

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 11/19/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>34491</p> <p>Based on interview and record review, the facility failed to ensure misappropriation of medications did not occur for 1 of 3 residents (R2) reviewed for misappropriation of medications in the sample of 13.</p> <p>The findings include:</p> <p>R2's Admission Record, printed by the facility on 11/19/2024, showed he had diagnoses including, but not limited to, methicillin resistant staphylococcus aureus infection, a stage 4 pressure ulcer of left heel, personal history of malignant neoplasm of bladder, peripheral vascular disease, weakness, and localized edema. R2's Medication Administration Records (MARs) for August 2024 and September 2024 showed an order for Levaquin 750 mg daily for wounds, for seven days. The MARs showed R2 received the Levaquin as ordered.</p> <p>On 11/19/2024 at 8:48 AM, V4 (Registered Nurse/RN) was observed at the medication cart preparing medications for a resident.</p> <p>On 11/19/2024 at 10:45 AM, V1 (Administrator) said the only allegation the facility received regarding a nurse taking residents' medications involved V4. V1 said V5 (RN) and V9 (Nurse) reported to him on 10/2/2024 that they thought V4 took medications. V1 said he tried to call V4, however, V4 had already left for the day. V1 said he notified V3 (VP of Clinical Operations) and V3 said she would follow up in the morning.</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
---	-------	-----------

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 11/19/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/19/2024 at 11:03 AM, V3 said V1 told her about the allegation on 10/2/2024 around 7:00 PM. V3 said she asked V1 if it was something that she could follow up on in the morning as long as there was no danger to any residents. V3 said the next morning (10/3/2024), V5 and V9 came up to her and said they reported the allegation to V1 the previous night. V3 said she asked V5 and V9 what they saw. V3 said they were both talking and said they saw V4 with a medication card, popping out the medications and putting them in his pocket. V3 identified the medication as R2's Levaquin (an antibiotic). V3 said she called the pharmacy to see when the antibiotic was ordered and delivered. V3 said it turned out that 2 medication cards of Levaquin had been delivered. V3 said the first card was signed for by one of the nurses on 8/30/2024. V3 said on 9/1/2024, the nurse on duty called the pharmacy to get more antibiotics, because the nurse could not find the medication. V3 said she thought V4 may have been going through the medication cart on 10/2/2024 and found the card from 8/30/2024. V3 said she interviewed V4, and he said he did not put any medications into his pocket, and he felt the staff member that made the allegation was trying to get him fired. V3 said she informed V4 that she was going to put the allegation and her follow up in his file. V3 said she discussed with V4 that if a nurse takes a resident's medication, it would be drug diversion. V3 said V4 told her that he did not take any medications and told her that he would send any leftover medications to the facility pharmacy. V3 said she spoke with R2 and asked him if he had been on an antibiotic, and if he received all his ordered medication. V3 said it had been 20 some days after R2's antibiotic medications had been given. V3 said V5 has issues with other male nurses at the facility. V3 said there was no actual evidence of diversion. V3 said if a resident's medication is changed or discontinued, the medication is put in a tote in the medication room and sent back to the pharmacy. V3 said the facility does not document when a medication is sent back to the pharmacy.</p> <p>On 11/19/2024 at 12:08 PM, V4 (RN) said he was called to the office to discuss an antibiotic that was discontinued for a resident. V4 said he took the pills. V4 said it was no more than 5 pills. V4 said initially, since the pills were discontinued, he was going to take them and keep them for himself, in case he got sick. V4 said later, he did not feel comfortable taking them, so he flushed them down the toilet at his home. V4 said he did not tell V3 that he took the pills home, he just told her that he destroyed them. V4 said that is never supposed to happen. V4 said he regrets doing it, but he cannot go back in time.</p> <p>On 11/19/2024 at 12:59 PM, V3 said she spoke with V4 prior to this interview and asked him to read the conversation from her investigation. V3 said V4 read the interview and agreed that had been their conversation. V3 said she asked V4 if he told this surveyor something else. V3 said V4 told her that he informed this surveyor that he flushed the medications that were in his pocket down the toilet. V3 said she asked V4 if he flushed them down the toilet at the facility or at his home. V3 said V4 said I don't know, I don't know. V3 said V4 was physically shaking in V1's office.</p> <p>On 11/19/2024 at 1:29 PM, V5 (RN) said he saw V4 pop about seven pills out of a medication card, put the pills in a plastic pouch used to put pills in to crush them, staple the pouch and put the pills in his pocket. V5 said V4 put the empty medication card into the shred bin and walked away. V5 said he grabbed the medication card out of the bin, and it was R2's medication card. V5 said he reported the incident to V1 right away. V5 said he was the only one that witnessed V4 doing it, however, there was a camera right by V4's cart when he did it. V5 said he told V1 he could look at the camera footage.</p> <p>(continued on next page)</p>		

