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 _____	10/24/2024

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
S 000	Initial Comments Annual Licensure Certification & Complaint Survey: 2417920/IL178684 & 2418563/IL179611	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1210b) 300.1210d)5 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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 _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 1	S9999		

care needs of the resident.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review the facility failed to follow up a report of a stage 1 pressure injury resulting in the progression of the injury,and not being identified and treated until it became a stage 3, and failed to implement interventions to prevent the development of a pressure injury for 2 of 3 residents (R90, R122) reviewed for pressure injuries in the sample of 33.

The findings include:

1. R90's admission record shows he was admitted to the facility on 1/8/19. The 9/30/24 resident assessment and care screening documents R90 to have severe cognitive impairment and is dependant on staff for his personal hygiene needs and mobility. The same

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 _____	10/24/2024

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 2	S9999		

assessment shows he is at risk of developing pressure ulcers/injuries and had one stage 4 pressure injury present. The bowel and bladder assessment shows he is always incontinent.

The October 2024 bath and shower sheet shows on 10/10/24 a reddened area was noted by V31 (CNA/Certified Nursing Assistant) during his bed bath. The nursing progress notes were reviewed for skin check and assessment related to the reddened area and none were found.

On 10/23/24 at 9:30 AM, R90 was observed in bed, he had a dressing to his right hip. The wound on his right hip was noted to be irregular in shape and just larger than a quarter. The surface of the wound was covered with white tissue and the edges were slightly reddened. R90 was not able to provide any information or voice concerns due to his cognitive status.

On 10/23/24 at 10:00 AM, V25 (RN/Registered Nurse) said (R90) acquired the pressure wound to the right hip in the facility. He said the new wound was initially identified at a stage 3 after it was reported by a CNA about 2 weeks ago. V25 said it is ideal to find wounds prior to becoming stage 3. He said he completed an assessment after it was reported to him.

The wound and skin alteration reviews for October 2024 show on 10/9/24, R90 had wounds to his sacrum and right buttocks. The 10/16/24 weekly skin assessment completed by V25, shows a stage 3 pressure injury measuring 3.0 x 2.0 x 0.2 cm (centimeters) on the right hip. The area was documented as a new wound. The actions taken were orders received and carried out. The family notification was not marked and not documented in the comments of the report or

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 _____	10/24/2024

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 3 in the nursing progress notes. On 10/24/24 at 10:29 AM, V30 (CNA) said residents get showers twice a week and if they refuse it is reported to the nurse. When residents are incontinent they are changed and care is provided every 2 hours, and skin is checked at that time. V30 said (R90) does refuse his showers and gets bed baths. He is also incontinent of bowel and bladder so staff has to change him every 2 hours and do his skin checks. If there is any reddened areas or spots, they are reported to the nurse and V25. If found during a bath, it is marked on the shower sheet by circling the area. V30 said the shower sheets are then turned into the Director of Nursing. On 10/24/24 at 9:39 AM, V16 (LPN/Licensed Practical Nurse) and former wound nurse said skin checks done with showers twice weekly. If they refuse showers we will just ask to see their skin. It is important to make sure there is no skin breakdown if any skin breakdown is starting it is important to get interventions started to prevent any further breakdown. If a CNA finds reddened areas, it should be reported to the floor nurse and the wound nurse. Nurses should be documenting in the progress notes when any skin issue is identified or reported. The initial assessment should be completed by whoever finds it and include measurements and location of the skin issue. She said notifications are done to the wound physician, V2 (DON/Director of Nursing), V25, and the POA (Power of Attorney)/Guardian. and NP (Nurse Practitioner). V16 said skin breakdown/wounds should be identified prior to becoming a stage 3. She said there would be signs such as redness before it becomes a stage 3.	S9999		

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	IL6001135	A. BUILDING: _____ B. WING _____	10/24/2024

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 4	S9999		

The facility 7/2022 policy for wounds shows 3. Upon identification of the development of a wound, the wound assessment will be documented. 5. Residents should be examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers. 6. Nurse Aides should complete a shower sheet on all residents when they are bathed or showered and given to the charge nurse. b. After review by the charge nurse, the shower sheet should be given to the wound nurse, or designee for appropriate follow up.

