Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: ________ B. WING ________	C 08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S 000	Initial Comments Facility Reported Incident of 8/4/2020/IL125667: F600 J & F689 J Complaint 2016342/IL125679: F600 J & F689 J	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the safety of one resident (R1) by not separating two incompatible roommates; the facility failed to properly implement increased supervision for a resident (R2); and the facility failed to identify a resident with a history of violence towards roommates and the facility failed to prevent resident to resident abuse. These failures resulted in a physical altercation between R1 and R2 and the subsequent strangulation and death of R1. This applies to 2 residents (R1, R2) reviewed for safety/supervision.

R1's Face Sheet showed an original admission date of 6/30/2020 with diagnoses to include: Type II diabetes, Schizoaffective Disorder, and Major Depressive Disorder.

R2's Face Sheet showed an original admission date of 6/17/2020 with diagnoses to include:

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Schizoaffective disorder, Bipolar, Anxiety, and psychosis not due to a substance or known physical condition.

R2's "Notice of Room Transfer" showed R2 was moved in with R1 on 7/16/2020. R1 and R2's room was the second to last room (end) of their hallway.

R1's Social Service note from 7/21/2020 at 10:21 AM showed, V5 "SS (Social Services) approached resident in his room following a report that resident was not getting along with roommate. Staff inquired what the issue was, and (R1) replied, He smells, take your mask off and you can smell him. The CNA responded that resident's roommate had just showered but resident continued to state that the roommate had body odor. Staff suggested a room move but resident denied and continued to ignore..."(Incident occurred within 5 days or residents becoming roommates.)

R2's Social Service Note from 7/21/2020 at 11:03 AM showed, "SS (Social Services) met with (R2) regarding an issue with roommate. It was reported that resident and roommate were not getting along...reminded him that if he still wants to transfer rooms, staff will assist him to move once a room became available..." Note signed by V5 Social Services (SS).

On 8/6/2020 at 12:35 PM, V5 Social Services stated, in regard to the 7/21/202 SS note, "When I walked in, (R2) was telling me that (R1) said he smelled. So, (R2) asked about deodorant. I said Do you want a room move? He (R2) said if there was room he would like to move rooms; but I told him at that time we don't have a room available but when one comes available we will move him.

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S9999	Continued From page 4 He (R2) said he would like to move in the future when available...It's not like there wasn't room for him to move, but I didn't feel like it was necessary at the time. I did communicate that with (V4 SS Director) ..." The facility's Amended Incident Report from the event on 8/4/2020 at 11:31 PM showed, there was a physical altercation between R1 and R2; R2 "grabbed (R1) around the neck. At some point, (R1) passed out. (R2) then came to the nurse's station to report the incident. (R1) remains in the neuro intensive care unit at (a local hospital). The Police Report dated 8/5/2020 showed an interview between police and R2. The report showed R2 and R1 had argued for the last week regarding R1 breaking the toilet and R1 breaking the window that morning. The report continued, R1 approached R2 and "he (R2) said he does not like when people larger than him get close to him because he was raped in the past." The report showed R1 punched R2 and R2 put him in a "headlock until (R1) he became unconscious." On 8/11/2020 at 10:30 AM, V22 R1's Attending Physician stated, there has been little change in R1's condition and "there is little hope for any neurological recovery...There is no etiology (cause) to explain his condition other than the strangulation. The CT was negative for fractures or subluxation. (dislocation)" On 8/12/2020 at 3:50 PM V26 Social Worker at local hospital stated R1 had passed away the afternoon of 8/12/2020. R1's Incident Note from 8/5/2020 at 1:25 AM showed, "At approximately (11:25 PM), client's	S9999		

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roommate [R2] said to staff, 'I think I killed my roommate.' Staff rushed to client's room and observed him unresponsive lying face down on the bedroom floor. The 1st bed (roommate's) was pushed diagonally toward the 2nd bed (client's). A code blue and 911 was called. CPR was initiated ... "

On 8/5/2020 at 3:07 PM, V11 Licensed Practical Nurse stated, R2 approached the second-floor nursing station at approximately 11:30 PM on 8/4/2020. V11 stated, "...(R2) goes by the phone and asks to use the phone and I told him it's kind of late thinking he wanted to call his Mom." V11 said, as R2 was walking away he said, "You need to call 911...my roommate jumped on me and punched me in the nose, and I think I killed my roommate." V11 stated, she ran to R1/R2's room and found R1 lying face down, unresponsive, pulseless, and not breathing.

On 8/7/2020 at 8:56 AM, R1 was observed in the Neuro Intensive Care Unit (ICU) at a local area hospital where he was on a ventilator. R1 had bruising to his bilateral knuckles and two quarter sized scabs to his left knee. V21 R1's ICU nurse suctioned R1's throat and no gag reflex was seen. V21 attempted painful stimuli and there was no response. On 8/7/2020 at 9:05 AM, V21 stated R1's sedative had been turned off for approximately 30 minutes and R1 was "not gagging" despite having a breathing tube in place.

On 8/7/2020 at 10:30 AM, V7 R1 and R2's Emergency Room physician on 8/5/2020 said, "(R2) admitted to doing the choking but he didn't know how long he choked him for. (R2) said, he punched me so I choked him." V7 stated "...Strangulation could have caused the condition he came in with if it was long enough." V7 said,

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"He (R2) said they were fighting over the light in the room, one wanted it on and the other wanted it off. (R2) got up to turn it off and the other guy (R1) got up and punched him and that's when (R2) choked him."

