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 01/10/2020

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 Facility Incident Investigations: 12/17/19/IL118677 - F689G 12/26/19/IL118741 - F600J	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.615e)j) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by	S9999	**Attachment A** **Statement of Licensure Violations**	

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 01/10/2020

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 1	S9999		

Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

j) 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 background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

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. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

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 01/10/2020

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		

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify a resident with a history of violent behaviors (R8) and failed to prevent a resident (R7) from sustaining physical abuse and psychosocial harm for 3 residents (R6, R7, R9, R12) reviewed for abuse. These failures resulted in R8 hitting R7 in the face and pushing R7 to the ground on 12/26/19. R7 suffered broken ribs and a broken left hip which required surgical intervention.

The findings include:

R8's Admission Record shows he was admitted to the facility on 11/13/19 with diagnoses including: Bipolar disorder, autism, cognitive communication deficit, and insomnia.

R8's Social History and Assessment dated

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 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	S9999		

11/14/19 shows, "Discuss any psychiatric history/treatment, psychiatric illness in the family, substance abuse in the family, and any problems with the law/legal system, arrest, incarceration (Is there a criminal history?)" R8 said he was unsure. This assessment also asks if there are adjustment/mental health behavior issues. Conflictual relationships and adjustment issues are marked as yes. V4 Social Service Director said that the social service department conducted this assessment.

R8's electronic name based background check dated 11/14/19 shows R8's name with a birthdate of 3/22/88. This background check came back with "No record on file". R8's electronic name based background check dated 12/28/19 (two days after the incident with R7) with his correct date of birth (3/20/88) shows "Multiple hits-fee fingerprints requested." On 1/2/2020 at 8:33 AM, V1 (Administrator) said, "We found out we ran it without the right birthdate and then we ran a new one." At 8:45 AM via telephone V8 (Social Services Assistant) said a background check for R8 was not ran again until 12/28/19. The original background check dated 11/14/19 came back clean because they had the wrong birthdate. "We did not know the incorrect date of birth was on there."

The County 17th Judicial Circuit Court Record shows R8 had previous charges for battery/makes physical contact, aggravated battery/pregnant/handicapped, and aggravated battery/victim 60+ on 11/27/2018. Aggravated battery/victim 60+ class 3 felony and battery/pregnant/handicapped class 3 felony on 1/23/19. Assault/deadly weapon on 5/18/2009, with knowingly damage to property <$300 two times on 5/31/2006. Disorderly conduct on

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 01/10/2020

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		

11/9/2005. Aggravated battery/school employee class 3 felony on 11/9/2005, and with battery on 4/27/2005.

R8's Physician Progress note written by V21 Physiatrist, dated 11/21/19 shows, "Patient is resting in bed, stating that he is going to court today for assaulting someone in the past."

On 12/31/19, V10 LPN (Licensed Practical Nurse) said she remembers R8 telling her he had to go to court for something he did prior to being admitted to the facility. At 3:40 PM, V18 RN (Registered Nurse) said R8 has said he has been to jail before and V18 thought it involved an altercation in the past because that is what R8 told him. On 1/9/2020 at 9:47 AM, V23 CNA (Certified Nursing Assistant) said she was not aware that R8 had a history of aggression, getting in trouble with the law, or court appearances. V10 said that R8 ambulated on his own throughout the facility and she was not told about the need to monitor R8. R8 did not need any special interventions for aggression.

R8's Mood/Behavior note dated 12/14/19 at 4:48 AM documents, Staff personnel (CNA) informed writer that resident (R8) was slightly agitated due to peer (two doors down had awakened this resident), resident (R8) observed per writer (V5 Charge Nurse) throwing personal items, suitcase against wall, clothes on floor, and talking to self, 'I'm going to kick his as*." Extensive attempts per writer to re-direct, de-escalate present aggressive behaviors, resident threw stationary chair into wall, ambulating down hallway, stated, "I'm kicking his as*, you're going to see why I got two felonies, I'm tired of hearing that sh*t, I don't want to calm down." Interventions included temporary bedroom/medication and/or conversing with staff

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 01/10/2020

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		

regarding appropriate coping skills, resident replied, "I'm not going to another room, I'm not taking no dam* medicine and I don't have to talk to nobody, all I need to do is find him." Resident (R8) then attempted to enter bedrooms 407 and 408, writer intervened/redirected, resident replied, "That's alright, I'll get him at breakfast." Nurse practitioner notified and order received to transport to emergency room involuntary for evaluation and treatment if needed. Resident stated, "Good get me the hel* out of here." Dispatch notified, will bring police for back up ...5:15 AM two attendants (Emergency medical technicians-EMTs) and two police personnel here, resident continued with disruptive behaviors towards police/technicians stated, "Bunch of punk bit**es, all racists." Resident left via stretcher with extremities restrained. Accompanied per EMTs and police personnel .