The 2/1/22 policy for change in resident's condition documents it is the policy of the facility, except in a medical emergency, to alert the resident's physician/NP (Nurse Practitioner) and resident's responsible party of a change in condition.

2. On 10/23/24 at 9:13 AM, V25 (RN/Registered Nurse/Wound Care Nurse) and V22 (LPN/Licensed Practical Nurse) went into R122's room to provide care and dressing change for her pressure injuries. R122 was laying on her back in bed. V25 removed the blanket from R122's legs and feet. R122's off loading boot was not in place to her right foot. V25 stated he did not remove R122's offloading boot before coming in to provide wound care. V25 stated R122 has a deep tissue injury to her right heel and came back from the hospital with the wounds. V25 had gloves on and applied skin prep to R122's right heel. The right heel had a large dark purple/black area present.

The Wound Care Physician's Initial Wound Evaluation & Management Summary dated 10/15/24 for R122 showed, deep tissue injury of the right heel. Float heels in bed; off-load wound;

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 _____	10/24/2024

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 5	S9999		

reposition per facility protocol; turn side to side every 1-2 hours if able.

The Care Plan dated 10/18/24 for R122 showed, documented pressure ulcer to right heel and left lateral foot, unstageable deep tissue injuries related to mechanical forces, pressure over bony prominence's, impaired circulation, and psychogenetic factors manifested by being dependent for activities of daily living/mobility, generalized weakness, diagnoses of dementia, epilepsy, and subdural hemorrhage. Right heel measures 3.5 x 5.7 cm. Maintain off-loading heel boots.

The Face Sheet dated 10/23/24 for R122 showed diagnoses including transient cerebral ischemic attack, dementia, cardiac arrhythmia, hypertension, traumatic subdural hemorrhage, hyperlipidemia, and epilepsy.

The Pressure Ulcer and Skin Condition Assessment policy (10/2011) showed, the resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. The policy did not address pressure ulcer prevention.

(B)

Licensure Violations 2 of 3

300.610a)
300.1210b)
300.1210d)1
300.1210d)2

Section 300.610 Resident Care Policies

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 _____	10/24/2024

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 6 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These Requirements were NOT MET as	S9999		

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 _____	10/24/2024

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 7	S9999		

evidenced by:

Based on interview, and record review the facility failed to ensure a resident with a history of embolic strokes (R167) and another resident (R116) received physician ordered anticoagulants for 2 of 8 residents (R167 & R116) reviewed for significant medication error in the sample of 33. This failure resulted in R167 requiring emergency transport to the hospital for an acute embolic stroke. R167 was hospitalized until 10/15/24, when he passed away.

The findings include:

1. R167's Facesheet dated 10/22/24 showed diagnoses to include, but not limited to: stroke due to embolism, nicotine dependence, encephalopathy, hypertension, deep vein thrombosis, chronic obstructive pulmonary disease, unsteadiness on feet, repeated falls, weakness, and long-term use of anticoagulants and antithrombotics/antiplatelets. This document showed R167's original admission to the facility was 9/27/24.

R167's Physician Order Sheet printed 10/22/24 showed an order for Xarelto 15 mg (milligrams) twice a day for stroke due to embolism. This order was entered on 9/27/24.

R167's MAR (Medication Administration Record) showed he R167's was scheduled to received Xarelto 15 mg in the morning and the evening, starting 9/28/24. R167's MAR showed there were entries for 9/29/24, 9/30/24 and 10/1/24 that showed the medication was on order from pharmacy or a progress note was entered. (According to pharmacy, R167's Xarelto was delivered to the facility on 10/1/24. R167's should

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 _____	10/24/2024

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 8	S9999		

have received 6 doses of the medication during that time.)

