first assessed him, then obtained vital signs, he had oxygen so she would have asked him how he feels. V2 stated she would have given as needed nebulizer treatments if it was warranted. V2 stated if R1 had been wheezing he should have been given a nebulizer treatment. V2 stated she would have continued to monitor R1 to make sure he did not have any more wheezing or had any shortness of breath. V2 stated the documentation for R1 did not support ongoing monitoring. On [DATE] at 12:25 PM, V6 (Licensed Practical Nurse/LPN) stated R1 looked sick when he came back from the hospital like he should not have been discharged . V6 stated R1 was not with it and was staring off into space. V6 stated wheezing was not normal for R1. V6 stated if a resident has wheezing, she can see if the resident has an asthma pump or nebulizer treatment. V6 stated she thought R1 had nebulizer treatments as ordered. V6 stated R1 did not have any medication for nebulizer treatments at the facility. V6 stated medications that are not available can be obtained from the medication dispensing machine. V6 stated she did not think she had access to the medication dispensing machine at the time, but another nurse could have obtained the medications for her. R1's medical record did not show any additional assessments after the [DATE] assessment at 5:46 PM until a note was documented on [DATE] at 4:37 AM that R1 had no complaints this shift, blood pressure , d+[DATE], pulse 96, respiratory rate 20, and oxygen saturation 99%. The Physician Orders dated [DATE] for R1 showed, albuterol sulfate nebulization solution (2.5 mg (milligrams)/3 ml (milliliters) 0.083%; 3 ml inhale orally via nebulizer every 4 hours as needed for wheezing and shortness of breath. Ipratropium-albuterol solution 0XXX,d+[DATE].5 (3) mg/ml - 3 ml inhale orally every 4 hours as needed for shortness of breath or wheezing via nebulizer. The [DATE] MAR (Medication Administration Record) for R1 showed on [DATE] he did not receive any as needed nebulizer treatments. The Face Sheet dated [DATE] for R1 showed diagnoses including acute on chronic respiratory failure with hypoxia, congestive heart failure, pneumonia, obstructive sleep apnea, hypertension, myocardial infarction, atherosclerotic heart disease, hyperparathyroidism, cardiac pacemaker, sepsis, end stage renal disease, and dependence on renal dialysis. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated [DATE] did not show any documentation related to nebulizer treatments. The facility's Medication Administration policy (,d+[DATE]) showed, Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. The facility's Inhalation (oral and nasal) Administration policy ([DATE]) showed oral and nasal inhalation medication will be administered according to the physician's orders using safe and sanitary practices. The facility's list (no date) of medications available in the medication dispensing machine showed they have Ipratropium-albuterol solution 0XXX,d+[DATE].5 (3) mg/ml available.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on interview and record review the facility failed to give a resident his evening medications for 1 of 3 residents (R1) reviewed for medications and respiratory treatments in the sample of 8. The findings include: On [DATE] R1 could not be observed at the facility; R1 died on [DATE]. The Admission Summary dated [DATE] at 3:03 PM for R1 showed, Patient arrived at facility from the hospital at 2:00 PM; patient is mentally altered. Tried contacting POA (power of attorney) at 2:34 PM for consent to treat. POA unavailable; left voicemail. The Medication Administration Record dated [DATE] for R1 showed on [DATE] at 5:00 PM, R1 was to receive the following medications: Entresto Oral Tablet ,d+[DATE] mg (milligrams), Metoprolol Tartrate 25 mg, and Hydralazine HCl 10 mg. R1's [DATE] MAR showed the medications were not signed of as being given. On [DATE] at 8:33 AM, V2 (Director of Nursing/DON) stated if R1 came in a 2:00 PM they would have put medication orders in after he arrived. V2 stated staff are to try to put the orders in within the first hour after the resident's arrival and can ask for assistance if needed. V2 stated the pharmacy delivers medications 3 times per day during the week and twice a day on Sundays. V2 stated medications are delivered between 10:00 AM - 11:00 AM, 4:00 PM - 5:00 PM, and 10:00 PM - 12:00 AM. V2 stated R1's medications should have come in on [DATE] between 10:00 PM - 12:00 AM. V2 stated if R1 had medications due at 5:00 PM and the medications were not here then staff could pull the medications from the medication dispensing machine. V2 stated there is a standing order to give medications when they arrive from pharmacy if they are not in the medication dispensing machine. On [DATE] at 12:25 PM, V6 (Licensed Practical Nurse/LPN) stated she did not enter R1's medication orders into the system when he returned to the facility on [DATE]. V6 stated V5 (Registered Nurse/RN) entered R1's orders for her. V6 stated R1 did not receive any medications from her on [DATE]. V6 stated R1 was not given his 5:00 PM medications on [DATE] because he did not have any medications at the facility. V6 stated she was not sure if she had access to the medication dispensing machine, but another nurse could have obtained the medication for her. On [DATE] at 12:56 PM, V5 (RN) stated, all she did with R1 on [DATE] was enter his medications orders into the system. V5 stated orders have to be entered within 1 hour of being admitted to the facility. V5 stated if a medication is not available, or it is taking too long for pharmacy then they can get some medications from the medication dispensing machine. The Face Sheet dated [DATE] for R1 showed diagnoses including acute on chronic respiratory failure with hypoxia, congestive heart failure, pneumonia, obstructive sleep apnea, hypertension, myocardial infarction, atherosclerotic heart disease, hyperparathyroidism, cardiac pacemaker, sepsis, end stage renal disease, and dependence on renal dialysis. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's list of medications (no date) contained in the medication dispensing machine at the facility showed hydralazine 10 mg and metoprolol tartrate 25 mg is stocked in the machine. The Pharmacy Oder Form dated [DATE] at 11:28 PM for delivery tracking showed the facility received R1's medications including Entresto Oral Tablet ,d+[DATE] mg, Metoprolol Tartrate 25 mg, and Hydralazine HCl 10 mg at 11:25 PM. The facility's Ordering Medications policy ([DATE]) showed, Policy: Medications and related products are ordered from the pharmacy on a timely basis. New medication order requests can be faxed to the pharmacy's main fax number, sent via electronic health records, electronic health record system, electronically prescribed by the prescriber, and/or called in by the appropriate personnel according to state laws and regulations.