On 8/6/2020 at 12:35 PM, V5 Social Services stated she was called to see R1 and R2 regarding an incident on 7/21/2020. V5 said, "When I walked in, (R2) was telling me that (R1) said he smelled. So, (R2) asked about deodorant. I said, 'Do you want a room move?' He (R2) said if there was room he would like to move rooms; but I told him at that time we don't have a room available but when one comes available we will move him. He (R2) said he would like to move in the future when available...It's not like there wasn't room for him to move, but I didn't feel like it was necessary at the time. I did communicate that with (V4 SS Director) ..."

On 6/29/2020 at 3:08 PM, the facility received medical records from R1's previous Long-Term Care facility. The following documents were contained in that packet. R1's Nurse Practitioner note from 4/1/2020 showed, "...He had gotten angry at his roommate and they got into an altercation. He states that this was a long time coming and they have had issues..." R1's physician note from 4/8/2020 showed, "...His behaviors have been a bit off lately. He had an argument with a roommate and has since had to change rooms..." R1's physician note from 5/7/2020 showed, "...His behaviors continue to be a bit of a problem. Recently he had some issues with roommates as well..."

On 8/7/2020 at 1:30 PM, V9 Director of Nursing

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at R1's previous long-term care facility, was contacted in regard to these roommate issues and R1's behavior. V9 stated, R1 was in a physical altercation with his roommate. V9 said, "After the roommate incident, we changed roommates and put him on 15-minute checks and we also did some anger management therapy with the two of them. (R1) was the instigator in that incident with the roommate. He (R1) was complaining that his roommate smelled, and he didn't want to live with him anymore; he was picking a fight."

On 8/7/2020 at 2:47 PM, V4 SS Director stated, she was not aware of the roommate issues described in the medical records from R1's previous long-term care facility. V4 stated, "If I had known about the incident at (R1's previous long-term care facility) I would have looked at putting him (R1) in a single room by himself."

R1's Care Plan showed, "Pt (patient) exhibits behaviors that include but are not limited to verbal and physical aggression towards other. On 7/8/2020 Pt displayed verbal aggression towards staff."

R2's 6/15/2020 Background Check showed "Multiple Hits" regarding criminal past.

R2's 6/17/2020 Discharge Order and Transition Record from a local Behavioral Hospital showed, "Reason for Admission: Danger to self with psychosis, Lack of impulse control, Danger to others with psychosis" The record continued, "Triggers and Stressors (Behaviors, situations and circumstances that put at emotional risk) are: Certain environments, People touching your stuff, and Like things to be a certain way."

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S9999	Continued From page 8 R2's Nursing Facility Placement Assessment Summary Information dated 6/17/2020 showed, "6-7 prior arrests (dates unknown) According to hospital staff, the patient has been arrested three times for stealing cars...and a few times for purchasing guns. In May 2020 he stole his grandfather's car. He was driving to Indiana and was stopped because he was driving on the wrong side of the road. It is unclear, but the patient may have a restraining order against him from his family...The patient has a tendency to start fires at his home or in hotels...He continues to exhibit poor reality contact with no insight or judgment to the severity of his MI (Mental Illness)...The patient was hospitalized on 5/16/20 (for) worsening psychosis, inability to care for self, being kicked out of family homes and hotels for destructive behaviors, and paranoia with no regard to his own well-being. His mother has legal guardianship of the patient due to his inability to care for himself. He is rather impulsive with no regard for himself or others (i.e. his paranoia was so intense he tried to jump out of a moving car with his mother driving just before being hospitalized)...He has gone to Indiana on several occasions to purchase firearms because he does not need a FOID (Firearms Owner Identification) card. He has been court ordered to treatment multiple times..." R2's Identified Offenders Program (commonly referred to as CHAR report) shows him to be a "Moderate Risk-This resident requires closer supervision and more frequent observation than standard or routine for most resident in an open facility..." On 8/7/2020 at 11:34 AM, V19 Certified Nursing Assistant stated, "I was not aware of their (R1, R2) backgrounds or histories. We were not doing	S9999		

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any special supervision for them (R1, R2). We are supposed to do rounds on everyone, every 2 hours. We only do 15-minute checks when warranted; (R1 or R2) were not on 15 minute checks whenever I worked with them."

On 8/14/2020 at 8:45 AM, V15 Licensed Practical Nurse stated, there are some residents that are monitored more frequently; however, "(R1) and (R2) were not on any increased monitoring."

On 8/13/2020 at 11:50 AM, V4 Social Service Director stated the only increased supervision R2 received was 1 to 1 group therapy twice a week and "usually a daily visit" by social services.

R2's 6/30/2020 Care Plan Conference Participation Log showed there was no staff, family, or guardian participation.

On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated she was not contacted for a care plan meeting. V20 stated she had to contact the facility to set up the meeting and it was not done until a week before the incident.

On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated, "(R2) told me, and (V4 SS Director) knows this, that he didn't really like his roommate. (R2) said (R1) talks about me under his breath and I told him he has to get along. I told him (V4) and I had a conversation; that (R2) had requested another roommate. She called me about it and I never heard any more about it... I felt like that she was going to move him to another room, but she was trying to find him a match." V20 said, "His (R2) impulse control is bad."

'The facility's Abuse Prevention Program Facility

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S9999	Continued From page 10 Policy and Procedure reviewed on 1/4/2019 showed "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm...Willful as used in this definition of abuse, means the individual must have acted deliberately, .not that the individual must have intended to inflict injury or harm." (A)	S9999		