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	09/23/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48308 Based on interview and record review, the facility failed to protect residents' privacy, as staff took photographs of residents, with a mobile device, without the resident's consent. This applies to 4 of 4 (R6, R9, R10, R11) residents reviewed for resident privacy. On September 10, 2024, at 4:20 PM, V33 (CNA) stated she had taken photos of residents in the facility on May 19, 2023, May 21, 2023, and June 1, 2023, on the dementia unit. V33 stated she had shared the photos with V46 (CNA). On September 11, 2023, at 1:22 PM, V38 (CNA) stated V46 showed the photographs V33 sent to her via cell phone, to both herself and V24 (CNA). On September 12, 2024, at 1:05 PM, V1 (Administrator) and V2 (Director of Nursing) reviewed photos that V1 stated she had received from V46 that were identified as having been taken by V33. There were 7 photos, 4 depicting 2 different unknown female residents (R10, R11) seated in a wheelchair with what appeared to be a sheet tied around the waist, taken in the dining room. There were 2 photos of a female resident (R9) lying in the bed clothed with the bed pushed blocking the door to exit the room, and 1 photo of a man (R6) lying in bed with wheelchairs blocking the exit from the side of the bed. V1 and V2 stated they had no knowledge of the photos or conditions prior to Saturday September 7, 2024. V1 stated there was no consent obtained prior to staff taking the photographs. R6 (no longer in the facility) was identified in the photo as lying in bed, with two wheelchairs pushed against the side of the bed to block R6 from getting out of bed. V2 identified the resident in the photo as R6. V2 tentatively identified R9, as there were staff who thought R9 could be 2 different residents. R10 and R11 were unable to be named but appeared to be residents previously discharged from the facility. The photographs were identified as having been taken in the facility in the dementia unit dining room and rooms identified as being on V33 (CNA) usual assignment on the dementia unit. The Facility's policy, titled Abuse Prevention Program, dated January 2019, showed VII. Prevention .Staff photographing or recording residents or their private space (even if the resident is not present) for other than medical or facility a purpose as described in a signed Audio Video or Photographic release form is strictly prohibited.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	09/23/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48308 Based on interview and record review, the facility staff failed to immediately report suspicions of abuse in accordance with their policy. This applies to 4 of 4 (R6, R9, R10, R11) residents reviewed for allegations of abuse. The findings include: On September 10, 2024, at 4:20 PM, V33 (Certified Nursing Assistant-CNA) stated she had taken photos of residents in the facility on May 19, 2023, May 21, 2023, and June 1, 2023, on the dementia unit. V33 stated she had shared the photos with V46 (CNA). V33 was unable to positively identify any of the residents in the photos she took except for R6. V33 stated she did not report the alleged abuse depicted in the photos at any time to either the previous administrator, V1 (Administrator, who was not the Administrator at the time the photos were taken), or V2 (Director of Nursing, who was DON at the time of the pictures were taken). Review of the facility's incident reports of abuse from May of 2023, until September 18, 2024, showed there were no incident reports regarding abuse for the dates of May 19, 2023, May 21, 2023, or June 1, 2023, that described the conditions depicted in the photos. On September 10, 2024, at 1:18 PM, V1 stated she received a verbal allegation of abuse from V46 (CNA) on Saturday September 7, 2024, and initiated an investigation. On September 11, 2024, at 1:22 PM, V38 (CNA) stated she had not worked on the dementia unit for 2-3 years but had worked in the facility for almost 5 years. V38 stated V46 had shown her photos, on Saturday September 7, 2024, of a resident lying in the bed that was pushed against the door blocking the exit from the room. V38 identified the photos as needing to be reported as abuse. V38 stated the resident in that photo had been discharged . V38 stated she had not worked with V46 before. V38 stated V24 (CNA) was also present and viewed the photos. Neither V38 nor V24 reported the photos to V1. On September 12, 2024, at 1:05 PM, V1 and V2 reviewed photos that V1 stated she had received from V46 that were identified as having been taken by V33. There were 7 photos, 4 depicting 2 different unknown female residents (R10, R11) seated in a wheelchair with what appeared to be a sheet tied around the waist, taken in the dining room. There were 2 photos of a female resident (R9) lying in the bed with the bed pushed blocking the door to exit the room, and 1 photo of a man (R6) lying in bed with wheelchairs blocking the exit from the side of the bed. V1 and V2 stated they had no knowledge of the photos or conditions prior to Saturday, September 7, 2024. R6 (no longer in the facility) was identified in the photo as lying in bed, with two wheelchairs pushed against the side of the bed to block R6 from getting out of bed. V2 identified the resident in the photo as R6. V1 stated she did not know why someone would do this as it is a restraint, but unsure if the photo may have been staged. The identities of the female lying in the bed (R9), or the females (R10, R11) sitting in the wheelchairs in the photo could not be positively identified, however V2 stated none of the residents depicted in the photos were previously residents in the facility. (continued on next page)

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	09/23/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's policy, titled Abuse Prevention Program, dated January 2019, showed, IV. Reporting .V. Identification of Allegations/Internal Reporting Requirements .Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment, or a crime against a resident they observe, hear about, or suspect to the Administrator.