R8's local emergency room notes dated 12/14/19 documents, Patient brought by emergency medical services (EMS) for aggressive behavior at nursing home, per nursing home staff patient was woken up by another resident and was angry and started threatening nursing home staff, patient on arrival was restrained with soft restraints.

R8's Nursing Progress Noted dated 12/14/19 at 8:11 AM shows, "Resident arrived from the hospital after being sent out for aggression ...resident stated he would stay away from the peer and would not be aggressive towards anyone."

On 12/31/19 at 10:30 AM, V2 Regional Quality Assurance/previous Director of Nursing said there was an incident with R8 when another resident (R13) was yelling in the middle of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 6	S9999		

night and R8 "got up to shut him (R13) up". R8 left his room and headed towards R13's room and staff redirected R8.

On 1/2/2020 at 2:45 PM, V15 CNA said, one day R8 got woken up because another resident was screaming (R13). R8 said he better shut up and he was going to get out of the bed. R8 wanted to hit him (R13) because (R13) was screaming. R8 came out of his room and V15 got two male CNAs because V5 Charge Nurse felt R8 was going to get out of control. The police came and they strapped (R8) down. R8 was not nice to the police and ambulance personnel.

On 1/2/2020 at 9:00 AM, V5 (LPN) said, there was an incident with R8 about two weeks ago. R8 was upset that another resident (R13) was having a behavior (yelling out). "I tried to calm him down (R8). I called 911 before things escalated. He (R8) was saying that he was going to find the resident and he (R8) said he may have to do something but he didn't know what. He said if I didn't take care of it he was going to punch him (R13). I wanted to get him (R8) out before he inflicted bodily harm. The chair he threw, was the one in his room. He (R8) told me, "Hey you are going to find out why I have two felonies.'"

On 12/31/19 at 4:13 PM, V1 (Administrator) said he wasn't sure how long ago R8 got mad at the nurses station because a resident was loud and woke him up. V1 stated the staff was able to redirect him. V1 did not recall R8 being sent out to the hospital for behaviors. When V1 was asked if R8 had a history of aggression prior to coming to the facility, V1 stated, "I am sure he (R8) probably did. A lot of people have a history of aggression before coming here." In regards to R8, V1 said staff were working on how to handle

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 01/10/2020

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		

situations as they came along. "To me something would go on and we would notice that he would begin getting more agitated more rapidly."

R8's Care Plan initiated 12/14/19 shows, "Patient exhibits behaviors that include but are not limited to verbal and physical aggression towards peers ... (V24 psychiatrist) to evaluate and treat as indicated and as needed." On 1/8/2020 at 1:58 PM, V4 Social Services Director said, V24 sees residents upon admission and comes to the facility every two weeks. If someone is having a behavior V4 puts the resident on V24's list of visits. V4 could not recall if R8 was added to V24's list but verbal or physical behaviors would warrant a resident to be added to V24's list. R8's Progress Notes show R8 was last seen by V24 on 11/19/19.

On 12/31/19 at 3:52 PM, V3 DON (Director of Nursing) said she was not aware of an aggressive history with R8 in the past. V3 was not aware of any incidents that R8 had with others residents while in the facility. V3 said if there is an incident that happens on the floor, staff report it to V1 directly. The facility has a meeting every morning or afternoon that goes over anything that is in risk management. V2 also said she was not aware of any aggressive history with R8. "I just assume everyone has a history."

R8's Screening Assessment for Indicator of aggressive and/or harmful behaviors dated 12/15/19 shows, R8 is a moderate risk. The assessment's inaccurate due to the history of criminal behavior is marked 0.

