

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145937	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Forest City Rehab & Nrsng Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Arnold Avenue Rockford, IL 61108	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798</p> <p>Based on interview and record review, the facility failed to ensure resident's family/Power of Attorney were informed of their change in condition and hospitalization for 1 of 3 residents (R1) reviewed for change in condition in the sample of 3.</p> <p>The findings include:</p> <p>On 4/9/24 at 11:45 AM, V5, Licensed Practical Nurse (LPN), said if a resident goes to the hospital, the POA/family is notified. V5 said the nurse documents who was informed and when they were informed of the resident's change in condition/status in the resident's Nurse's Notes.</p> <p>On 4/9/24 at 12:07 PM, V9, LPN, said the nurse informs a resident's family/POA/Guardian when a resident goes to the hospital and documents when they are informed in Nurse's Notes.</p> <p>On 4/9/24 at 1:24 PM, V10, R1's family/POA, said she is R1's POA and she was not informed by the facility that R1 was unresponsive and being sent to the hospital (on 1/3/24). V10 said she got a phone call from someone at the hospital asking her if she knew her loved one (R1) was in the hospital. V10 said the facility never told her.</p> <p>On 4/11/24 at 2:15 PM, V8, Registered Nurse, said R1's primary nurse was on break when staff came to get her to help R1 (on 1/3/24). V8 said R1 was lethargic and moaning, but was not responding verbally. V8 said she thought R1 was septic. V8 said someone called 911 and she prepared R1 to go to the hospital. V8 said R1's primary nurse returned and she left the rest to him. V8 said she hopes someone called R1's family to notify them of his change and condition and that he was sent to the hospital.</p> <p>V8's Nursing Progress Note for R1 dated 1/3/24 at 3:49 PM shows V8 was asked to replace R1's sacral dressing by a CNA (certified nursing assistant). V8 observed R1 to be lethargic, his mental status was altered, his heart rate was elevated and his oxygen levels were low. Emergency Medical Services (EMS) was called and arrived to transport R1 to the emergency department. There are no other notes documenting R1's family/POA, V10, was notified of R1's change in condition or that he was sent to the hospital. No further documentation was added to R1's Progress Notes until he returned to the facility on [DATE].</p> <p>R1's Census List dated 4/9/24 shows R1 left the facility on [DATE] and was readmitted on [DATE].</p> <p>(continued on next page)</p>

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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Change in Resident's Condition Policy (reviewed 2/1/22) shows the nursing or social service staff will alert the family of a resident's change in condition and the communication will be documented in the resident's medical record.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798</p> <p>Based on interview and record review, the facility failed to identify, assess, and implement pressure wound treatment and prevention interventions for 1 of 3 residents (R1) reviewed for pressure wounds in the sample of 3. These failures contributed to R1 developing an additional Stage 2 pressure wound and worsening of his other wounds.</p> <p>The findings include:</p> <p>R1's hospital Nursing Discharge/Transfer Communication dated 12/5/23 shows R1 has wounds on his coccyx and heels.</p> <p>R1's Census List dated 4/9/24 shows R1 was admitted to the facility on [DATE]. R1's current Care Plan (Review last completed on 12/18/23) provided by the facility shows R1 is at increased risk for alteration in skin integrity and was admitted on [DATE] with a stage 3 pressure wound to the left heel and a wound to the sacrum. The same care plan shows no treatment or prevention interventions for R1's increased risk for alteration in skin integrity and only shows nursing staff are to check R1's skin during routine care and during his weekly bath/shower. No new interventions were ever added to R1's care plan.</p> <p>R1's Order Summary Report dated 4/9/24 shows R1 never had any wound treatment orders until 12/13/23. R1's Wounds Treatment Administration Record for 12/1/23-12/31/23 show R1 did not receive any wound care treatments to his sacrum and left heel from his admitted [DATE] until 12/27/23.</p> <p>R1's Census List dated 4/9/24 shows R1 left the facility on [DATE] and returned on 1/16/24. R1's Order Summary Report dated 4/9/24 shows R1 did not have treatment orders for his left heel and sacral wounds until 1/24/24. R1's Wounds Treatment Administration Record for 1/1/24 to 1/31/24 show R1 did not receive any wound care from his return to the facility, on 1/16/24, and 1/24/24.</p> <p>The facility was unable to provide any documentation which shows a complete wound assessment was completed by the facility for R1's wounds, between 12/5/23 and 12/26/23, including the type of wound, site, size, stage, odor, drainage, description, and date and the name/credentials of the person performing the assessment.