STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest View Rehab & Nursing Center	535 South Elm Itasca, IL 60143

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview and record review, the facility failed to successfully notify the resident's legal representative regarding a significant change in condition for R3 who was sent out to the hospital. This applies to 1 of 4 residents (R3) reviewed for significant change in condition. The findings include: The EMR (Electronic Medical Record) showed R3, a [AGE] year-old, with diagnoses includes dementia, schizophrenia, Alzheimer's disease, bipolar disorder, psychosis, anxiety disorder and COPD (chronic obstructive pulmonary disease). R3 was admitted to the facility on [DATE]. The MDS (Minimum Data Set) dated 4/19/2024 showed R3 was moderately impaired with cognition with BIMS (Brief Interview Mental Status) with a score of 9/15. The MDS also showed R3 was identified with history of fall prior to admission to the facility. The progress notes dated 6/4/2024 showed R3 was noted with the following: -3:15 A.M., R3 was restless and had a near fall scenario as staff assisted R3 to the floor by bedside. The notes showed staff had brought R3 out of the room for monitoring. The notes showed R3 was found in multiple occasions in risky position for fall and was smearing feces all over the room. The staff had assisted R3 to safety, including monitoring, reassured of safety due to anxiety. The notes documents around 3 A.M., issue was resolved, and R3 fell asleep. Monitoring was ongoing. -5:38 A.M., R3 was sent out to hospital for further evaluation. R3 was kneeling at the side of the bed, weak and with abnormal vital signs (HR 118, bp 154/83, R-22) sent via 911. The notes showed R3's family was notified. -R3 was admitted to the hospital 6/4/2024. The hospital record dated 6/4/2024 showed admitting diagnoses was UTI (urinary tract infection). The hospital record dated 6/11/2024 showed R3 was also admitted for leukocytosis, urinary retention, severe hyponatremia, and altered mental status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SBAR (Situation Background Assessment Recommendation) dated 6/4/2024, documented by V10 (RN/Registered Nurse) showed V17 was notified. Further review of the SBAR showed V10 wrote the number she called was R3's phone number. The Face sheet showed V17 is R3's daughter/POA and the Emergency contact #1. The face sheet showed V17 have 2 phone numbers (home and cell phone numbers). The face sheet also showed V18 (R3's husband) was the Emergency Contact #2 with available phone number and an email address. There was a third number which belongs to R3. The number documented on the SBAR family notified was R3's phone number. On 6/13/2024 at 9:30 A.M., V10 said during early morning around 1:00 A.M. of 6/4/2024, R1 was not her baseline status. V10 said R3 was smearing feces all throughout her bed, which was something new. V10 said R3 was weak and having near fall accident by kneeling on the floor. V10 added R3, who was ambulatory, was then assisted to wheelchair, and was placed by the nurse's station for close monitoring. V10 said when R3 seemed to settle down, at around 3:00 A.M., R3 was assisted back to bed. V10 said around 5:00 A.M., R3 was noted to be weak, more confused, and not baseline. V10 added she called NP (Nurse Practitioner) and was ordered for R3 to be send out to the hospital for evaluation. V10 said since it was for evaluation, a regular ambulance was called for transport. V10 said she was notified by the ambulance the expected arrival for transport was 2 hours. V10 said she then decided she must call 911 for expedited service for R3 to be transported to hospital. V10 said R3 didn't need an emergency life situation intervention, but rather take R3 sooner than wait for 2 hours. V10 said she called one phone number listed on the profile/face sheet and left a message. V10 added she did not report to incoming nurse she only called and left message to one of the three available phone numbers on the face sheet. V10 had no explanation why she used R3's phone number instead of using V17 and or V18's phone numbers. R3's progress notes showed there was no follow up to ensure family/POA was notified regarding R3's change in medical condition and was sent out to the hospital. On 6/13/2024 at 12:24 P.M., V11 (LPN) said on 6/8/2024, in the evening time, V17 and V18 came to stop by the facility to visit R3. V11 informed V17 and V18 that R3 was at the hospital since 6/4/2024. V11 said V17 and V18 were very upset since no one at the facility had informed them R3 was sent out to the hospital. V11 said she assisted V17 and V18 about R3's location at the hospital unit where R3 was located. On 6/13/2024 at 9:15 A.M., V9 (Social Worker) said V17 and V18 were upset for not being notified regarding R3 being out to the hospital. V9 said, There was a mistake that happened regarding notification, it was the wrong phone number that was used. On 6/13/2024 at 1:12 P.M., V19 (Director of Admission) said she had visited R3 at the hospital on 6/10/2024 since she was told about V17 and V18 being upset of not being notified. V19 said, There was a mistake that happened with notification, I do not know how why they (V17 and V18) were not notified. The EMR showed R3 was readmitted to the facility on [DATE]. On 6/13/2024 at 10:15 A.M., R3 observed to be ambulatory and was determined to go her smoking session. R3 was able to verbalize her needs but was forgetful. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated policy for Change in Resident's Condition showed; It is the policy of the facility to ensure the resident's attending physician and Representative are notified of changes in the resident's condition. 2.The nurse will notify the resident representative when .there is a significant change in the resident's physical, mental, or psychosocial status; .It is necessary to transfer the resident to the hospital.