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	06/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure the facility was free from physical abuse for 2 of 3 residents (R1, R2) reviewed for abuse in the sample of 10The findings include:R1's electronic face sheet shows R1 has diagnoses that include dementia and neurocognitive impairment with Lewy body.R2's electronic face sheet shows R2 has diagnoses that include compression fracture of lumbar area, diabetes and cerebral palsyA facility reported incident dated 6/14/26 with final dated 6/19/26 sent to the state agency documents, under allegation-physical abuse. R1 and R2 noted to have physical altercation. R1 noted with a superficial scratch on his face. The staff separated the residents. R1 was noted with a scratch on his right eyebrow when he got up from his nap for dinner. R1 was questioned by staff but did not recall how he obtained the scratch. Per staff, the resident was in his room napping prior to dinner. R1 was assessed and no other injuries were noted, the roommate (R2) was immediately interviewed. The roommate stated, he was touching my DVD player, and I didn't like it, so I scratched him. R1 was sent to the hospital at the request of the family. R2 has had a room change.On 6/25/26 at 8:45 AM R2 was sitting in his wheelchair. R2 was noted to have boxes of personal items including DVDs. A DVD player was noted on the cabinet below the TV. R2 speaks slowly but was able to be understood. R2 said he gets along with everyone provided they do not touch his personal belongings including his DVDs and DVD player. When asked about his previous roommate, R2 said he touched my stuff.On 6/25/26 at 8:35 AM, V3 License Practical Nurse-LPN said she was the Nurse working last 6/14/26 when the incident happened. R1 was noted to have scratches in both of his hands. R1 also had scratches on his right upper eyebrow. R1 has dementia and cannot tell what happened to him. R1 roams around and wanders independently without a device. V3 (LPN) said she went to talk to the roommate R2. R2 admitted to scratching R1 because R1 was touching his DVD player. R2 was moved to 2nd floor in a private room.On 6/25/26 at 8:55 AM, V4 (Certified Nursing Assistant-CNA) said she was R1 and R2's day shift CNA. R1 and R2 were roommates. R1 was in bed 1 by the door, and R2 was in bed 2 by the window. That day, (6/14/26) R1 was noted to be going towards R2 touching R2's DVDs. R1 cannot be redirected. R2 was getting upset at R1 every time he went to R2's space touching his DVD player. V4 said she was repeatedly redirecting R1 to go back to his area. V4 said before she left the day shift. V4 said she put R1 to bed. V4 said later that day, R1 was noted to have scratches.On 6/25/26 at 9:45 AM, V2 (Director of Nursing) said R1 was new at the facility. R1 was mobile, up and about independently needing no device. R1 wandered around the unit and his room. R1 has a roommate, R2. V2 (DON) said she got a call that day 6/14/26 around evening time that R1 was noted to have scratches on his arms and forehead. R1 cannot tell where it came from. R1 has dementia. V2 said she directed the staff to asked R2, R1's roommate. R2 admitted to scratching R1 due to R1 touching his DVDs. V2 said that incident was reported to the state agency as resident-to-resident altercation under physical abuse. The facility Abuse Policy dated 10/22 This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. To do so, the facility has attempted to establish a residents (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sensitive and resident secure environment. Physical abuse includes hitting, slapping, pitching, kicking, and controlling behavior, through corporal punishment.

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions of air mattress pumps were on and set to the residents' weights. This applies to 3 of 6 residents (R6, R7 and R9) reviewed for pressure injuries in the sample of 10.The findings include:1. On 6/25/26 at 8:35 AM, R7 was in bed sleeping. Hanging on the foot of R7's bed was an air mattress pump. The air mattress pump was turned off.On 6/25/26 at 8:43 AM, V8 (Certified Nursing Assistant) confirmed R7's air mattress pump was off. R7's Care Plan printed on 6/25/26 showed she was at risk for skin impairment.2. On 6/25/26 at 8:24 AM, R6 was in bed. Hanging on the foot of R6's bed was an air mattress pump. The air mattress weight setting was set to 620 pounds. R6 said her bed was too firm/hard. R6's Weight Summary for 5/20/26 showed R6 weight was 120.6 pounds. A difference of 499.4 pounds from the setting on the air mattress pump. 3. On 6/25/26 at 8:22 AM, R9 was in bed sleeping. Hanging on the foot of R9's bed was an air mattress pump. The air mattress pump was set to 350 pounds.R9's Weight and Vital Summary for 6/2/26 showed R9 weight was 188.4 pounds. A difference of 161.6 pounds from the setting on the air mattress pump.R9's Care Plan showed she was at risk for skin alterations. Listed under interventions was for an air mattress pump. On 6/25/26 at 9:59 AM, V9 (Wound Care Nurse) said air mattress pumps are a pressure relieving intervention. V9 said the pumps should be on and set to the resident's weight.