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 11/19/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/19/2024 at 3:55 PM, V1 said the facility does have video surveillance cameras. V1 was asked if anyone checked the camera footage to see if V4 put anything in his pocket, V1 said he would get back to this surveyor with the answer. V1 provided a report to the Illinois Division of Professional Regulations, dated 11/19/2024, in which he reported the incident involving V4. At 4:32 PM, V1 said no one reviewed the video footage to see if it showed V4 putting medications in his pocket.</p> <p>The facility's undated Abuse policy and procedure showed The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention .II.B. Internal Reporting. Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the Administrator immediately, to an immediate supervisor who must then immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to an individual who has been designated to act in the Administrator's absence .IV. Investigation. As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the Administrator or designee will initiate an investigation into the allegation which may include the following elements: Interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: All persons who reported the suspicion, allegation or incident; The alleged victim .The alleged perpetrator .Any witnesses or potential witnesses to the alleged occurrence or incident; Any staff having contact with the resident during the period of the alleged incident; Roommates, other residents, family or visitors. The investigation shall conclude whether the allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation can likely be sustained. Records of the investigation shall be maintained.</p>		

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 11/19/2024
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 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>34491</p> <p>Based on interview and record review, the facility failed to report an allegation of misappropriation of medications to the Illinois Department of Public Health for 1 of 3 residents (R2) reviewed for misappropriation of medications in the sample of 13.</p> <p>The findings include:</p> <p>On 11/19/2024 at 10:45 AM, V1 (Administrator) said an allegation was made on 10/2/2024 by V5 (Registered Nurse-RN) and V9 (Nurse) that V4 (RN) had taken medications. V1 said he tried calling V4, however, V4 had already left for the day. V1 said he notified V3 (VP of clinical operations), and she followed up with the investigation.</p> <p>On 11/19/2024 at 11:03 AM, V3 said V1 informed her of the allegation on 10/2/2024 around 7:00 PM. V3 said she asked V1 if she could follow-up on the allegations the next morning as long as no residents were in danger. V3 said she interviewed V5 and V9 regarding the allegations. V3 identified the medication as R2's Levaquin (an antibiotic) V3 said she spoke with V4 who said he did not take any medication. V3 said she did not report the allegation to IDPH (Illinois Department of Public Health) because it turned out that two orders of the Levaquin had been delivered; one on 8/30/2024, and another on 9/1/2024 due to the nurse on duty not being able to find R2's Levaquin in the medication cart. V3 said the facility paid for the second card of Levaquin that was delivered, not Medicare or Medicaid, so it was not the resident's property that was alleged to have been taken. V3 said R2 received all his ordered Levaquin. V3 said there was no evidence of drug diversion, so she did not report the allegation to IDPH. V3 also said it is her understanding that according to the regulations that they are to notify IDPH of any serious incident or accident that causes physical harm or injury to a resident.</p> <p>On 11/19/2024 at 12:08 PM, V4 (RN) told this surveyor that he had taken the antibiotic pills, and later flushed them down the toilet at his home, because he did not feel comfortable taking them.</p> <p>On 11/19/2024 at 12:59 PM, V3 said V4 was being suspended and V1 was reporting the incident to the Illinois Division of Professional Regulation.</p> <p>A copy of the report to the Illinois Division of Professional Regulation was provided by the facility and reviewed.</p> <p>V3's investigation regarding the 10/2/2024 allegation was reviewed.</p> <p>The facility's undated Abuse policy and procedure showed V. Reporting and Response .C. Initial Report. An initial report to the State licensing agency, Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed . i. Report contents. The initial report shall include the name of the resident allegedly harmed; when the allegation was received; the time and date of the alleged incident; who was notified and when; and the steps the facility has taken in response to the allegation, including the steps to protect the resident. A copy of this initial report shall be maintained.</p>		

