STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. Building B. Wing	10/24/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on interview and record review the facility failed to notify a resident's representative of an involuntary transfer to the hospital for 1 of 3 residents (R167) reviewed for notifications in the sample of 33. The findings include: R167's Facesheet dated 10/22/24 showed diagnoses to include, but not limited to: stroke due to embolism, nicotine dependence, encephalopathy, hypertension, deep vein thrombosis, chronic obstructive pulmonary disease, unsteadiness on feet, repeated falls, weakness, and long-term use of anticoagulants and antithrombotics/antiplatelets. This document showed V27 was listed as Emergency Contact #1. R167's facility assessment dated [DATE] showed he had severe cognitive impairment. R167's Social Service Note dated 9/27/24 at 6:27 PM, showed R167 was admitted from the hospital at 2:30 PM. R167 was alert and disoriented with no psychiatric diagnosis at the time of admission. R167 is not oriented to place/time/situation. This note showed shortly after admission, R167 wanted to leave the facility AMA (Against Medical Advice). R167 was not oriented to time/place/situation and was not considered safe for AMA. Education was met with disorientation and refusal. Social Services coordinated with nursing to send R167 to the local emergency room for evaluation and treatment. The patient would be a risk to himself in the community if he was to leave AMA. R167 was sent out to the hospital at approximately 6:00 PM. (This note does not show that V27 (R167's spouse) was notified of R167's involuntary transfer to the hospital). R167's Progress Notes were reviewed. There was not a nursing note that showed that V27 (R167's spouse) was notified of his involuntary transfer to the hospital. (continued on next page)

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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R167's Involuntary Transfer Petition completed 9/27/24 showed the petition was initiated by reason of: Emergency inpatient admission by certificate. The Respondent is currently detained in a mental health facility or hospital .I assert that [R167] is a person with mental illness who; because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed. (Is) a person with mental illness who. refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or two. (Is) in need of immediate hospitalization for prevention of such harm . [R167] is presenting with elopement risk, unsteady gait and disorientation. He is alert and disoriented to time/place/situation. He is not receptive to staff education regarding safety. Resident refusing to accept facility admission. He is at risk to himself due to disorientation and confusion that will put him at risk in the community. He is need of hospitalization for safety. This form was completed by V2 (DON/Director of Nursing) and V4 (PRSC/Psychiatric Rehab Services Coordinator). This form did not list V27 (R167's spouse) as a responsible party and did not indicate that V27 was aware of the transfer. R167's Physician Certificate for Surrogate Decision Making dated 9/28/24 showed V27 (R167's spouse) was identified as R167's surrogate decision maker. On 10/22/24 at 2:00 PM V3 (Social Services Assistant Director) said she assisted with R167's involuntary transfer because the assigned staff had to leave. V3 said shortly after R167 arrived at the facility he was threatening to leave AMA. V3 said R167 was alert, but disoriented and appeared to be in the early stages of dementia or Alzheimer's. V3 said R167 had disorganized thinking, seemed disoriented, and couldn't stand or walk. V3 said it was reported that R167 didn't recognize his wife. V3 said the facility did not feel it was safe to allow R167 to leave AMA, and the decision was made with nursing that R167 would be involuntarily transferred. V3 said she did not call V27 (R167's spouse). V3 said social services assists with the petition paperwork, but the nursing staff are responsible for notifying the family/resident representatives. V3 said, There should be a progress note to show that (R167's) family/resident representative was notified, but I don't see one. On 10/22/24 at 2:15 PM, V2 (DON) said R167 was admitted to the facility on [DATE]. The surveyor asked why R167 was an involuntary transfer back to the hospital within hours of his admission to the facility. V2 said she would have to review his notes. V2 said there's a social services note that he was wanting to leave AMA and he was sent out to the hospital at 6:00 PM. V2 said the notes don't show if [V27 (R167's spouse)] was notified of his transfer. V2 said she didn't notify V27 (R167's spouse). V2 stated, If [V3/Social Services Assistant Director] wrote it (this progress note), I can guarantee [V27] was notified of the transfer. The surveyor asked her how she knows it was done? V2 replied, There's no note, so I guess I don't know. V2 said the family/resident representative notification should be part of the progress notes because the emergency contacts need to be updated on their loved one. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 1:35 PM, V5 (LPN/Licensed Practical Nurse) said she was assigned to R167 on 9/27/24. V5 said R167 was confused. V5 said completed an assessment and helped unpack his belongings. V5 said he was in his room for a few hours, then came to the nurses' station and said someone was going to pick him up from the gas station. V5 said she reported this to the DON and ADON (Assistant Director of Nursing). V5 said they tried to talk him out of it and he calmed down for a little bit, then he started up again. V5 said R167 couldn't walk, he wasn't safe to leave AMA. V5 said the DON and ADON were handing it. V5 said she did not notify V27 (R167's spouse) that he was involuntarily transferred to the hospital. V5 stated, I thought they (ADON/DON) took care of that. The facility's Change in Resident Condition Policy reviewed 2/1/22 showed, It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician/NP [Nurse Practitioner] and resident's responsible party of a change in condition. Responsible Party: RN, LPN, Social Services. Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident. b. There is a significant change in the resident's physical, mental or emotional status. c. There is a pattern of refusing treatment or medication. d. The resident wants to be discharged or leaves AMA. e. It is deemed necessary or appropriate in the best interest of the resident. 2. Appropriate assessment and documentation will be completed based on the resident's change in condition or indication. 3. Once the physician/NP has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and any physician orders. 4. The communication with the resident and their responsible party as well as the physician/NP will be documented in the resident's medical record or appropriate documents .