R8's Incident Note dated 12/26/19 shows, Resident (R8) involved in an altercation with a peer in first floor dining room at approximately

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 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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		

7:35 AM while preparing for breakfast. Staff reported to writer (V10 LPN) that the two residents were heard arguing over a seat at the dining room table. Both had hands on the chair. Resident (R8) became angry and pushed peer (R7) to the floor before staff could intervene, while staff yelled for resident to stop, he (R8) was able to shove resident to the floor again before staff arrival. Resident (R8) walked from the dining room while staff assisted peer (R7). Writer observed resident (R8) at the first floor nursing station cursing, "That motherfu**er hit me first, I'm not scared of the fuc*ing police, take me to jail." Resident (R8) kicked the Christmas decoration over and knocked over the trash can, punched the phlebotomy case sending it crashing to the floor. Police in facility at this time following situation. At 12:21 PM, R8's Social Service Note shows, "Social Services staff was informed about this morning incident with (R8) displayed physical aggression towards a male peer. Police at the facility and took (R8) to jail where he will need to talk to a judge before he can return to the facility."

R8's hospital discharge paperwork dated 12/14/19 shows he is 31 years old and 6 feet 1 inch tall and weighs 260 pounds. R7's electronic medical record of 12/29/19 shows R7 is 70 years old and he weighs 169.4 pounds (almost 100 pounds less than R8) and is 73 inches (6 feet 1 inch).

The facility's surveillance video was observed on 12/31/19 with V1. R7 was sitting at the dining table in the dining room. There was an empty chair with pillows in it next to R7 that V1 stated is where R10 sits. R10 walked to exit the dining room and walked passed R8. R8 walked to the empty chair, took the pillow out and set them on the table. R8 proceeded to take the chair and R7

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 01/10/2020

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		

took hold of the right arm of the chair. R7 and R8 were both holding the chair and struggling to pull it in opposite directions. R8 then hit the front of R7's head with a closed right fist. R7 touched his head with his right hand, and then took his glasses off and set them on the table. R7 stood up and R7 and R8 had a hold of each others hands pushing against each other. V17 CNA started to walk over to R7 and R8. R8 looked at V17 and then pushed R7 down. R7 hit another chair and landed on the floor on his left side. V17 attended to R7 while R8 walked out of the dining room.

On 12/31/19 at 12:20 PM, V17 said, while in the dining room, she heard R14 yelling something and she went over to R7 and R8. R8 pushed R7 down. She saw a red mark on the middle and left side of R7's forehead. She helped R7 get up into the chair. R7 stated to V17 that he was saving the seat for R10. R7 said his hip hurt. V17 went to the nursing station and yelled to call psych social. R8 was knocking stuff off of the counter. V10 LPN was at the nurses' station trying to calm R8 down. Shortly after the ambulance came and got R7. V17 said that R7 and R10 sit by each other in the dining room all the time and R8 sits at various places in the dining room. V17 stated that R7 is a really sweet guy. At 1:50 PM, V10 said she didn't see the incident happen, but R8 was upset and said to her "Mother fu**er hit me and I hit his as* down." R8 kicked the Christmas decorations and kicked the garbage can. V10 attempted to calm R8 down. R8 went upstairs with V18 RN and stayed with him until police got there. At 3:40 PM, V18 said he didn't see the altercation but he brought R8 upstairs to remove him from the situation. R8 told V18 that he hit R7 and pushed him down. V18 brought R8 downstairs when the police arrived.

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 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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		

The County 17th Judicial Circuit Court Records show R8 was charged with 2 counts of aggravated battery/great bodily harm class 3 felonies on 12/27/2019.

R7's hospital paper work dated 12/26/19 shows he was admitted to the hospital from 12/26/19-12/29/19 with left hip and rib fractures.

On 12/31/19 at 4:13 PM, V1 Administrator said he received a call from V17 and she said that R8 hit and pushed R7. V1 said that he could hear R8 yelling in the background. R7 got sent to the hospital because he complained of hip pain. R7 had broken ribs and a broken hip. The police were called and reviewed the video surveillance. V1 said he knows that R8 was charged with a felony for this incident.

On 1/2/2020 at 1:10 PM R7 had a walker next to his bed. R7 said, "I was saving a chair in the dining room and a man beat me up." R7 said he had surgery on his hip and now after this incident his pain is rated a 9/10. Before the incident occurred, R7 said his pain was a 5/10 but was general pain. R7 said his head hurt after the incident occurred. R7 said, "(R8) acted like he was the boss around here. I feel safe now that R8 is not here anymore. The police pressed charges against him (R8). I wouldn't feel safe if R8 was back in here. Now I am paranoid to think that he (R8) could do that. Before this happened I was able to walk by myself really well, and now I have to walk with a walker. And look, now I am a fall risk."