R167's Progress Note dated 9/28/24 at 4:02 PM, showed R167 had returned to the facility from a facility initiated transfer.

R167's Progress Note 9/29/24 at 11:05 PM, showed "This writer just spoke with [consulting pharmacist] regarding the status of atorvastatin and xarelto. Atorvastatin will be delivered tonight. Xarelto is not covered by resident's insurance. Asked pharmacist what would be covered as an alternative and he reports it is not in the notes, billing department will know that and they will be in tomorrow morning at 0600. [V12-NP] informed.

R167's Progress Note dated 10/1/24 showed he lost his balance, pushing his wheelchair and fell on the dining room floor. There were no injuries noted.

R167's Progress Notes dated 10/4/24 at 9:15 PM, showed, "Residents family have been here with resident most of the PM shift. Resident has had no changes in baseline mental status. Resident's niece states at 9:10 PM, "I'm scared my uncle might have had a stroke earlier when we were taking to him, but I really don't know." CNA [Certified Nursing Assistant] reports she just assisted resident back to bed and that his behavior was fine, he was speaking to her, and had no abnormalities. This RN [Registered Nurse] did neuro assessment and no signs that resident had a stroke..."

R167's Progress Notes dated 10/5/24 at 5:50 PM, showed "At approximately 5:50 PM resident started having seizure in the dining room that lasted 2 minutes. Staff immediately notified

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 _____	10/24/2024

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 9	S9999		

nursing - accucheck 168. Pulse oximetry 73% on room air... 911 called while nursing helped resident in the dining room... 23:00PM resident admitted with stroke diagnosis."

R167's Xarelto prescription dated 9/27/24 showed the medication was to be administered twice a day.

R167's Xarelto Manifest showed it was delivered to the facility on 10/1/24 at 8:00 PM.

R167's Emergency Room records dated 10/5/24 showed he had a history of strokes, had a seizure prior to arrival. The facility reported the patient had a two minute seizure in the dining room. The records showed the family reported an episode of aphasia yesterday, which as resolved. These notes showed R167's was admitted to the hospital on 10/5/24 for an embolic stroke.

R167's Neurology Progress Note dated 10/7/24 showed R167 had recurrent bi-hemispheric embolic strokes.

R167's Hospital Discharge Summary dated 10/15/24 showed R167 died.

R167's Death Certificate showed he died on 10/15/24 and the primary cause was recurrent emobilic strokes.

On 10/22/24 at 2:15 PM V2 (Director of Nursing/DON) said when a resident is admitted from the hospital the discharge medication list is used to order the resident's medications at the facility. V2 said the nurse will enter the orders when the resident is admitted. V2 said when the order is entered, the order is sent to pharmacy to fill the medication. V2 said sometimes there is an

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 _____	10/24/2024

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 10	S9999		

issue with the insurance and pharmacy will send an authorization notice. V2 said if the medication isn't available for more than a shift and a half, then I get involved. V2 said she expects the nurses to report any medication that has not been received from pharmacy to her. V2 stated, "I know I was in contact with the pharmacy about [R167's Xarelto]. I told them to send it." V2 said she isn't sure if Xarelto is in the automated medication dispensing system, but stated, "It should be." V2 said she thought the issue was taken care of because the nurses hadn't reported any issues to her. V2 said she doesn't know if R167 received his scheduled Xarelto prior to 10/1/24. V2 said she doesn't know why the Xarelto was documented as "administered" by some nurses. V2 said she had no idea how a nurse would give a medication that wasn't available because they aren't supposed to "borrow" medications from another resident. (R167's Xarelto was delivered on 10/1/24 at 8:00 PM.) V2 said the automated medication dispensing system was changed six months ago and there are a few nurses that still don't have access to it. V2 said Xarelto is a blood thinner and is used to prevent clot formation and decrease the risk for stroke. V2 said she wasn't sure what happened to R167. V2 reviewed R167's Electronic Medical Record (EMR) and said it looked like he had seizure activity and was sent to the emergency room. At 3:28 PM, V2 accessed the automated medication dispensing system. The automated medication dispensing system was small, the size of a mini-refrigerator and across the room there was a plastic storage container, with a padlock affixed to it. V2 said if the medication isn't inside the smaller automated medication dispensing system, then a key will be obtained to open the lock on the plastic container. V2 checked for Xarelto and was unable to obtain

