

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/24/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was safely transferred with a gait belt and failed to ensure a resident was safely moved outside in a wheelchair. This applies to 2 of 3 residents (R1 and R2) reviewed for safety in the sample of 3. The findings include: 1. R2's Incident Report dated 11/14/25 showed R2 fell while staff transferred R2 to the toilet. The same documentation showed a Certified Nursing Assistant lowered R2 to the floor. On 11/24/25 at 10:53 AM, V2 (Director of Nursing) said a gait belt was not used by the CNA when R2 was transferred and fell on [DATE]. On 11/24/25 at 11:09 AM, V7 (Licensed Practical Nurse) said she was the nurse taking care of R2 when R2 fell while transferring on 11/14/25. V7 said a gait belt was not used by staff when R2 was transferred and fell. On 11/24/25 at 11:26 AM, V8 (Therapy Manager) said R2 was a one person assist to transfer and a gait belt was to be used when transferring R2. On 11/24/25 at 11:12 AM, V12 (Restorative Nurse) said a gait belt is used to support/guide a resident when transferring and provide staff a way to assist the resident without pulling on the resident's clothing or body parts. V12 added that gait belts are also used to lower residents to the floor if needed. R2's facility assessment done on 11/14/25 showed R2 required substantial/maximal assistance for toilet transfers. R2's Care Plan with an initiated date of 9/9/22 showed R2 was at risk for falls. The facility's Gait Belt/Transfer Guideline policy with a revised date of 2/23 showed a gait belt is a safety device made of cloth that buckles securely around a resident's waist. The device provides a secure grasping surface to aid during transfer and ambulation. Commonly used for residents who are at risk for falls and those who require assistance during transfers. 2. R1's Facesheet, dated 11/24/25 shows R1 has diagnoses that include, but are not limited to, rheumatoid arthritis, osteoarthritis of the left hip, and difficulty in walking. R1's Restorative Nursing Screener progress note from 11/1/25 shows R1 used a manual wheelchair to ambulate. The restorative nursing screener progress note also shows R1 did not attempt walking without assistive devices due to R1's medical condition and safety concerns. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/25 at 11:40 AM, V5 (R1's Family Member) said R1 was admitted to the facility from a local hospital after R1 became unable to walk with pain in R1's left hip from osteoarthritis. On 11/24/25 at 11:20 AM, V3 (Receptionist) said on the evening of 11/2/25, V3 saw R1 self-propel in a wheelchair from the elevator, approximately fifteen feet towards the main lobby. V3 said R1 had called out for help, but nursing staff could not hear R1. V3 asked R1 if V3 could help and R1 had requested V3 bring R1 to the window to wait for V5 to arrive at the facility. When V5 arrived, R1 requested V3 to bring R1 out the front doors to greet V5. V3 said the main front door has two doors. V3 said V3 had wheeled R1 out of the first door and the second door began to close on R1 and V3. V3 then positioned herself to prop open the entrance door with one arm and used the other arm to assist R1 out of the doorway. V3 said when R1 was completely out of the doorway, V3 saw V5 at the bottom of the sidewalk, let go of the wheelchair without ensuring R1 had R1's feet on the ground to prevent the wheelchair from going down the sloped sidewalk. V3 also said V3 did not engage the wheelchair brakes before letting go of R1's wheelchair. V3 then went to turn around and go back inside when R1 uncontrollably wheeled down the sidewalk, eventually falling forward from R1's wheelchair and scraping R1's knees on the sidewalk. On 11/24/25 at 12:07 PM, V4 (Scheduling Coordinator) said once a wheelchair proceeds past the door threshold at the main door, it's almost an immediately downward slope towards the parking lot that would take the wheelchair down the slope by gravity without the resident having their feet on the ground or having staff assisting the wheelchair descend. V4 said V4 has an active certified nursing assistant license and V4 would have ensured R1's wheelchair brakes were engaged or that R1's wheelchair was on a more level surface before letting go of R1's wheelchair. On 11/24/25 at 1:10 PM, V14 (Assistant Director of Nursing) said in hindsight, after the event, V3 should have ensured either R1's feet were on the ground or that R1's wheelchair brakes were engaged before letting go of R1's wheelchair.		