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 _____	12/07/2023

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 Annual Licensure Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.625 b) 1. Section: 300.625 - Identified Offenders b.) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review failed to ensure the safety of residents while awaiting an Identified Offender Report for 1 of 3 residents (R426) reviewed for Identified Offenders in the sample of 32. The findings include: On 12/5/23 at 11:23 AM, R426 was was walking around his room. R426 had a roommate (R116). R116 was lying in his bed with a can next to his bed. R116 said he was blind and used the cane to get around. R426's Illinois State Police Criminal Background performed on 11/21/23 contained a 15 page criminal history, including burglary, criminal trespass to land, resisting a peace officer,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 aggravated battery, and DUI/Alcohol. The IDPH (Illinois Department of Public Health) Identified Offenders Program effective 1/2020 showed burglary and aggravated battery as "qualifying offenses." On 12/5/23 at 1:53 PM, V21 (CNA Supervisor) said she last week she was getting off the elevator and heard R426 talking loud. V21 said R426 saw here and started walking toward her and V20 (CNA) was standing in the hallway by a resident room. V21 said R426 said, "She won't do what I am asking her to do. She won't listen to me. V21 said R426 was verbally aggressive and agitated. V21 said she went to V20 (CNA) to find out what was happening. V21 said V20 told her that she was providing care in another resident's room when R426 went in the resident's room, shut the door, and started yelling to turn down the TV. V21 said V20 told her that she left the other resident's room and tried to calm down R426. V21 said she did not see V20 (CNA) yelling at R426. V21 stated, "All I heard was R426 yelling." On 12/5/23 at 2:03 PM, V20 (CNA) said she was providing care, when R426 came into the resident's room to confront him about the TV. V20 stated, "I was in the room, so I went over by the door to tell him that I would take care of it. He got close to me. I never threatened him. I was basically just trying to diffuse the situation about him being upset over the TV. I asked him to close the door and asked the resident to turn down the TV, but [R426] just kept carrying on." On 12/5/23 at 1:57 PM, V5 (Assistant Social Services Director) said she runs the Criminal Background Checks on residents prior to their admission to the facility. V5 said R426 had "HITS"	S9999		

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S9999	Continued From page 2 on his extensive Criminal History Report and a fingerprint analysis had been ordered. V5 said R426's fingerprints had been completed last week and the facility was awaiting the ISP (Illinois State Policy) evaluation. V5 said based on the results of the final evaluation, residents are provided appropriate interventions. V5 said identified offenders are categorized as Low, Moderate, or High Risk. V5 said High Risk Identified Offender residents were placed in a private room for the safety of the other residents. V5 said she is part of the team that determines room placement for new admissions. V5 said R426 was admitted to the facility on 11/21/23 and had been in the same room since admission, with a roommate. V5 said R426 had aggressive interactions with the facility staff, but she did know of any issues with other residents. V5 stated, "All I know is there was an issue with alcohol and him getting drunk." At 2:21 PM, V5 said the social services staff only round weekly on identified offenders that have had their level of risk assessed. V5 stated, "We are currently moving [R426] to a private room. The surveyor asked V5 why they are moving R426. V5 stared blankly, then stated, "We decided to move him to a private room while we wait for the results of R426's risk evaluation." On 12/6/23 at 1:10 PM, V15 (Admissions Director) said the resident background checks are completed prior to admission. V15 said R426's initial room placement was with roommate R116, but he was moved to a private room. The surveyor asked V15 why R426 was moved to a private room. V15 replied, "I guess there was a lengthy criminal history report. He was moved to the private room while we wait for the results of the fingerprints and ISP evaluation. Social Services handles that part of the admission	S9999		

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S9999	Continued From page 3 process. On 12/6/23 at 2:00 PM, V2 (DON - Director of Nursing) said R426 was very intoxicated one night and the police had to be called. V2 said R426 was aggressive with the staff and the police. V2 said R426 was removed from the facility in handcuffs, but returned later that evening. V2 stated, "He's been angry since them. He has spinal pain and he was pretty intoxicated, so his doctor held the narcotic pain medication for a day. [R426] was furious! It was resumed after he sobered up but he's been more agitated since." On 12/7/23 at 10:35 AM, V9 (Social Services Director) said initially R426 was assigned with roommate (R116), but he was moved to a private room due to his lengthy criminal history. The surveyor asked why R429 was admitted on 11/21/23 (with the lengthy criminal history report), but wasn't moved until recently. V9 replied, "I guess it changed because you guys were asking about it." R426's Face Sheet dated 12/6/23 showed R426 was admitted to the facility on 11/21/23 with diagnoses to include schizoaffective disorder, cervical spinal cord injury at C5, COPD (chronic obstructive pulmonary disease), pain in the neck, and generalized muscle weakness. R426's Progress Notes showed on 11/27/23 R426 was found passed out, in his wheelchair, in his bathroom with an empty bottle of vodka, beer, and cigarettes. When the staff attempted to remove these items from R426's room, he because aggressive. R426 started yelling, "Give me back my shit!" and flipped the side table. The staff called 911 and R426 was aggressive with	S9999		

