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 01/28/2025

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FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S 000	Initial Comments Complaint Survey: 2510571/IL185023	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2)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		

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 interview and record review, the facility failed to assess a resident's pressure injuries in a timely manner and failed to implement pressure injury treatment interventions for 1 of 3 residents (R1) reviewed for pressure injuries. These failures resulted in R1's pressure injuries deteriorating from two Stage 2 pressure injuries into one unstageable pressure injury.

The findings include:

R1's Admission Record dated 1/27/25 shows R1 was admitted to the facility on 12/20/24 with the following diagnoses: sepsis, diabetes mellitus type 2, pressure ulcer of right buttock, stage 2,

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pressure ulcer of left buttock, stage 2, high cholesterol (hyperlipidemia), a right below knee amputation, congestive heart failure, methicillin resistant staphylococcus aureus infection, gastroesophageal reflux disease (GERD), osteomyelitis, hyperglycemia, and bacteremia (blood stream infection).

R1's After Hospital Care Plan (printed 12/20/24) shows orders for R1's Stage II pressure injuries of his right and left buttocks which were to be treated twice a day. R1's Order Recap Report dated 1/27/25 shows orders dated 12/20/24 for R1 to receive wound treatment to his left and right buttocks twice a day, every day beginning 12/20/24. R1's Wounds record (printed 1/27/25) for 12/1/24-12/31/24 shows R1 did not receive 16 of 19 treatments between 12/20/24 and 12/30/24. No documentation was provided showing R1 had refused any of those wound treatments.

The facility's Pressure Wound Report provided by the facility on the morning of 1/27/25 with a reporting date of 1/21/25, shows R1 has an unstageable pressure ulcer of his sacrum (upper buttocks area) and does not have a statement signed by the physician to indicate it is "unavoidable." As of 1/28/25 at 10:26 AM, there was no "Unavoidable Disruption in Skin Integrity" statement for R1, nor were there any documented refusals of wound care treatment for R1.

R1's current care plan provided by the facility marked "care plan closed date 1/27/25" "reason for close: discharge," shows R1 has a self care deficit related to weakness, impaired balance, limited range of motion, pain, and physical inactivity and requires extensive to total assistance with mobility related tasks and dressing. R1 needs two staff assistance with

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turning/repositioning and transferring with a mechanical lift, he is non-ambulatory, and his primary mode of locomotion is via a wheelchair. The same care plan shows a focus that R1 (as of initiation date of 12/22/24) is at increased risk for alteration in skin integrity as evidenced by mechanical factors, pressure over bony prominences, moisture, impaired circulation, and alteration in sensation.

R1's Admission/Readmission Screener dated 12/20/24 at 4:55 PM, under the question, "Does the resident currently have any skin abnormalities (i.e. bruising, skin tears, pressure injuries, etc)?" There is no pressure injury listed. R1's Wound and Skin Alteration Review (Wound Nurse) dated 12/27/24 at 10:59 AM shows R1 has a nonstageable (NS) sacral (upper buttocks area) pressure injury measuring 7.2 by 8 by 0.1 centimeters with 90 percent slough. Under number 7. Healing Process, "New Wound" is marked. This same document shows a Stage 2 Pressure Injury is partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough and an Unstageable Pressure Injury is full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown, and/or eschar (tan, brown, or black) in the wound bed.

On 1/27/25 at 11:50 AM, V3, Wound Care Nurse, said residents' wounds are supposed to be assessed within 24 hours of being admitted. V3 said R1's initial wound assessment was not done until 12/27/24; the admitting nurse did not identify R1's buttock wounds upon admission (on 12/20/24). V3 said R1's admitting diagnoses show R1 was admitted with Stage 2 pressure wounds of his right and left buttock, but when he

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assessed R1's wounds he saw overlapping wounds and classified the wound as an unstageable pressure wound of the sacrum. V3 said R1 was admitted with wound treatment orders on 12/20/24 to be done twice a day, every day of the week to the right and left buttocks. V3 said R1's wounds should have been assessed upon admission and treatments completed as ordered. V3 said the purpose of wound treatment is to try to help heal the wound, prevent infection, and to prevent it from deteriorating and getting worse. V3 said without wound treatment, wounds can deteriorate and get worse.

On 1/27/25 at 12:46 PM, V2, Director of Nursing (DON), said R1 was admitted to the facility on 12/20/24 and she entered R1's wound treatment orders from his discharge orders from the hospital which should have been started that same day, as per physician orders. V2 said if the wound care nurse is in facility, when a resident is admitted, they do the admission skin/wound assessment, otherwise the admitting nurse does it. They should measure open wounds, but, some floor nurses are not comfortable staging them, a full wound assessment should be done optimally within 24 hours of admission. V2 said V4, Licensed Practical Nurse (LPN), was covering the wound care position on 12/18/24, 12/19/24, and 12/20/24 while V3 was on vacation.

On 1/28/25 at 8:33 AM, V4 LPN said she was covering the wound care position on 12/18/24, 12/19/24, and 12/20/24 while V3 was on vacation. V4 said her responsibilities as wound care nurse included everything the wound nurse would do, such as wound treatments and (skin/wound) assessments of any new admissions. V4 said new admission assessments are done within the first hour or two after residents arrive. If the

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wound care nurse is not in the facility, he/she would do it the following day, but the admitting nurse would do a skin assessment, although they would probably not stage a pressure ulcer (pressure injury), they would document it and some nurses would measure and document the wound characteristics. V4 said the wound nurse would do the full assessment which includes identifying the type of wound, measurements, what the wound/peri wound looks like, any odor, any drainage, any characteristics, any pain, location, and she would stage a pressure ulcer. V4 said R1 was admitted on a Friday after she had already left, so she never saw him or his wound. V4 said the admitting nurse needs to look at the orders and put them in the computer as the floor nurses are responsible for wounds on the weekends. V4 said it would not be ok to do the initial wound assessment a week after a resident was admitted. V4 said a wound could deteriorate during that time. V4 said wound treatments are done per physician orders. The nurse looks at the TAR (treatment administration record), the MAR (medication administration record), and the Wound tabs to see what treatments need to be administered. If a day(s) was crossed out on those tabs, the nurse would not do the treatment. The responsible nurse signs off the day once the treatment is done. V4 said she does not know if R1's primary care provider (PCP) would have seen R1's wound but said if the PCP is giving the treatment orders for a wound, she would think they are evaluating or have evaluated the wound.

On 1/28/25 at 9:04 AM, V5, Nurse Practitioner (NP), said the facility needs to do wound treatments as ordered. If a resident refuses, they need to document that. V5 said R1 should have been seeing the wound care doctor and she did not look at his pressure wounds when she saw

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him in the facility. V5 said a wound can deteriorate in a week and lack of wound treatments could contribute to a wound deteriorating.

On 1/27/25 at 11:01 AM, V6, LPN, said the wound care nurse does the wound care treatments except for on the weekends. The floor nurse would look under the Wound tab to see if there are any wounds requiring treatment and carry out the orders. Once the treatment is completed, the treatment is signed off as being done; if the treatment is not signed off, it was not done. V6 said the purpose of wound care treatment is to keep wounds clean and healing.

The facility's Wound Policy (reviewed 11/2022) shows the purpose is to promote a systematic approach and monitoring process for the care of residents with existing wounds and to promote healing of existing pressure ulcers. The goals of wound treatment include protecting the ulcer from contamination and promoting healing. The policy shows that current standards of Clinical Practice will be utilized.

(B)