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 11/19/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>34491</p> <p>Based on observation, interview and record review, the facility failed to conduct a thorough investigation of an allegation of misappropriation of medication for 1 of 3 residents (R2) reviewed for misappropriation of medications in the sample of 13.</p> <p>The findings include:</p> <p>On 11/19/2024 at 10:45 AM, V1 (Administrator) said on 10/2/2024 V5 (Registered Nurse-RN) and V9 (Nurse) reported an allegation of V4 (Registered Nurse-RN) taking medications. V1 said he tried calling V4, however, V4 had already left for the day. V1 said he informed V3 (VP of Clinical Operations) about the allegation and she was going to follow-up with the investigation the following morning.</p> <p>On 11/19/2024 at 11:03 AM, V3 (VP of Clinical Operations) said V1 informed her of the allegation on 10/2/2024 around 7:00 PM. V3 said she asked if she could follow up on the allegation the next morning as long as there was no danger to any residents. V3 said she interviewed V5 and V9 the next morning and they told her that they thought they saw V4 popping pills out of a medication card and putting them in his pocket. V3 said V5 and V9 identified the medication as R2's Levaquin. V3 said she spoke with V4, and he said he did not take the medications. V3 said she contacted the facility's pharmacy to see when the medication was ordered and dispensed. V3 said it turned out that R2's Levaquin was sent twice, once on 8/30/2024 and again on 9/1/2024 because the nurse on duty on 9/1/2024 could not find the medication. V3 said she spoke with R2 and asked him if he had been on an antibiotic, and if he had received all his prescribed doses. V3 said it had been 20 some days after the medication had been given. V3 said R2 received all his prescribed medication. V3 said she asked other residents if they had any concerns receiving all their medications, however, there were no resident interviews other than R2 documented in the investigation. The investigation did not show any other staff that were interviewed, other than V4, V5, V9, and the facility's pharmacy.</p> <p>On 11/19/2024 at 12:08 PM, V4 (RN) told this surveyor that he initially took the pills to keep for himself, in case he got sick. V4 said later, he did not feel comfortable about taking the pills and flushed them down the toilet at his home.</p> <p>On 11/19/2024 at 1:29 PM, V5 (RN) said on 10/2/2024 he saw V4 pop, he thinks about 7 pills out of a medication card, put them in a plastic pouch used to crush medications, staple the pouch and put the pills into his pocket. V5 said he reported the incident to V1 right away. V5 said there was a video camera by where V4 was when he put the pills in his pocket. V5 said he told V1 he could look at the video footage to see V4 taking the pills. V5 said after V4 put the pills in his pocket, he threw the medication card in the shred bin and walked away. V5 said he (V5) went to the bin and picked up the medication card and saw that it was R2's medication.</p> <p>On 11/19/2024 at 3:55 PM, V1 (Administrator) said the facility has video surveillance cameras. V1 was asked if anyone looked at the video footage to see if it showed V4 putting the pills in his pocket. At 4:32 PM, V1 said no one looked at the video footage to see if it showed V4 putting medications in his pocket.</p> <p>(continued on next page)</p>		

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 11/19/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's undated Abuse Prevention policy and procedure showed The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention .II.B. Internal Reporting. Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the Administrator immediately, to an immediate supervisor who must then immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to an individual who has been designated to act in the Administrator's absence .IV. Investigation. As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the Administrator or designee will initiate an investigation into the allegation which may include the following elements: Interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: All persons who reported the suspicion, allegation or incident; The alleged victim .The alleged perpetrator .Any witnesses or potential witnesses to the alleged occurrence or incident; Any staff having contact with the resident during the period of the alleged incident; Roommates, other residents, family or visitors. The investigation shall conclude whether the allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation can likely be sustained. Records of the investigation shall be maintained.</p>		

