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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)3 300.1210d)6 300.3210(t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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 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	S9999		

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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:

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.

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 300.3210 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 supervise a resident with escalating

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behaviors of physical and sexual aggressions with known behaviors. This failure resulted in R1 not being supervised after exhibiting physical behaviors towards residents (R2, R3) and sexually assaulting R4. This applies to 1of 10 residents (R1) reviewed for safety in the sample of 10.

The findings include:

1. R1's face sheet shows he is a 62-year-old male admitted to the facility on 3/20/24 from a long-term care facility. His diagnoses include hemiplegia and hemiparesis following cerebral infarct affecting left non-dominant side, unspecified dementia with other behavioral disturbance, cognitive communication deficit and metabolic encephalopathy.

R1's Minimum Data Set assessment dated 3/27/24 shows his cognition is moderately impaired has poor decision-making skills and requires cues/supervision. R1 has physical, verbal behaviors directed towards other including (hitting, kicking, pushing, grabbing, abusing others sexually) and puts others at significant risk for physical injury. R1 has wandering behaviors and there was no assessment of daily and activity preferences completed.

R1's Criminal History Background Check dated 3/29/24 shows result: HIT with Felony convictions including armed robbery/discharge of firearm in 1980, 1984, attempted murder in 1987. R1 was sentenced to 15 years of imprisonment at the Department of Corrections. R1 was released for parole in November 1996. R1 was charged with resisting a peace officer in 2002, attempt to resist peace officer 2011, resisting a peace officer 2013, and driving reckless, suspected DUI in 2019

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sentenced to 24 months probation and 30 days periodic imprisonment.

R1's Social Service note dated 3/20/24 documents, R1 arrived at the facility, he is alert/disoriented with diagnoses including but not limited to Dementia, Type 2 diabetes and hypertension. R1 has never been married he completed the 5th grade and worked...for over 40 years retiring 5 years ago. R1 states he has three children and in his free time likes to watch sports. R1 admits he has a history of abusing alcohol and has never been arrested. R1's community access was determined to be supervised.

R1's nurse's note dated 3/21/24 documents R1 became agitated during casual conversation. R1 lunged towards staff yelling "F*** You." R1 is unable to be redirected.

R1's nurse's note dated 3/23/24 documents social services was notified R1 was following a CNA (Certified Nursing Assistant) and trapped her in his room masturbating in front of her. R1 was displaying physically aggressive behaviors following her around the nurse's station. R1 began pushing on the front door trying to leave.

R1's nurse's note dated 4/1/24, R1 got upset and displayed aggressive behaviors towards staff. R1 was not able to receive redirection.

V3's (Psychiatrist) Progress note dated 4/3/24 documents staff report physical aggression and (R1) placed a "choke hold" on staff. Staff report abrupt and random behaviors are often unpredictable without notable triggers ...social history POA reports substance abuse history and inappropriate sexual behaviors and advance towards others ...mental status examination:

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speech: aphasic and rarely speaks per staff report, insight: lack of insight concerning matters of self; judgement lacks judgement regarding everyday activities.

R1's nurse's note dated 4/9/24, R1 was displaying aggressive behaviors after family visit. Staff report this is a recurrent behavior and he is unable to receive redirection.

R1's nurse's note dated 4/13/24, R1 hit a male peer (R2) while passing each other on the 400 halls ...R1 is on 15 minutes checks for safety precautions.

On 4/29/24 at 9:23 AM, R2 was observed on the 2nd floor sitting in his wheelchair. He was alert to person and confused to time and date.

On 4/29/24 at 9:59 AM, V13 (Certified Nursing Assistant-CNA) said on 4/13/24 she was passing meal trays on the 400-wing. R2 was in the hallway self-propelling in his wheelchair. R1 stopped R2 and was punching him on his left cheek really fast three to five times. I told R1 to stop. R1 gets paranoid and thinks people are going to come in his room. R2 had a bruise to his left cheek. R1 had a history of being aggressive with staff, but this was the first time he was going after another resident.

R2's Incident Report dated 4/13/24 documents staff reported witnessing being struck in the left facial cheek; injury type: bruise on the face.

R1's nurse's note dated 4/14/24, R1 remains on observation monitoring post physical aggression initiated towards male peer.

R1's social service note dated 4/14/24, R1

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displaying aggressive behaviors and the police called.

R1's social service note dated 4/15/24, due to R1's physically aggressive behaviors, attempting to send him out for psychiatric hospitalization.

R1's social service note dated 4/15/24, Investigator visited today regarding background check. R1 given reminders from the Investigator about appropriate conduct with staff and peers.