</p> <p>V6's, Wound Care Physician, Wound Evaluation & Management Summary for R1 dated 12/19/23 shows R1 has a Stage 3 pressure wound of the left heel, a Stage 4 pressure wound of the sacrum, and a Stage 2 pressure wound of the left, medial buttock. R1's left heel and sacral wound were both exacerbated or worse and the buttock wound was new as indicated by a duration of greater than three days with no documentation under Wound Progress as is included with the two other wounds referenced above. The facility was unable to provide a Wound Care Physician, Wound Evaluation & Management Summary for R1 for the prior week (12/12/23). V6's Wound Evaluation & Management Summary for R1 dated 12/26/23 shows R1's sacral pressure wound was worse compared to the prior evaluation. V6's Wound Evaluation & Management Summary for R1 dated 1/2/24 shows R1's left heel and sacral pressure wounds were worse compared to the prior evaluation. V6's Wound Evaluation & Management Summary for R1 dated 1/23/24 shows R1's sacral wound was worse compared to the prior assessment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/24 at 10:30 AM, V4, Wound Care Nurse, said the admitting nurse does an initial skin assessment when a resident is admitted to the facility. If there are any skin issues, she does her own assessment, and consults the wound doctor to see the resident. V4 said she will contact the wound doctor and get wound treatment orders which begin right away. V4 said she charts when she completes the wound treatment on the Wound Administration tab. V4 said she does all the wound care treatments Monday through Friday, unless she is not at work, and on the weekends. V4 said the floor nurses do the wound treatments when she is gone, on the weekends, and if the dressing comes off or becomes soiled. V4 said if a resident refuses treatments or treatment interventions, such as wound care or repositioning, the nurses should chart the refusals. On 4/11/24 at 11:09 AM, V4 said she was not doing the wound assessments on the resident's EMR (electronic medical record). V4 said her weekly wound assessment is V6's wound assessment.</p> <p>On 4/9/24 at 1:41 PM, V2, Director of Nursing (DON), said when a resident is admitted, the wound nurse does the initial skin assessment if she is in the facility, otherwise, the admitting nurse does it. If skin issues are found, then they have standing orders for the resident to see the wound care physician. V2 said some residents come with wound treatment orders which they follow until the wound care physician sees them. If there are no wound care orders, they will call the physician to get them. The nurse will put the orders in and act on them right away. The nurses chart on the Nurse's Notes or the Admission/Readmission screening. V2 said every time they do a treatment, they chart it on the Wound TAR (treatment administration record). V2 said if residents refuse care, it should be documented. V2 said if a resident refused a wound treatment, a box opens up where narrative can be typed to explain what happened. On 4/9/24 at 4:08 PM, V2 said she cannot account for the lack of wound care on R1's Wound TAR. V2 said she would have to assume if it's not documented, it's not done. V2 said she cannot explain why R1 does not have wound treatment orders upon admission and readmission. On 4/11/24 at 9:30 AM, V2, Director of Nursing (DON), said the resident's wound assessment notes are supposed to be a part of their record, it should not be done on shower sheets.</p> <p>On 4/9/24 at 2:58 PM, V5, Licensed Practical Nurse, said R1 never refused wound care. V5 said R1 could be a bit resistive at first, but once you eased into his care and explained what you were going to do, he was cooperative. V5 said R1 did not have behaviors (of refusing care).</p> <p>On 4/9/24 at 5:40 PM, V6, Wound Care Physician, said R1 did not refuse wound care when he saw R1 in the facility. V6 said it is important to do the wound care treatments, especially for R1's sacral wound. V6 said a lack of wound care treatments and non-compliance with the wound treatment plan is the perfect recipe for wounds to deteriorate.</p> <p>On 4/11/24 at 12:12 PM, V7, Care Plan Coordinator, said the purpose of the care plan is so everyone knows the care the resident requires. V7 for a resident with pressure wounds, there should be more interventions to treat and prevent new and/or worsening wounds. V7 said the care plan should include seeing the wound care physician, wound care treatment, a turning/repositioning schedule, if appropriate, and probably a special mattress. V7 said only checking the resident's skin weekly and with daily care is not adequate for someone with pressure wounds.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Pressure Ulcer and Skin Condition Assessment Policy (revised 10/17/2020) shows pressure ulcers will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved Wound Assessment Form. The purpose of the policy is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented. An individual Wound Assessment Form will be initiated when pressure and/or other ulcers are identified by the wound nurse or licensed nurse. This form is a permanent clinical record. The Wound Care Nurse will measure and stage pressure ulcers. Wound assessments will be documented in the medical record for each identified ulcer area and will include: site, size (length by width by depth), stage of pressure ulcer, odor, drainage, description, date and initials of the individual performing the assessment per electronic record. A notation will be made in the nurse notes, TAR, or on weekly bath sheet when NO skin problems are observed. The resident's care plan will be revised to reflect alteration of skin integrity, approaches and goals for care. Physician ordered treatments shall be initialed by the staff on the TAR AFTER each administration. Other nursing measures not involving medications shall be documented in the progress notes. The treatment nurse is responsible for completing the Director of Nursing's Weekly Pressure Ulcer Report on the day assigned by facility.		