On 12/31/19 at 3:11 PM, V2 Regional Quality Assurance/previous Director of Nursing said R8 is still in jail, the police were pressing felony

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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		

charges against R8 because R7's age is greater than 65.

On 12/31/19 at 11:20 AM, R6 stated she feels so sorry for R7. She had heard that R8 did this at another place. R6 stated she does not feel safe in the facility and feels like some of the residents need 24 hour psychiatric care.

On 1/2/19 at 1:45 PM, R9 said, "Everything is edgy here. I feel nervous. There's a lot of disruptions from residents here. One man broke my friends hip. I don't feel safe here." At 1:50 PM, R12 stated she does not feel safe from other residents in this facility.

On 1/2/19 at 10:30 AM, V4 Social Services Director said, "We do our best, but we can't have eyes on people 24/7 365 days. All residents are treated the same, behaviors can happen whether it is a person with a history or a little old lady." V2 former director of nursing and current quality assurance said, "Even if the background check was done correctly, it wouldn't have changed anything. We would not have done anything different for him (R8) anyway. We don't base our admissions on background checks."

R7's Admission Record shows he was admitted to the facility on 1/7/19 with diagnoses including: chronic obstructive pulmonary disease, cognitive communication deficit, generalized anxiety disorder, and dementia. R7's MDS dated 12/5/19 shows he is cognitively intact. Prior to this incident, R7 walked and transferred independently and required no mobility devices like a walker. R7's screening assessment for indicators of aggressive and/or harmful behaviors dated 12/6/19 shows he is minimal risk for aggression.

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 01/10/2020

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		

The facility's Abuse Prevention Program Facility Policy and Procedure dated 1/4/19 shows, "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."

(A)

2) Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)2)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in

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 01/10/2020

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		

operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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. Restorative measures shall include, at a minimum, the following procedures:

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.

Section 300.1220 Supervision of Nursing Services

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 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 14	S9999		

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the safety of a

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 01/10/2020

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 15	S9999		

resident with a known history of suicide attempts and failed to accurately assess a resident at risk for self harm for 1 resident (R1) reviewed for safety with suicidal ideation. This failure resulted in R1 attempting to commit suicide by cutting her left wrist with broken glass.

The findings include:

R1's face sheet showed R1 was a 52 year old female who was admitted to the facility on February 20, 2019 with diagnoses to include suicidal ideations, insomnia, anxiety disorder, schizoaffective disorder, bipolar disorder, and major depressive disorder.

R1's Admission History and Physical report dated January 17, 2019 showed, "[R1] ... tried to overdose on a number of pills ... has been hospitalized for mental illness at least 10 times... attempted suicide twice, once by cutting herself ... "

R1's progress note dated December 17, 2019 at 11:28 AM by V4 (Social Services Director) showed, "CNA (Certified Nursing Assistant) came to SS (Social Service) office and asked SS to come to patient's room right away. When SS arrived, SS witnessed patient lying in her bed with blood all over her pillow, sheets, both hands, hair, on the floor next to her bed, and on the top drawer of her nightstand. Nursing staff was in the process of wrapping [R1's] left wrist and SS was informed [R1] cut her wrist vertically with a sharp piece of glass she got after breaking a picture frame ..."

R1's nursing note entered by V10 LPN (Licensed Practical Nurse) dated December 17, 2019 at 10:45AM showed, "Resident noted by Rehab NP

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 01/10/2020

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 16	S9999		

(Nurse Practitioner) at approximately 10:25 AM in resident's bedroom bleeding profusely, blood on the floor and bed, resident sitting in bed, writer called to room. Upon entering room writer noted [R1] to be semi sitting/lying in bed which was soiled with bright red blood, resident's hands, hair and arms also covered in blood along with gown. Writer did a quick body check ... a deep, vertical jagged laceration approximately 2 inches to the left pulse area was noted, fresh red blood was trickling at this time with some coagulation noted at perimeters, 911 called ... blood trail was followed to bedside table where a big piece of broken glass from picture frame was found with blood smears and bloody fingerprints were noted ..." (Resident was bleeding from left wrist area, nursing note showing "pedal" pulse area is not accurate.)

R1's acute care hospital records showed R1 was admitted to the acute care hospital on December 17, 2019 at 10:58 AM for a suicide attempt.

