

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 10/18/2024
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>22499</p> <p>Based on interview and record review the facility failed to ensure that staff follow the Abuse Prevention Policy.</p> <p>This applies to 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 3.</p> <p>The findings include:</p> <p>The undated facility policy entitled Abuse Prevention Training Program Protocol states, The objective of the Abuse Prevention Program is to comply with the seven step approach to abuse and neglect detection and prevention. This same policy also states, The direct care staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered.</p> <p>On 10/17/24 at 11:40 AM V4 (Corporate Nurse) stated, (V4- Activity Aide) had a suspicion but she didn't come to us right away. She told (V3- Activity Aide) about it.</p> <p>On 10/17/24 at 9:44 AM, V4 (Activity Aide) stated, I went in (R1's) room to get him for the activity and (R2) was next to (R1). (R1) was in the bed. I asked if (R1) was going to go to the activity and (R2) said, 'No (R1) wants to take a nap.' (R2) was acting strange as he was tucking the blankets in around (R1)- like he had just been caught doing something he shouldn't. When (R2) saw me, he quickly threw the blanket over (R1). I did not try to get (R2) away from (R1). I left and (R2) came down to the activity about 15 minutes later. V4 stated Administration was upset because I didn't report it right away. At 2:10 PM V4 stated, I saw (R1) up in his chair (on 10/15/24) about 9:20 AM, I was surprised when I came back up at 9:45 AM that he was not waiting at the elevator like he normally is, so I went to find him in his room. That is when I saw (R2) in there with him. (R1) did not go to the morning activity .We reported it to Administration about 2:30-3:00PM. (About 5 hours later)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145751	If continuation sheet Page 1 of 3

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>22499</p> <p>Based on interview and record review the facility failed to ensure that staff report suspicions of sexual abuse to administration in a timely manner.</p> <p>This applies to 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 3.</p> <p>The findings include:</p> <p>The facility Reported Incident dated 10/15/24 states, Activity Staff alleged that when they checked on resident (R1) to see if he was attending an activity, staff observed (R2) putting a blanket over (R1) and tucking in the blanket .</p> <p>The activity staff were suspicious of the gesture and reported to the administrator that (R2) may have touched (R1) in his private areas. Staff denied seeing (R1) touch (R2). Both residents were fully clothed with pants on.</p> <p>On 10/17/24 at 9:44 AM, V4 (Activity Aide) stated, I went in (R1's) room to get him for the activity and (R2) was next to (R1). (R1) was in the bed. I asked if (R1) was going to go the activity and (R2) said, 'No (R1) wants to take a nap.' (R2) was acting strange as he was tucking the blankets in around (R1)- like he had just been caught doing something he shouldn't. When (R2) saw me, he quickly threw the blanket over (R1). I did not try to get (R2) away from (R1). I left and (R2) came down to the activity about 15 minutes later. (R2) and (R1) got close during activities, he is always touching (R1) on the arm and whispering things in his ear. (R2) is too friendly with other residents too. (R2's) relationship with (R1) is just weird. Before the nail activity that day, (R2) had (R1) were in the corner and he was talking to him. (R1) has episodes where he freaks out and (R2) is always right there trying to help. A lot of times after about 10 minutes (R1) is ready to get away from (R2). Yesterday (R1) was freaking out in the dining room and worried that (R2) would be coming around in the activity. (R1) told the psychiatrist (V8- Psych Nurse Practitioner) that my friend is touching me and the psychiatrist wanted to talk to me. Administration was upset because I didn't report it right away. (R2) is really a good guy, highly intelligent. It was a few hours before we reported anything because I really didn't see anything. (R1) went on his own and told (V1- Administrator) everything. As far as I know both residents were fully dressed. The police came and interviewed (R1) and said we should have reported it right away. They feel that nothing happened. Now they can be together in activities, but they have to be watched.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/24 at 9:20 AM, V3 (Activity Aide) stated, I didn't see anything. (V4) came out of the room and told me you know how someone acts when they get caught doing something they are not supposed to- that is how (R2) was acting. (R1) was in bed-he got in by himself. He is not supposed to, but he can. (R1) has the mind of a child and (R2) is very intelligent. That whole day (R2) was very connected to (R1) and wouldn't leave his side. When he finally did, I asked (R1) if (R2) has been touching him in his private area and (R1) said 'yes'. I went to (V1) and (R1) went there too. (R1) started telling (V1) that (R2) had touched him in his private area. Then (V1) went to the Nurses on the third floor and told them not to let (R2) come up there. Yesterday was really bad and (R1) kept saying that he did not want (R2) up there. He is like a child, and I had to ask him the right question to get the answer. He had never reported it before. I know they talked to (R2), but I don't know what (R2) said. He is very smart and sneaky. (V5- Corporate Nurse) and V1 talked to R2. (V4) didn't see under the covers if (R1) was dressed or not. Once (V4) came in the room (R2) covered (R1) up really quick.</p> <p>On 10/17/24 at 11:40 AM, V5 (Corporate Nurse) stated, (V4) had a suspicion but she didn't come to us right away. She told (V3) about it. When I interviewed (R1) he said the staff downstairs told me that my friend was touching me inappropriately. (V3) said (R2) is a sexual predator. (R2) is autistic and doesn't really hang out with other residents . We were told about this last Tuesday. (V3) and (R1) came together. By that time a lot of people knew about this situation .</p> <p>On 10/17/24 at 2:10 PM V4 stated, I saw (R1) up in his chair (on 10/15/24) about 9:20 AM and he asked me what we were doing in activities, and he waved at me as I went downstairs. I was surprised when I came back up at 9:45 AM that he was not waiting at the elevator like he normally is, so I went to find him in his room. That is when I saw (R2) in there with him. (R1) did not go to the morning activity. Then he went down for the 2pm activity- nails- and his face looked different, so I asked him what was wrong? (R2) was right there and asked (R1) if I was taking good care of him. Then (R2) left and (R1) went to (R3) and she asked him about (R2) touching him and he told her yes. We reported it to Administration about 2:30-3:00PM.</p> <p>The undated facility policy entitled Abuse Prevention Training Program- Protocol states, The direct care staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual.</p>		