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	09/24/2024

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 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** 39537 Based on interview and record review the facility failed to ensure an intravenous antibiotic was administered and failed to administer medication at the scheduled times for 1 of 3 residents (R1) reviewed for pharmacy services in the sample of 10. The findings include: On 9/24/24 at 10:36 AM, R1 was lying in bed. R1 said he had major surgery on his back and was on antibiotics for an infection. R1 said there were issues with the IV (intravenous) antibiotics. R1 said the IV was removed yesterday and he had completed the medications, but not without issues. R1 said his antibiotics were late multiple times, the nurse would leave the IV connected long after the medication was finished, and there were times that he didn't even know if he got the antibiotic. R1's Facesheet printed 9/24/24 showed diagnoses to include, but not limited to: chronic blood clots in his femoral artery; generalized muscle weakness; bacteremia; extradural and subdural abscesses; osteomyelitis of the thoracic vertebrae (spine); opioid dependence; psychoactive substance abuse; and surgical aftercare. R1's facility assessment dated [DATE] showed he was cognitively intact and did not have behaviors, delusions, or hallucinations. R1's Alteration in Musculoskeletal status Care Plan initiated 8/5/24 showed he had orders for cefazolin 2 grams for osteomyelitis of his thoracic vertebrae. R1's August 2024 MAR (Medication Administration Record) showed he had Cefazolin (antibiotic) ordered IV every 8 hours from 8/6/24 until 9/20/24. This document showed 9 documented on the 8/18/24 and 8/19/24 doses scheduled for 12:00 AM. The document showed 9 means Other/See Progress Notes. R1's Progress Notes dated 8/18/24 and 8/19/24 did not contain an explanation for the 9. R1's Cefazolin Administration History for 8/6/24 to 9/20/24 showed R1's antibiotic was administered late 30 times. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	On 9/24/24 at 11:03 AM, V4 (RN-Registered Nurse/Unit Manager) the nurses have 1 hour before and 1 hour after the scheduled medication time to administer medications. V4 said it's important that the nurses follow the physician's orders, especially with timed medications like antibiotics. V4 said 9 on the MAR is a non-administration category on the MAR. It means the medication was not given and the nurse should enter a progress note. V4 reviewed R1's progress notes for 8/18/24 and 8/19/24 12:00 AM doses. V4 said V5 (LPN - Licensed Practical Nurse) did not enter an explanation, but she should have. V4 said everyone knows if it wasn't documented, then it wasn't done. V4 said V5 is an LPN and R1 had a PICC (Peripherally Inserted Central Line), so an RN (Registered Nurse) had to administer the antibiotic. V4 said some of the LPNs will document 9, and enter a note that a specific RN administered it. The surveyor asked R1 why the LPNs are signing out the IV antibiotic, if the RN is administering it? V4 replied, I'm not sure. That is best practice. V4 said R1 was on antibiotics for osteomyelitis of his vertebrae, and it is important for his antibiotics to be administered correctly to monitor the effectiveness, evaluate the progression of treatment, and to treat his infection. On 9/24/24 at 12:52 PM V2 (DON-Director of Nursing) said the RN administering the medication should sign it out in the MAR, but some of the LPNs will use the 9. V2 stated, I think it's just a personal choice. V2 said if the nurse documents 9 on the MAR, then there should be an explanation in the progress notes. V2 said she did not see an explanation for R1's missed doses on 8/18/24 or 8/19/24. V2 said there is no documentation to prove that the antibiotic was administered. V2 said the nurses have a window of time, 1 hour before and 1 hour after the scheduled time, to administered medications. V2 said it's important that antibiotics are administered as ordered. The facility's Medication Administration Policy dated July 2024 showed, Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis .