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 08/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments FRI of 8/13/2023/IL163299	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.3210t) 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 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from abuse for one of six residents (R1) reviewed for abuse in the sample of six. This failure resulted in R1 experiencing a fractured nose.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

The findings include:

R1's Admission Record shows he was admitted to the facility on October 15, 2020 with diagnoses including heart failure, generalized anxiety disorder, major depressive disorder, emotional lability, and history of falling.

R2's Admission Record shows he was admitted to the facility on June 6, 2022 with diagnoses of schizoaffective disorder, generalized anxiety disorder, and morbid obesity.

The facility's Initial Incident Report dated August 13, 2023 shows, "Staff reported that they heard resident [R1] yelling at resident [R2] in the back of the dining room. Staff reports that's resident [R2] then stood up and hit resident [R1] in the face. Residents separated immediately. [R1] was assessed for injuries. A small amount of bleeding from bridge of nose and bleeding from nose noted. [R1] did not want the police notified and initially refused to go to the hospital. After education and encouragement, [R1] did agree to be seen at the hospital for evaluation. [R2] placed on 15 minute checks. Both residents were educated to seek out staff assistance when needed."

R1's After Visit Summary dated August 13, 2023 shows R1 had a diagnoses of nasal fracture.

On August 22, 2023 at 9:54 AM, V1 Administrator said the incident between R1 and R2 occurred at dinner time. V1 said that R1 was calling R2 an "ogre." V1 said that R1 "pushes other residents' buttons" at times. V1 said according to the video, R1 began to wheel away from R2, but then turned around and pointed at R2's face. That is when R2

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S9999	Continued From page 2	S9999		

hit R1 in R1's face. V1 said that R2 has never had any altercations with other residents in the past. V1 said that R2 has never been angry towards another resident before. V1 said that R2 went to the hospital and had a fractured nose. At 10:13 AM, V11 CNA (Certified Nursing Assistant) said he was fixing supper trays when he heard R1 yelling and screaming at R2. When V11 turned around to look, he saw R2 hit R1. V11 said R1 and R2 always sit with each other at the same table. V11 said that R1 has behaviors of "bullying" people at times. V11 said R2 never has any behaviors and that R2 is quiet. V11 said he has never seen R2 get aggressive. At 10:34 AM V9 CNA said she had stayed over her scheduled shift to help with dinner. V9 said she was getting dinner trays ready when another resident yelled V9's name. V9 said she turned around and saw R2 hit R1 in his face. V9 said nothing was happening prior to the incident. V9 said she was shocked when she saw R2 hit R1. V9 said R2 has never had behaviors before and that R1 and R2 have sat at the same table for a long time. V9 said that R2 was crying and R2 said he felt bad for hitting R1. At 10:57 AM, V10 CNA said she was setting up hallway trays for dinner when she heard another resident telling R1 to stop and leave R2 alone. V10 said when she came around the corner to see what was going on, R1's nose was bleeding. V10 said she pulled R2 out and sat him by the nurses station. V10 said that R2 was crying because he didn't want to hit R1 but R2 told V10 that R1 kept calling R2 a "big fat ogre." V10 said this was the first time that she saw R1 be aggressive. V10 said that R2 is very sweet. At 12:43 PM, R2 said that he feels safe in the facility. R2 said that R1 was calling R2 an ogre. R2 said he asked R1 to stop and R1 did not stop so R2 hit R1 in the face. R2 was calm during this interview. At 2:00 PM, R1 said that he feels safe

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S9999	Continued From page 3	S9999		

in the facility and has no pain. R1 said that R2 hit him in the nose, but R2 apologized and they are friends. At 2:21 PM, V8 CNA said she heard a scream and turned to see what was going on. V8 said R2 had hit R1 in the face. V8 said that V7 CNA directed R2 out of the dining room. V8 said she does not remember seeing or hearing any arguing prior to R2 hitting R1. V8 said that R2 has never had behaviors before and R2 hitting R1 is out of R2's norm. At 2:46 PM, V7 CNA said she did not see the incident between R2 and R1 occur. V7 said after the incident, she took R2 and walked with him. R2 told her that R1 kept calling R2 an "ogre." V7 said R2 felt bad and asked R1 if he was ok. V7 said that R2 was calm and that she felt safe with R2. V7 said that R2 has no behaviors and is a really sweet resident. V7 said she was surprised that R2 hit R1.

The facility's Abuse Prevention Program policy January 4, 2019 shows, "This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment."

(B)