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 10/07/2024

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview, and record review the facility failed to ensure a resident who had a change of condition received services timely for suspected urinary tract infection. This applies to 1 of 4 residents (R1) reviewed for quality of care in the sample of 4. The findings include: R1's face sheet shows she is a [AGE] year-old female with diagnosis including congestive heart failure, anorexia, type 2 diabetes, major depressive disorder, atrial fibrillation, hearing loss, generalized anxiety, kyphosis, and history of pulmonary embolism. On 10/7/24 at 12:54 PM, V11 (R1's POA) said her mom (R1) has had a change in the last couple of weeks. She has been more lethargic and not her normal self. On 9/23/24 a care conference was held, and she expressed her concerns regarding the change in her mom. She requested labs and urinalysis (UA). She followed up with V3 (Ground Floor Manager) regarding the labs and was told they were not done yet. No one seems to know when my mom started to have this change of condition. She was not notified when the physician ordered the antibiotic. On 10/7/24 at 2:00 PM, V3 (Unit Manager) said R1 is alert to self, with periods of confusion, she is overall cooperative but has her moments. R1's POA reported she was more lethargic, requested labs and UA because she was concerned she had an infection. On 9/25/24 she reported to the floor the nurse to enter orders for R1 for labs and UA. When she came back over the weekend, she checked the orders, and they were not entered. On 9/30/24 she entered the orders herself. R1 was refusing straight catheterization to obtain the UA. After the lab results returned, and based on her symptoms an order was received for an antibiotic. On 10/7/24 at 10:56 AM, V6 (Licensed Practical Nurse-LPN) said R1 had a change of increased confusion, lethargy, and agitation last week. She was started on an antibiotic for treatment of urinary tract infection and improved over the weekend to her baseline. Nursing should notify the POA new medications are ordered. A calendar copy dated 9/23/24 shows R1's care plan was held at 1:30 PM with R1's POA concerns listed include urine test, CBC, and CMP (lab tests). A grievance form dated 9/25/24 documents R1's POA has concerns her mom is sleepier then normal. The form shows Labs & UA ordered. (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

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NAME OF PROVIDER OR SUPPLIER PA Peterson at the Citadel		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 Parkview Avenue Rockford, IL 61107	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician Order Summary Report dated September 2024 shows orders dated 9/30/24 to collect UA via straight cath and CBC/CMP. R1's physician progress note dated 10/2/24 documents R1 seen today at request due to increased confusion and fatigue, labs reviewed, refused straight cath will empirically treat for suspected UTI. R1's nurses note dated 10/2/24 does not show R1's POA was notified regarding treatment for the UTI.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview and record review the facility failed to ensure a resident with significant weight loss received the recommended nutritional supplements. This applies to 1 of 4 residents (R1) reviewed for weight loss in the sample of 4. The findings include: R1's face sheet shows she is a [AGE] year-old female with diagnosis including congestive heart failure, anorexia, type 2 diabetes, major depressive disorder, atrial fibrillation, hearing loss, generalized anxiety, kyphosis, and history of pulmonary embolism. On 10/7/24 at 8:27 AM, R1 was observed in bed with her eyes closed. She did not respond to stimuli after several attempts of calling out her name. An empty water mug was on her bedside table. The meal tray cart was located in the hallway. R1's breakfast tray with her diet card was on the cart, with an unopened milk carton, serving of eggs, toast and bowl of oatmeal. R1's meal tray appeared not eaten and there was no signs of spillage around the bowl. There was not another breakfast tray with R1's name located on the meal cart. On 10/7/24 at 11:43 AM, R1 was observed in the dining room. She was served turkey with gravy on toast, mashed potatoes, and mixed vegetables, and milk. R1's diet card did not list ice cream. At 11:53 AM, staff assisted her with noon meal, and she exhibited no behaviors of agitation. At 12:06 PM, V11 arrived and assisted her with the noon meal. V11 said R1 did not get her ice cream. V11 notified staff and requested for her ice cream. V11 said R1 has not been getting her ice cream, they say they don't have any. She has to request the staff get her ice cream because she has not been receiving it on her tray. On 10/7/24 at 8:42 AM, V7 (Certified Nursing Assistant) said R1 needs assistance with meals, she did not eat her breakfast, she threw her tray on the floor, and spit on me. She refused her meal. On 10/7/24 at 2:00 PM, V3 (Ground Floor Manager) said R1 is alert to self, with periods of confusion. She is overall cooperative but has her moments. She does not have behaviors, but she heard today R1 got upset and threw her tray, she's not an aggressive resident. She doesn't think R1 could pick up the tray and throw it on the floor. Staff should be assisting her meals. On 10/7/24 at 2:28 PM, V1 (Dietitian) said she started at the facility the end of August. R1 triggered for significant weight loss from August to September, her weights had been fairly stable prior to that. She recommended weekly weights, health shake, milk with meals, ice cream with her noon meal, and staff should be assisting her meals. She emails the recommendations to the V2 (DON) and the dietary manager. The dietary manager should update the meal cards. On 10/7/24 at 4:20 PM, V1 (Administrator) said the facility did not have ice cream today and food deliveries come on Wednesday. He was not aware of this and did not know how long they have been out of ice cream. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Dietary progress note dated 9/25/24 documents R1 triggers for a significant weight loss of 11% in one month. Current weight 162.4 lb. (pounds), R1's previous weight was stable in the 180's in the last year. Weight History x 1 month: 180.6 lb., x 3 months: 181.6 lb., x 6 months: 182.4 lb. Recommendations for milk with meals, ice cream daily with lunch, and house shake daily to prevent further weight loss. V11 (R1's POA/daughter) reports R1 enjoys milk and ice cream and V11 would like to ensure R1 is receiving assistance at meals. R1's weight recorded 9/30/24 shows 159.2 lb. R1's current care plan shows R1 has periods of refusing care and hitting revised on 10/7/24, with no updated interventions. R1's care plan also shows her cognition is impaired, she has difficulty understanding information, and difficulty being able to respond to such communication. Provide R1 with cues, prompts, and remainders to maintain safety. The facility's Weight Assessment and Intervention Policy states, The nursing staff and the Dietitian will be cooperative to prevent, monitor and intervene for undesirable weight loss .significant weight changes are defined as more or less than 5% withing 30 days; interventions for undesirable weight loss or gain should focus first on food (extra food, snacks, calorie-dense food etc.). Liquid nutritional supplements per facility formulary, may be considered if resident caloric intake remains inadequate to stabilize or increase weight .