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 _____	10/24/2024

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 11	S9999		

it from the automatic dispensing system. V2 stated, "I'll have to sign out the key and check over there." V2 signed out the key and opened the plastic storage container to expose multiple small, divided containers. V2 picked up a small plastic container and stated, "Look at this. There isn't even a label on this to tell me what is inside. I just have to look at each separate medication. This system is ridiculous. I hate it." V2 stopped and stated, "This will take forever. Do we have to go through each one? Can I just get the list from pharmacy that shows what medications are available." V2 locked the cabinet and returned the keys to the automated dispensing system.

On 10/22/24 at 1:10 PM, V6 (Licensed Practical Nurse/LPN) said she wasn't sure if Xarelto was available in the automated medication dispensing system. V6 said she didn't have access to the system. V6 said the system was changed about 6 months ago and there were still nurses that didn't have access.

On 10/22/24 at 4:03 PM, V9 (LPN) said she doesn't remember R167 or any specific information regarding him. V9 said she does not have access to the facility's automated medication dispensing system. V9 said she would have to ask another nurse to access, but stated, "She hasn't come across anyone that had access to it while I was working."

On 10/23/24 at 7:59 AM, V12 (Nurse Practitioner/NP) said R167 was admitted from the hospital after he had a stroke. V12 said the nurse reviews the medications and enters the orders into the EMR. V12 said she expects the medications to be administered as ordered. V12 said R167 was on Xarelto because he had a stroke caused by a blood clot. V12 said it was

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 _____	10/24/2024

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 12	S9999		

important R167 received the medication as it was ordered to prevent blood clot development and reduce the risk of stroke. V12 said missing 6 doses of the Xarelto could have contributed to R167 having an acute embolic stroke on 10/5/24. V12 said she didn't order an alternative blood thinner because she was under the understanding that insurance issue was addressed promptly. V12 said she would expect the facility to obtain R167's medications in a timely manner.

On 10/23/24 at 9:08 AM, V11 (Pharmacy Consultant) said Xarelto is an anticoagulant medication that is prescribed to prevent blood clots and strokes. V11 said R167 could be at an increased risk of stroke if multiple doses were missed. V11 said Xarelto was not a medication stocked in the automated medication dispensing system. V11 stated, "Today [V2-DON] called and we will be adding Xarelto to the stock." At 10:34 AM, V11 said R167's Xarelto order was entered on 9/28/24 at 11:48 PM; the pharmacy sent a message to the facility that authorization was needed on 9/29/24 at 7:49 AM; the facility responded to the authorization message on 9/30/24 at 8:17 AM; and the medication was delivered to the facility on 10/1/24 (at 8:00 PM).

R167 no longer resides in the facility; expired in the hospital

2. R116's face sheet showed he was admitted to the facility on 1/24/24 with diagnoses to include chronic systolic congestive heart failure, atrial flutter, stage 3 chronic kidney disease, cardiomyopathy, anemia in chronic kidney disease, and cirrhosis of liver.

R116's October 2024 Physician Order Sheet

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 _____	10/24/2024

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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S9999	Continued From page 13	S9999		

showed an order for an anticoagulant dated 10/18/24 for Rivaroxaban (Xarelto) 20 mg daily for atrial flutter.