R1's social service note dated 4/16/24, R1 educated about respecting all the residents and their privacy...will continue to monitor.

R1's social service note dated 4/16/24, R1's neurologist suggested a new medication. After discussion with the IDT team, the referral process has been put on hold ...social service will continue to monitor R1 for behaviors.

R1's nurse's note dated 4/16/24 documents, R1 flipped peer (R3) out of his chair in the dining room. This appeared unprovoked.

R1's nurse's note dated 4/16/24 documents, at 9:02 PM, R1 was observed walking down the wrong hall heading toward another resident's room. When CNA attempted to redirect R1, he ran toward CNA with fists raised and CNA went into nurses' station and R1 threw a full can of pop at the CNA. R1 continued to pace and agitated. R1 sent out to the local hospital.

R1's nurse's note dated 4/17/24, received call from local hospital does not meet criteria in patient admission.

R1's nurse's note dated 4/17/24 at 4:03 AM, R1

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returned to the facility. ER Dx: Aggressive behavior due to dementia ...nursing will continue to monitor for behaviors ...15-minute observation monitoring in place.

R1's nurse's note dated 4/18/24 at 7:38 AM, R1 remains on observation monitoring 15-minute checks post physical aggression.

R1's nurse's note dated 4/18/24 at 11:48 AM, R1 attempted to kick a peer, he missed the chair.

On 4/29/24 at 10:38 AM, R3 said R1 got mad at me and pushed me over in my chair and I fell on my side. It hurt.

On 4/29/24 at 2:21 PM, V10 (Licensed Practical Nurse-LPN) said she was R1's nurse on 4/16/24 when she had the incident with R3. R1 has dementia and a stroke and could not communicate well. Around dinner time she was at the nurse's cart, and she heard the staff yell out for help, she went to the dining room and R3 was on the floor. R1 flipped R3 out of his chair. V10 said she had an incident with R1 one day. R1 got his coat and was trying to leave the facility. She called out his name to come back and he turned around and came at me with his fists in the air. There was another incident when he threw a can of pop at another staff member. He had unprovoked behaviors.

On 4/29/24 at 2:33 PM, V14 (CNA) said she was in the dining room on 4/16/24 the day of the incident with R1 and R3. My back was turned and she heard R3 yell and saw him on the floor. R1 came up to R3 and kicked his chair over to the floor.

R3's Incident Report dated 4/16/24 documents

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(R1) pushed the chair onto the floor in the dining room. R3 was very scared afterwards. Resident description: (R1) threw me over in my chair.

The facility's Final Abuse Report dated 4/21/24 documents on 4/16/24 at 5:00 PM, staff reported R3 was sitting in a chair that R1 was sitting in. R1 tipped the chair over and R3 fell to the floor.

R1's nurse's note dated 4/18/24 at 4:18 PM, R1 will be a 1:1 until further notice.

The facility's Final Report dated 4/23/24 documents on 4/18/24 at 3:30 PM, R4 stated R1 came to her room and exposed himself. R1 does not recall and denies doing this .... R1 was placed on 1:1 supervision until his discharge on 4/21/24. The final report does not include R1 was arrested and taken into custody with police.

R1's Police Incident Information dated 4/20/24 shows incident/reason for stop: aggravated criminal sexual abuse.

R1's nurse's note dated 4/20/24 documents R1 exited the building with Police escort.

On 4/30/24 at 12:35 PM, V1 (Administrator) said R1 was admitted from another local long term care facility. We did have some knowledge of some behaviors. We sent a representative to evaluate him, and we decided to admit him. This facility tries to take the more difficult patients. The first red flag was the incident of him exposing himself to a female staff, R1 also became physically aggressive with the housekeeper. On 4/13/24, R1 made contact with R2 in the hallway, he was placed on supervised checks. On 4/16/24, R1 flipped R3 out his chair and R3 landed on the floor. On 4/18/24, R1 was in the hallway outside

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of R4's room. R1 exposed himself to R4 and tried to touch her. We've had residents like this before. R1 was being supervised, supervised checks anybody and everybody can have eyes on him there is no assigned person to monitor him. After the incident R1 was placed on a 1:1 on 4/18/24. On 4/20/24 he received a call from his staff, the police were in the building for R1. R1 was arrested and escorted with the police.

On 5/1/24 at 9:55 AM, V3 (R1's Psychiatrist) said he heard of R1 causing lots of behaviors. We would recommend supervision checks every 15 minutes and if behaviors continues, he should have been placed on a 1:1 supervision. I would have recommended not to admit this resident.