R1's care plan for history of suicide attempts and self-harm was initiated on February 20, 2019 and last revised on March 5, 2019 with interventions to include, "(1) as warranted conduct a room check/search and remove any sharp objects or similar contraband (razor blades, razors, knives, scissors, etc, alcohol/drugs, including over-the-counter medications, cleaning supplies, any other objects that (in the opinion of the health care professionals) may pose a threat to safety, (2) as warranted conduct random room safety checks, personal wellness check, mouth check during medication pass, behavior monitoring of the resident, evaluation of mental status, mood state, thought content, (3)assure the resident that staff members are available to help and that staff has an open door policy if resident has a concern

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 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 17	S9999		

resident wants to discuss, (4) educate on the importance of reporting such issues in order to keep self safe. Offer support and reassurance as needed for agitation and anxiety and (5) enroll [R1] in the Symptom Education Group and encourage her to participate in the 1:1 sessions if needed, (6) evaluate potential indicators of depression and evaluate potential signs/symptoms of psychosis, (7) intervene if any self-injurous behavior is observed ...."
On December 27, 2019 at 2:10 PM, V10 LPN (Licensed Practical Nurse) said R1 had a stay at a psychiatric hospital prior to this suicide attempt. V10 said when R1 came back from the psychiatric hospital she was still delusional. V10 said she was not aware of R1 trying to harm herself in the past.

On December 31, 2019 at 3:27 PM, V2 RN (Registered Nurse, Former Director of Nursing, Current Quality Assurance Nurse) said R1 was refusing everything when she came back from the hospital. V2 said she is not aware of any interventions that were in place for R1's suicidal ideation. V2 said if a resident would be admitted to the facility with previous suicidal attempts she would expect that they would figure out what kind of an attempt was made and put interventions into place specific to the type of attempt. V2 said for example if someone cut themselves we would want to make sure that we are taking away those sharp objects. V2 said the psych-social department would be the ones who would determine if a resident's room should be checked.

The facility's room check logs for February 2019 through December 2019 were reviewed and showed R1's room had not be checked for the length of her stay.

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 01/10/2020

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 18	S9999		

R1's "Screening Assessment for Evaluation Self Harm/Suicide Risk" completed by V7 PRSC (Psychiatric Rehabilitation Services Coordinator) dated February 20, 2019 showed R1 to be a "moderate risk" for self-harm and reflected that R1 had a history of a previous attempt. V7 included a note which showed, "Resident ... is a moderate risk for self- harm. She has a long history of mental illness and suicidal ideation."

R1's "Screening Assessment for Evaluation Self Harm/Suicide Risk" completed by V8 (Social Services Assistant) on May 27, 2019 and August 27, 2019 erroneously showed R1 did NOT have any previous suicide attempts and V8 entered a note which showed R1 to be a "low to moderate risk".

R1's medical record showed she was sent to an acute care psychiatric hospital on November 23, 2019 and was readmitted to the facility on December 12, 2019.

R1's progress notes from December 12, 2019 through December 17, 2019 showed R1 continued to display delusions and reported auditory hallucinations in addition to refusing assessments and medications.
R1's December eMAR (electronic medication administration record) showed R1 refused her bedtime medications on December 15 and December 16.

On December 27, 2019 at 10:30 AM, V4 (Social Services Director) said she knows R1 well. V4 said R1 has severe mental illness and has had this for a long time. V4 said R1 is paranoid and suspicious at her baseline. V4 said R1 will do well for a period of time and then she will start to get

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 01/10/2020

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 19	S9999		

more paranoid and delusional and start to refuse medications. V4 said when R1 starts to refuse her medications her symptoms get worse, and she is sent for an inpatient psych stay. V4 said this is R1's cycle. V4 said R1 is involved in psych-social groups and see the facility psychiatrist. V4 said if R1 does not attend the group meetings they do a 1:1 meeting with her to discuss what was talked about in the group.

On December 31, 2019 at 12:47 PM, V6 (PRSC) said R1 was in two groups with psych-social, Symptom Education Group and Social Skills Group. V6 said R1 did not once participate in group or participate in 1:1's. V6 said all refusals are documented on the group sheets regardless if it is a group or a 1:1 refusal. V6 said there is no other scheduled interactions with residents besides the two groups.

R1's Group Record of Participation for August 2019 through December 2019 was reviewed and showed R1 did not participate in group or 1 on 1 sessions.

On December 31, 2019 at 3:52 PM, V3 DON (Director of Nursing) said she does not really know anything about care plans and what interventions are in place for residents with a history of suicide attempts. V3 said she is not aware of any specific interventions in place for R1's suicidal ideation.

(A)