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S9999	Continued From page 4 the police officers. R426 was placed in handcuffs and taken to the hospital. On 11/28/23 at 2:03 AM, R426 returned to the facility (with a diagnosis of aggressive behaviors) and was demanding is narcotic pain medications. R426's Nurse Practitioner held the narcotic pain medication for 24 hours due to R426's intoxication. On 11/28/23 R426 received a smoking violation and became upset with V9 (Social Services Director). The notes showed several attempts were made to explain the facility smoking policy and R426 became loud and refused to speak with staff. On 12/5/23 V9 (Social Services Director) met with R426 and explained that he was moved to a private room due to his criminal history and he will remain in a single room until further notice. R426's Behavior Chart showed on 11/26/23 he was yelling/screaming, using abusive language, and had threatening behaviors. On 12/4/23 R426 had threatening behaviors and on 12/5/23 R426 was yelling/screaming and used abusive language. The facility's undated Identified Offender Facility Policy and Procedure showed, "It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions... While the background or fingerprint checks, waiver request, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents..." (B)	S9999		

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S9999	Continued From page 5 2 of 2 Violations 300.1210b) 300.1210c) 300.1210d)6 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These Requirements were not et as evidenced by: Based on observation, interview and record	S9999		

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S9999	Continued From page 6	S9999		

review the facility failed to ensure fall prevention interventions were implemented for 1 of 2 residents (R5) reviewed for safety in the sample of 32. This failure resulted in R5 falling out of bed while being provided personal care and recieving a laceration requiring stitches to his head.

The findings include:

R5's Face Sheet shows diagnoses of: hemiplegia affecting the left side, schizoaffective disorder, dementia, epilepsy, osteoporosis and traumatic brain injury. R5's Minimum Data Set Assessment dated 10/10/23 shows that he is dependent on staff to roll from left to right.

On 12/5/23 at 9:43 AM, R5 was sitting in his room in a high back wheelchair. R5 had a laceration above his right eyebrow. On 12/6/23 at 10:39 AM, R5 was provided incontinence care. R5's body was contracted and rigid with spastic movements at times. No fall mats were observed in R5's area of the room.

R5's Final Fall Incident Report dated 11/28/23 shows R5 fell out of bed on 11/24/23 at 8:30 PM. The report shows, "Resident rolled out of bed during hygiene care. Blood noted to right eyebrow area. An order was obtained from [Nurse Practitioner] to send resident to [local Emergency Room] for evaluation and treatment.....Resident returned with 8 sutures....CNA (Certified Nursing Assistant) were educated to always perform care with [R5] with 2 staff members to ensure safety."

R5's Nursing Notes dated 11/24/23 at 8:30 PM shows, "Resident rolled out of bed while CNA were cleaning him up during bed check rolled off bed.... has a gash above his right eye.....called

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S9999	Continued From page 7 911 D/T (due to) resident getting head injury..... resident transported 8:45 PM to [local hospital]. On 12/6/23 at 3:05 PM, V24 (Certified Nursing Assistant/CNA) said that she provided care to R5 on 11/24/23. V24 said that she provided care to R5 by herself. V24 said that she was located on R5's left side of the bed during the care. V24 said that she turned R5 to his right side and all of a sudden, he just fell onto the floor. V24 said that he fell directly onto the floor and there was no floor mats on the floor. V24 said that he was bleeding from his head. On 12/6/23 at 11:06 AM, V23 (CNA) said that she had asked V24 (CNA) to help her provide care to R5 since she was not familiar with him and staff had told her that he needed two people for cares. V23 said that when she entered R5's room, V24 was already providing care to R5 so she started providing care to his room mate. V23 said that R5 was turned to his right side and V24 was putting his brief on when he fell. V23 said that R5 was "fidgeting" and all of a sudden she saw him fall to the floor and hit his head on the floor. V23 said that she was standing on the roommate's right side of the bed so she was not close to R5 when he fell. On 12/7/23 at 11:59 AM, V2 (Director of Nursing) said that R5 needs two persons for cares and should have had two people providing care on the day that he fell out of bed. V2 said that R5 requires the use of fall mats as well. V2 verified that R5's area of the room did not have fall mats in it. V2 said that "pair care" means that the staff should always do care with 2 staff member for resident and/or staff safety. On 12/6/23 at 2:52 PM, V25 (Nurse Practitioner)	S9999		

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S9999	Continued From page 8 said that she received a call that R5 had fallen out of bed and sustained an injury and was being sent to the Emergency Room. V25 said that the injury was directly related to his fall. R5's Emergency Room After Visit Summary dated 11/24/23 shows diagnoses of: closed head injury and forehead laceration. R5's Emergency Room notes dated 11/24/23 shows, "Patient reportedly rolled out of bed. He did strike his head.....laceration length: 4 cm (centimeters)....Number of sutures: 8.." R5's CT of the Head dated 11/24/23 shows, "Right frontal scalp hematoma." R5's Fall Care Plan shows, "Always provide pair care with resident" with an initiation date of 10/2/23." The Fall Care Plan also shows, "Floor mats on both side of the bed" with an initiation date of 3/30/16. (B)	S9999		