On 4/29/24 at 10:28 AM, V5 (Psych Rehab Social Services) said she was not aware of R1's history of behaviors. We were trying to send R1 due to physical aggression and attempted to find placement. Residents with behaviors should be placed on 15-minute checks or 1:1 supervision. Someone should be assigned to the checks, it's typically the CNAs or the nurse doing the checks.

On 4/29/24 at 12:42 PM, V4 (Social Service Director) said once we receive a referred from another nursing home, management decided if they are appropriate to be admitted. She is not part of the admission process and was not aware of his behaviors. R1 had physical behaviors shortly after being admitted to the facility towards staff then became physical aggressive towards residents and sexually inappropriate to R4. R1 was supposed to be on 15-minute checks before the incident with R4 due to his behaviors. We communicate to the nurses and CNAs when a resident is on supervised checks. Nursing does the documentation of the checks. R1 was an

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identified offender, we usually place them in groups to manage behaviors/coping skills but due to his diagnosis of dementia he could not retain the information. Behavior monitoring should be done as well. We were aware of the potential situation, that's why he was supposed to be supervised. I don't know what else we could have done, we tried to send him out. R1 went to jail from here, after the incident with R4.

On 4/29/24 at 2:21 PM, V10 (RN) said R1 had dementia and could not communicate well. On 4/16/24, she was R1's nurse. R1 flipped R3 out of his chair and threw a can of pop at one of the CNA's. He was sent out to the local hospital and returned. After that incident he was supposed to be on 15-minute checks. There is paper sheet to sign. Usually, the CNAs sign off the sheets because they are the ones on the floor. The nurses are too busy to sign off the sheets.

On 4/29/24 at 2:33 PM, V14 (CNA) said R1 was very combative, usually towards the staff. On 4/16/24, she was R1's CNA when he flipped R3 out of his chair. I don't know if was on 15-minute checks. The CNAs are responsible for signing off the checks, there's a sheet of paper we have to initial the time and location of the resident.

On 4/30/24 at 8:20 AM, V12 (LPN) said R1 was confused and aggressive at times. R1 was supposed to be on supervised checks, the form is at the nurse's station, and we all sign it off. We all participate on signing of the checks. R1 was then placed on 1:1 supervision after several incident towards residents.

On 4/30/24 at 9:46 AM, V19 (LPN) said she had been R1's nurse on several occasions. There was an incident when R1 was being sexually

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inappropriate to a CNA, there was an incident when a staff member got "choked up," and another time when R1 was following a CNA around the nurse's station. On 4/18/24 she was R1's day nurse. We were short CNAs; we were supposed to keep an eye out for him. R1 was supposed to be supervised after he attacked other residents, but we were short staffed. Not sure who was signing off the sheets, the 15-minute check sheet is at the nurse's station, anybody can sign it.

On 4/30/24 at 8:01 AM, V11 (LPN) said on 4/18/24, he was R1's nurse during PM shift. Sometime after 3:00 PM, I was starting to pass resident medications. I noticed management running down the 400 hall. It was reported to me R1 had sexually assaulted another resident (R4). Prior to the incident R1 was allowed to walk around freely. He was not on supervision prior to the incident only 1:1 after the incident.

On 4/30/24 at 8:54 AM, V15 (CNA) said on 4/18/24 she heard a female resident yelling out for help she saw R1 in the hallway outside of R4's room pulling up his pants. R4 said R1 touched me and exposed himself to her. R4 was crying and distressed. She was so scared she urinated through her pants. V15 said she was not R1's CNA, that day she just happened to respond to R4 yelling for help. V15 said she had heard of some of the incidents he had with other staff and residents. R1's behaviors were unpredictable.

On 4/30/24 at 9:19 AM, V16 (CNA) said R1 was very combative and irate he was not really redirectable. On 4/18/24 she worked the PM shift; he was supposed to be on 15-minute checks prior to the incident with R4. She was not his assigned CNA and was not doing the supervision

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checks.

On 4/30/24 at 9:25 AM, V17 (CNA) said R1 would walk around the facility, he used to fight with other residents then walk off and start another fight. I saw him start fights unprovoked. On 4/18/24, she worked the PM shift on the 300 hall. The 400 hall where R1's room was, split between staff. If a resident is on 15 checks it depends on who is available to monitor the resident. She was not assigned to R1 that day and was not supervising him.

On 4/30/24 at 9:33 AM, V18 (CNA) said on 4/18/24 she worked the PM shift, we split the rooms on the 400 hall, I do not recall having him that day. If a resident is on 15-minute checks the nurse will notify you and the CNA is responsible for doing the checks.

