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	03/02/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to ensure pressure ulcer prevention interventions were in place for residents at risk for pressure ulcers and failed to ensure treatment orders were implemented for a resident with a pressure ulcer for 3 of 3 residents (R1, R2 and R3) reviewed for pressure ulcers in the sample of 3.The findings include:1.R3's Braden Score dated 1/12/26 shows that she is at high risk for developing pressure ulcers. R3's Physician's Order Sheet shows an order dated 10/11/24 for: protective heel boots to both feet at all times. R3's Skin Integrity Care Plan shows that she is at risk due to impaired cognition, incontinence, impaired mobility and impaired nutrition. R3's interventions include: air mattress, ensure that patient's air mattress is in place and functioning appropriately.On 3/2/26 at 9:50 AM, R3 was lying in bed sleeping. R3's heel protector boots were sitting on the bedside table. R3 had an air mattress. There were no lights on the air mattress indicating that it was on and functioning. V3 pulled down R3's covers and R3's heels were directly on the mattress. R3's right lateral malleolus was reddened. V3 (Wound Licensed Practical Nurse) moved R3's bed and saw that the air mattress was not plugged in. V3 stated that R3 should always have her heel protection boots on and her air mattress should be plugged in and functioning. On 3/2/26 at 1:35 PM, V3 said that R3 is at risk for pressure ulcers due to her contractures, lack of mobility and dependance on staff for turning and repositioning. V3 said that intervention that are in place to prevent pressure ulcers include: an air mattress, heel boots on at all times, frequent incontinence care and frequent repositioning. 2. R2's Braden Score dated 2/23/26 shows that he is at moderate risk for developing pressure ulcers.On 3/2/26 at 9:30 AM, R2 was lying in bed. R2 had protective heel boots in his room, one was on his dresser and one was on the floor. R2's heels were directly on the mattress. R2's bilateral heels were slightly reddened. R2 said that sometimes they put his boots on and sometimes they do not. R2 said that he does not mind wearing them. On 3/2/26 at 1:35 PM, V3 (Wound Licensed Practical Nurse) said that R2 is at risk for pressure ulcers due to his immobility. V3 said that R2 tends to want to lay in bed most of the day. V3 said that R2's interventions in place to prevent pressure ulcers include: heel boots when in bed, turning every two hours and nutritional supplements. 3. R1's Specialty Physician Initial Wound Evaluation and Management Summary dated 2/12/26 shows that R1 has a unstageable pressure ulcer to his sacrum measuring 9 centimeters (cm) x 8.5 cm x 0.1 cm consisting of 80% necrotic tissue and 20% viable tissue. R1's wound was debrided and a treatment plan was ordered. The treatment ordered was sodium hypochlorite solution (dakins) to be applied once daily and as needed, silver sulfadiazine 1% once daily as needed and a bordered gauze dressing as a secondary dressing. R1's Specialty Physician Wound Evaluation and Management Summary dated 2/19/26 shows that R1 had a stage 3 sacral pressure ulcer measuring 9 cm x 9.6 cm x 0.1 cm and was not at goal due to infection. R1's Physician's Order sheet shows an order dated 2/13/26 for: Sacrum: Cleanse site with wound wash, pat dry and apply Silvadene to wound bed and cover with bordered foam daily and PRN (as needed). There is no order to cleanse with dakins until 2/19/26.On 3/2/26 at 1:35 PM, V3 (Wound Care Licensed Practical Nurse) said that a wound nurse does rounds with the wound physician weekly and inputs all new orders into the resident's record. V3 said that all wound physician orders should be followed. V3 said that there is a difference between wound wash and dakins. V3 said that wound (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wash is a gentle wound cleanser and dakins is a bleach solution that is used to help with debridement and as an antimicrobial. On 3/2/26 at 2:51 PM, V4 (Wound Physician) said that when he first saw R1 he had a big, nasty wound on his sacrum. V4 said that he orders dakins solution if he suspects an infection. V4 said that dakins is a super strong wound cleanser. V4 said that he would expect the facility staff to follow his orders. V4 said that when he saw R1 on 2/19/26, R1's sacral wound was infected and he ordered additional treatments. The facility's Pressure Ulcer and Wound Prevention/Management Policy shows, It is the policy of this facility to:.Ensure a resident who has been admitted with pressure ulcers or develops pressure ulcers in-house receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, when possible.