R116's October 2024 eMAR (electronic Medication Administration Record) showed an order for warfarin (anticoagulant) was discontinued 10/18/24 and a new order for Rivaroxaban (anticoagulant) was started 10/19/24. R116's eMAR showed his warfarin was not administered 10/17/24 or 10/18/24 due to being on order with pharmacy. The same eMAR showed R116's Rivaroxaban was not administered 10/19/24, 10/20/24, and 10/21/24 due to not being delivered by pharmacy. R116 went without an anticoagulant for a 5 days.

R116's Late Entry Nursing Note entered on 10/23/24 at 1:18 PM (after an Immediate Jeopardy was declared related to anticoagulant therapy not being administered) but dated for 10/18/24 at 5:15 PM showed, "Received new order from [R116's Physician]. New order processed for Xarelto (Rivaroxaban) d/t abnormal EKG for Atrial flutter. Ok to start when arrives from pharmacy."

The facility provided a list of medications available in the automated medication dispensing system on 10/23/24. Xarelto was not a medication listed. There was a handwritten note attached to the list that stated, "Have already requested that Xarelto be stocked in the cubex."

The facility's Administering Medications Policy and Procedure dated 1/1/20 showed, "To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure: ...3.

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S9999	Continued From page 14	S9999		

Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity.... 6. Medications should be administered within one hour of the prescribed times..."

The facility's Physician's Order Policy dated 12/2013 showed, "All resident medications and treatments must be ordered by a licensed physician or nurse practitioner..."

The facility's undated Ordering Medications Policy showed, "Policy: Medications and related products are ordered from [contracted pharmacy] on a timely basis. Procedure: New medication order requests can be faxed to the pharmacy's main fax number, sent via electronic health records, EHR system, electronically prescribed by the prescriber, and/or called in by the appropriate personnel according to State laws and regulations..."

(A)

Licensure Violations 3 of 3

300.610a)
300.1210b)

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

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S9999	Continued From page 15	S9999		

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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

These Requirements were NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a resident with their last known weight of 1/2024 showing a significant weight loss, failed to conduct, monitor weights and record, failed to ensure a resident with significant weight loss had a quarterly nutritional assessment by a dietician, and failed to ensure a resident with significant weight loss had interventions implemented to prevent further weight loss for 1 of 6 residents (R103) reviewed for nutrition in the sample of 33.

These failures resulted in R103 not being weighed or seen by a dietician for 9 months after a significant weight loss occurred.

The findings include:

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S9999	Continued From page 16	S9999		

R103's face sheet showed a 73-year-old male with diagnosis of schizophrenia, major depressive disorder, and anxiety disorder.

On 10/23/24 at 9:30 AM, R103 was in his bed supine. R103 was pale, cachectic and lying on an unmade bed (no linens or pillows). R103 had clear speech and said he eats his meals in his room. R103 was calm and not interviewable.

At 12:23 PM, R103's lunch tray was untouched on a bedside table in his room. The table was not within reach of the resident. R103 was in bed covered with a coat. The room was dark. The lights were off, and the window coverings were closed.

At 10:00 AM, V19 (Licensed Practical Nurse/LPN) said meal intakes for R103 are "hit or miss." Sometimes he will throw his tray into hallway. It's just however he feels. V19 said restorative monitors resident weights. They do monthly weights. Maybe dietary does it too.

At 10:50 AM, V16 (Assistant Director of Nursing/ADON) was asked what nutritional approach performed meant on R103's physician order sheet and medication administration record (MAR). V16 said she wasn't sure and would find out. At 11:08 AM, V16 said it meant it was verified that the resident was served the correct diet.

At 12:25 PM, V19 (LPN) was asked what nutritional approach provided meant. V19 said she didn't know. V19 was asked if she monitored that the residents received the correct diet ordered and she said "The kitchen should be serving the correct diet and if not the CNA (Certified Nursing Assistant) will let me know if

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S9999	Continued From page 17	S9999		

the wrong diet is served. I do not go around checking each residents tray."