On 4/30/24 at 11:15 AM, V20 (CNA) said R1 wound wander a lot, he was on 15-minute checks on 4/18/24 from the start of my shift at 12:00 PM. I did not have him that day and was not doing his checks. V21 (Activity Aide) was supposed to be assigned to him.

On 4/30/24 at 11:41 AM, V21 (Activity Aide) said she worked on 4/18/24 from 11:00 AM to 8:43 PM. She did activities from 1:00 PM to 4:15 PM including happy hour and bingo. She started one to one monitoring with R1 about 4:45 PM until she left that night. R1 was being monitored due to his behaviors. She was not monitoring R1 prior to 4:45 PM, she was doing resident activities.

On 4/29/24 at 2:05 PM, V2 (DON) said R1 started having behaviors, erratic behaviors, all of sudden he was fine then not fine. R1 was on 15-minute checks prior to the incident when went off of the

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checks. R1 was doing great and walks down the hallway and does that. R1 exposed himself to R4 and tried to touch her right breast. I want to say he was off the checks prior to the incident. If a resident is on supervised checks who every is assigned to him should be documenting the location of the resident.

R1's 72 hour 15-minute check form dated 4/13/24 to 4/15/24 shows there were no checks signed off on 4/15/24.

R1's 72-hour 15-minute check form dated 4/16/24 to 4/18/24 shows on 4/16/24 at 9:15 PM to 4:45 AM, R1 was in the facility. (R1's nurse note dated 4/16/24 showed R1 was not in the facility at 9:15 PM, R1 left the facility at 9:02 PM and returned on 4/17/24 at 4:03 AM.)

The same form shows on 4/17/24 at 5:00 AM to 11:45 AM, R1's location is listed as hospital/ER. (R1's nurses note dated 4/17/24 showed R1 was in the facility at 5:00 AM to 11:45 AM, not in the ER).

R1's care plan initiated on 4/1/24 shows he has a history of aggressive, inappropriate, attention-seeking, and/or maladaptive behaviors ...the history includes threatening behavior, verbal or physical aggression, acting impulsively, erratically, disrespectful, insulting, demeaning behavior. Interventions include conduct a review of past behaviors and evaluate the likelihood for aggressive/inappropriate behaviors during initial assessment, intervene, communicate R1 must have self-control over impulse behaviors, refer to mental health professional, give psycho-active medications and record behavioral symptoms, refer to mental health professional including consulting psychiatrist for evaluation of the

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 05/07/2024

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
S9999	Continued From page 13	S9999		

resident's symptoms warrant further assessment or on-going management.

R1 exhibits behaviors that include targeting staff following staff being sexually inappropriate with interventions include to keep distance between residents and others if resident becomes physically aggressive, make sure resident is safe and allow time to calm self, intervene if inappropriate behavior is observed. Communicate to the resident must exercise self-control.

R1 has a history of criminal behavior. R1 has demonstrated stability during the admission process, does not appear to present an unusual risk and is there for considered appropriate for admission. According to the available history he has been arrested and convicted of a crime(s) and has served jail time or correctional facility. Risk assessment is still waiting to be received. (The care plan does not list the crimes R1 committed). Interventions include conduct a review of past behavior & evaluate potential for aggressive/high risk behavior. Screen the state police and DOC data base ...evaluate ability to control impulses. Document the information learned about the criminal behavior, provide supportive group, 1:1 or as needed intervention, teach impulse control strategies, follow appropriate standards when considering room assignments.

R1's Screening Assessment for indicators of aggression and/or harmful behaviors dated 3/27/24 shows he scored a 0 for history of recent episode of aggressive/agitated behaviors, 0 for history of substance abuse, 0 for history of criminal behavior. Total score of 2. The assessment documents R1 has no history of abuse prior to admission, no history of presence

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S9999	Continued From page 14 of dysfunctional behavior (including provoking, aggressive, disrespectful, inappropriate behaviors), no history of mistreating others. Total Abuse Score of 2.0. Indicating potentially to integrate into the peer community and minimal risk for aggression. R1's assessment does not show an accurate risk or abuse assessment was performed. R1's Behavior Monitoring and Interventions Report dated 3/20/24 to 4/17/24 shows "no results found." The facility's Safety and Supervision of Residents Policy & Procedure dated 9/22, states, "Resident safety and supervision and assistance to prevent accidents are facility wide priorities ...resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs ...the type and frequency of resident supervision may vary among residents ..." (B)	S9999		