Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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	10/18/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on interview and record review, the facility failed to ensure a resident's medical records included complete documentation of a resident's death. This applies to 1 of 3 residents (R12) reviewed for medical records in the sample of 15. The findings include: R12's face sheet shows he was a [AGE] year-old male, initial admitted [DATE] and readmitted on [DATE]. R12's diagnoses including COPD, weakness, unspecified dementia, aphasia, dysphagia, heart disease, and unspecified psychosis. R12's discharge date showed [DATE]; discharged to is left blank. R12's nurses note dated [DATE] at 4:28 PM, documents R12 seen by hospice nurse .R12 remained with audible crackles, respirations of 20, and oxygen 91% on 4 Liters via nasal cannula. No fluids or food intake, oral care provided, repositioned and kept comfortable. No pain or discomfort observed, cool to touch and mottling on bilateral lower extremities, family visited this afternoon. R12's electronic medical records showed no documentation regarding his death. On [DATE] at 9:48 AM, V4 (LPN-Licensed Practical Nurse) said nursing should document any change of condition in the resident's medical record. If a resident passes, nursing should make a progress note and notify family and physician. On [DATE] at 12:55 PM, V3 (ADON) said if a resident passes at the facility nursing should document a record of death assessment form and document a progress note including time of death, who was notified, the funeral home who picked up the body. V3 stated, It's basic nursing . we have to a record of what happened to the resident, records should be complete and accurate. V3 stated R12 was a hospice resident who expired at the facility. At 1:30 PM, V3 confirmed there was no documentation regarding R12's death in his medical records. The facility's Discharge Report dated [DATE] shows R12 expired on [DATE]. The facility's Guidelines for Nursing Documentation reference dated ,d+[DATE] documents . be timely in your documentation .whenever an unusual event occurs remember to also go to the chart to document your findings.

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