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	09/23/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46409 Based on interview and record review, the facility failed to ensure medications were administered with licensed nurse supervision. This applies to 1 of 3 residents (R3) reviewed for pharmacy services in a sample of 13. The findings include: On September 5, 2024 at 12:30 PM, V54 (Family Member) said R3 was given her 5 PM and 9 PM medications at the same time. V54 said R3 was told to take the 5 PM medications and then later take the 9 PM medications. On September 6, 2024 at 11:50 AM, R3 said a nurse came in and gave her the 5 PM and 9 PM medications and told her to take it. On September 17, 2024 at 9:43 AM, V7 (Social Services Assistant-SSA) translated to Spanish for R3, and when asked about the medication, said V10 (LPN/Licensed Practical Nurse) gave her two cups of medications, one for now, and one for later. On September 6, 2024 at 11:20 AM, V7 (SSA) said she was in R3's room earlier in the week and saw a cup with four to five pills sitting on the bedside table. V7 said she was not sure why it was in there and was not sure who the nurse was who did that. V7 said she asked R3 about the medications, and then told her to take the medications. V7 said she notified a CNA (Certified Nursing Assistant) that R3 had taken her pills. V7 said it was the first time she had seen medications left at the bedside. V7 said since R3 was Spanish speaking, she would round on R3 twice daily. V7 said she started working at the facility two weeks ago. On September 24, 2024 at 10:31 AM, V10 LPN (Licensed Practical Nurse) said she was under the impression R3 wanted her nighttime medications brought in at the same time her evening medications were due. V10 said she thought it was the resident's preference but was told it was not the correct method for medication administration. V10 said it was her mistake, and the risk was the resident could throw the medication away or they take it earlier or later than when it was due to be taken. On September 18, 2024 at 8:45 AM, V11 RN (Registered Nurse) said when he administers medications, he stays at the resident's bedside and makes sure they take it. V11 said he does not leave the medications at bedside because they could forget to take it or could spill the medications. V11 said he had never heard of any nurses bringing two cups of medications with different administration times and leaving the dose for the resident to take later. V11 said that was unacceptable as the resident could double their doses of medications, and it was unsafe. On September 17, 2024 at 4:15 PM, V2 (DON/Director of Nursing) said when the nurses are passing medications, they should stay at the resident's bedside until it is taken. The facility's undated 5.2: Medication Administration policy showed to Remain with the resident to ensure that the medication is swallowed. The facility's undated Tips for Safe Medication Administration policy showed to Never leave a medication in a resident's room without orders to do so.

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	09/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46409 Based on interview and record review, the facility failed to prevent a resident from being served food that was spoiled. This applies to 1 of 3 residents (R2) reviewed for spoiled food in a sample of 13. The findings include: On September 5, 2024 at 12:30 PM, V54 (Family Member) said R2 complained about mold all over her hamburger bun. On September 5, 2024 at 3:58 PM, R2 said she had mold on the bottom of her bun. R2 said she had not eaten any of the mold. On September 5, 2024 at 3:22 PM, V16 (Cook) said R2 had complained a few days ago about there being mold on the bread. V16 said the dietary staff had taken a picture of the burger bun with the mold, and when asked, showed the surveyor a picture of R2's food, which was observed to be the bottom slice of a hamburger bun with about a quarter to half dollar sized amount of a green, fuzzy substance. On September 17, 2024 at 9:22 AM, V6 (Social Services Director) said a CNA (Certified Nurse Assistant) had shown her R2's food, which had a quarter to half dollar coin sized amount of mold on it. V6 said she informed V1 (Administrator), and V1 reached out to the dietary manager. V6 said the CNA took the food tray away immediately, and none of the other residents or staff had complained about there being mold on their food. R2's MDS (Minimum Data Set) dated August 13, 2024 showed R2 was cognitively intact. The facility's Cold Food Storage policy dated April 2022 showed Food storage areas will be kept clean and dry, floor free of debris, frost free, free of ice build-up and free of mold.