At 12:31 PM, V38 (Restorative Nurse) said, "We do monthly weights. Some refuse and if they refuse, I try to remember to document that." V38 said, "We seldom catch (R103) 'in a good mood'.The other day he was receptive to me. (R103's) last recorded weight was in January and was 138.8 pounds. The dietitian looks at the weights after we record them."

On 10/24/24 at 8:54 AM, V32 (Dietary Manager) said R103 is on Med Pass (nutritional shake). V32 confirmed after reviewing R103's record with this surveyor that no nutritional dietary assessment was done by a dietitian since January 2024. V32 said a nutritional assessment should be done quarterly. If weights and dietitian assessments are not done weight loss can continue. V32 said there was no documentation or care plan interventions to increase calorie intake, diet compliance or encourage PO (oral) intakes. V32 said, "Any interventions would be implemented after a discussion between the Dietician and me and there is no documentation that occurred. Any new interventions should be care planned." Evidence of dietary interventions was requested, and none were received.

At 9:39 AM, V21 (Dietitian) said she had been at the facility for 2 to 3 months and was not aware of any concerns regarding R103. V21 said it was concerning he hasn't had any weights done. V21 said she speaks to the facility weekly and looks at everyone with a significant weight loss. V21 said, "If a resident refuses to be weighed they should be reapproached when they're having a good day and should be followed up. If there isn't a monthly weight documented, they should do a re-weigh.

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S9999	Continued From page 18	S9999		

Residents are weighed monthly to make sure they're on track. A weight loss or gain would trigger us to see and assess them. Residents whose weights are not monitored could continue to lose weight. Interventions might include extra portions, supplements, add foods based on their preferences and snacks. I do think more could have been done. Due to behaviors, if a resident refused weights or interventions, I would request staff to reapproach on another day the resident was more receptive."

R103's 8/15/24 showed severe cognitive impairment.

R103's nutritional risk reviews (done by V32 Dietary Manager) dated 2/23/24, 5/20/24, and 8/15/24 showed current weights of 138.8 pounds. All three reviews showed meal intakes of 26-75% independently with in-direct supervision.

R103's weight record showed his 12/6/23 weight was 151.2 pounds.

R103's last recorded weight was on 1/18/24 at 138.8 pounds (an 8.20% weight loss in one month).

R103's physician order sheet showed a general diet order with mechanical soft texture, regular thin liquid consistency, and a room tray. A 7/23/24 order showed nutritional approach performed every day and evening shift for monitoring. There were no current orders for nutritional supplements (Med Pass) or appetite stimulants. There were no orders for a snack, pudding, or double portions.

R103's 10/22/2020 care plan interventions included to weigh the resident monthly and make

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S9999	Continued From page 19	S9999		

a referral to the doctor/Registered Dietician if there is a 5% weight loss over 30 days. There have been no care plan interventions in 2024 to increase caloric intake, improve diet compliance, increase appetite, or encourage oral intake.

R103's medication administration record (MAR) showed V19 (Licensed Practical Nurse/LPN) provided nutritional approach 18 times (as indicated by her initials).

R103's restorative notes showed monthly weights were refused in May, June, August, and September 2024. There were no documented refusals for February, March, April, July, or October 2024.

R103's 1/15/24 dietitian note showed to add resident to weekly weights and perform a medication review for appropriateness of an appetite stimulant. This note showed a 7.8-pound weight loss in one month and recent significant weight loss months prior.

The facility's 1/2024 Weight Assessment and Interventions Policy showed the purpose was to ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner. Weigh the resident upon admission and weekly for a total of four weeks. Monthly weights will be done thereafter if no issues are identified. Weights will be entered in the resident's medical record. The dietician will review the weight record to identify and address weight issues. Significant weight changes are defined as 5% weight gain/loss in 30 days. The dietician will document desirable and undesirable weight changes and will discuss with the interdisciplinary team to identify possible approaches/interventions. If a

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S9999	Continued From page 20 resident refuses to participate in weight interventions, the dietician will document the resident's wishes. (B)	S9999		