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 11/19/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34491</p> <p>Based on observation, interview, and record review, the facility failed to ensure controlled medications were documented as administered in the narcotic reconciliation binder for 8 of 9 residents (R4, R6-R12) reviewed for controlled medications in the sample of 13.</p> <p>The findings include:</p> <p>On 11/19/2024 at 8:48 AM, V4 (Registered Nurse-RN) said he was preparing the medications for the last resident in his AM medication pass.</p> <p>On 11/19/2024 at 9:18 AM, this surveyor conducted a medication reconciliation count with V4 (Registered Nurse-RN) for the controlled medications in the ground floor east medication cart. During the medication count, the following residents' medications were not documented as administered in the narcotic reconciliation binder on 11/19/2024:</p> <p>R4's Tramadol Hydrochloride 50 mg (milligram)(for moderate to severe pain), the narcotic binder showed 25 pills, and the medication card had 24 pills in the card.</p> <p>R6's Norco 5/325 mg (pain medication), the narcotic binder showed 28 pills and there were 27 pills in the medication card.</p> <p>R6's Clonazepam 0.5 mg (anti-anxiety medication), the binder showed 28 pills and there were 27 pills in the medication card.</p> <p>R6's Pregabalin 50 mg (pain medication), the binder showed 11 capsules and there were 10 capsules in the medication card.</p> <p>R7's Pregabalin 25 mg (pain medication), the binder showed 30 capsules and there were 29 capsules in the medication card.</p> <p>R8's Norco 10/325 mg (pain medication), the binder showed 20 pills and there were 19 pills in the medication card.</p> <p>R8's Pregabalin 100 mg (pain medication), the binder showed 23 capsules and there were 22 capsules in the medication card.</p> <p>R9's Pregabalin 75 mg (pain medication), the binder showed 7 capsules and there were 6 capsules in the medication card.</p> <p>R10's Norco 5/325 mg (pain medication), the binder showed 4 pills and there were 3 pills in the medication card.</p> <p>R11's Morphine Sulfate 15 mg (medication for severe pain), the binder showed 25 pills and there were 24 pills in the medication card.</p> <p>(continued on next page)</p>		

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 11/19/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R12's Tramadol 50 mg (for moderate to severe pain), the binder showed 18 pills and there were 17 pills in the medication card.</p> <p>Between 9:18 AM and 9:36 AM, during the medication reconciliation count, V4 said he had not documented the pills that were given during the AM medication pass yet in the narcotic reconciliation binder. V4 asked the surveyor twice if he could just sign the medications off that he gave during the AM medication pass so the numbers would be the same. At 9:30 AM, V4 said controlled medications should be signed off in the narcotic binder when they are administered.</p> <p>On 11/19/2024, V2 (Director of Nursing) said the nurses are supposed to sign the narcotics out in the binder once they take them out of the cart and put them in the medication cup. It is important to do that because they need to be accounted for.</p> <p>On 11/19/2024 at 11:54 AM, V6 (RN) said controlled medications/narcotics should be documented in the narcotics binder right after they are administered to a resident. V6 said it is not acceptable to wait for the end of the medication pass to document all of the narcotics/controlled medications given. V6 said that is when medication errors can occur.</p> <p>The facility's policy and procedure titled Administering Medications, with a revision date of April 2019, showed 22. The individual administering the medication initials the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones.</p> <p>R4, and R6-R12's Controlled Drug Receipt/Record/Disposition Forms for the above listed medications showed Each dose signed for here requires charting on the medication record.</p>		

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 11/19/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34491</p> <p>Based on observation, interview and record review, the facility failed to ensure controlled medications were stored under a double lock in the medication room for 2 of 9 residents (R6 and R13) reviewed for controlled medications in the sample of 13.</p> <p>The findings include:</p> <p>On 11/19/2024 at 9:34 AM, the refrigerator in the medication room containing controlled medications was not locked. The lock to the refrigerator was resting on the latch, however, the lock was open. 10 ml (milliliters) of Lorazepam 2 mg/ml (milligrams per milliliter) for R6 were in the unlocked refrigerator as well as an opened bottle containing 1.5 ml of Lorazepam 2 mg/ml for R6. A container with 30 ml of Lorazepam 2 mg/ml was in the unlocked refrigerator for R13, as well as 2 ABHR suppositories (a compounded product using four different medications: lorazepam, diphenhydramine, haloperidol and metoclopramide (used to treat nausea and vomiting). Lorazepam is a schedule IV-controlled medication. V4 said the refrigerator should be kept locked when a nurse is not in the medication room.</p> <p>On 11/19/2024 at 9:43 AM, V2 (Director of Nursing) said the refrigerator in the medication room should be locked when there is not a nurse in the room because there are controlled medications in the refrigerator.</p> <p>On 11/19/2024 at 11:54 AM, V6 (RN) said the refrigerator in the medication rooms should be locked at all times when a nurse is not in the room. It is storing medications that are controlled and should be under a double lock.</p> <p>The facility's December 2017 policy and procedure titled Medication Storage in the Facility showed Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .9. All drugs classified as schedule II of the Controlled Substances Act will be stored under double locks. Schedule II-IV medications must be maintained in separately locked, permanently affixed compartments and cannot be stored with other non-scheduled medications.</p>		