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to ensure a resident with their last known weight of 1/2024 showing a significant weight loss, failed to conduct, monitor weights and record, failed to ensure a resident with significant weight loss had a quarterly nutritional assessment by a dietician, and failed to ensure a resident with significant weight loss had interventions implemented to prevent further weight loss for 1 of 6 residents (R103) reviewed for nutrition in the sample of 33. These failures resulted in R103 not being weighed or seen by a dietician for 9 months after a significant weight loss occurred. The findings include: R103's face sheet showed a [AGE] year-old male with diagnosis of schizophrenia, major depressive disorder, and anxiety disorder. On 10/23/24 at 9:30 AM, R103 was in his bed supine. R103 was pale, cachectic and lying on an unmade bed (no linens or pillows). R103 had clear speech and said he eats his meals in his room. R103 was calm and not interviewable. At 12:23 PM, R103's lunch tray was untouched on a bedside table in his room. The table was not within reach of the resident. R103 was in bed covered with a coat. The room was dark. The lights were off, and the window coverings were closed. At 10:00 AM, V19 (Licensed Practical Nurse/LPN) said meal intakes for R103 are hit or miss. Sometimes he will throw his tray into hallway. It's just however he feels. V19 said restorative monitors resident weights. They do monthly weights. Maybe dietary does it too. At 10:50 AM, V16 (Assistant Director of Nursing/ADON) was asked what nutritional approach performed meant on R103's physician order sheet and medication administration record (MAR). V16 said she wasn't sure and would find out. At 11:08 AM, V16 said it meant it was verified that the resident was served the correct diet. At 12:25 PM, V19 (LPN) was asked what nutritional approach provided meant. V19 said she didn't know. V19 was asked if she monitored that the residents received the correct diet ordered and she said The kitchen should be serving the correct diet and if not the CNA (Certified Nursing Assistant) will let me know if the wrong diet is served. I do not go around checking each residents tray. At 12:31 PM, V38 (Restorative Nurse) said, We do monthly weights. Some refuse and if they refuse, I try to remember to document that. V38 said, We seldom catch (R103) 'in a good mood'.The other day he was receptive to me. (R103's) last recorded weight was in January and was 138.8 pounds. The dietitian looks at the weights after we record them. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 8:54 AM, V32 (Dietary Manager) said R103 is on Med Pass (nutritional shake). V32 confirmed after reviewing R103's record with this surveyor that no nutritional dietary assessment was done by a dietitian since January 2024. V32 said a nutritional assessment should be done quarterly. If weights and dietitian assessments are not done weight loss can continue. V32 said there was no documentation or care plan interventions to increase calorie intake, diet compliance or encourage PO (oral) intakes. V32 said, Any interventions would be implemented after a discussion between the Dietician and me and there is no documentation that occurred. Any new interventions should be care planned. Evidence of dietary interventions was requested, and none were received. At 9:39 AM, V21 (Dietitian) said she had been at the facility for 2 to 3 months and was not aware of any concerns regarding R103. V21 said it was concerning he hasn't had any weights done. V21 said she speaks to the facility weekly and looks at everyone with a significant weight loss. V21 said, If a resident refuses to be weighed they should be reapproached when they're having a good day and should be followed up. If there isn't a monthly weight documented, they should do a re-weigh. Residents are weighed monthly to make sure they're on track. A weight loss or gain would trigger us to see and assess them. Residents whose weights are not monitored could continue to lose weight. Interventions might include extra portions, supplements, add foods based on their preferences and snacks. I do think more could have been done. Due to behaviors, if a resident refused weights or interventions, I would request staff to reapproach on another day the resident was more receptive. R103's 8/15/24 showed severe cognitive impairment. R103's nutritional risk reviews (done by V32 Dietary Manager) dated 2/23/24, 5/20/24, and 8/15/24 showed current weights of 138.8 pounds. All three reviews showed meal intakes of 26-75% independently with in-direct supervision. R103's weight record showed his 12/6/23 weight was 151.2 pounds. R103's last recorded weight was on 1/18/24 at 138.8 pounds (an 8.20% weight loss in one month). R103's physician order sheet showed a general diet order with mechanical soft texture, regular thin liquid consistency, and a room tray. A 7/23/24 order showed nutritional approach performed every day and evening shift for monitoring. There were no current orders for nutritional supplements (Med Pass) or appetite stimulants. There were no orders for a snack, pudding, or double portions. R103's 10/22/2020 care plan interventions included to weigh the resident monthly and make a referral to the doctor/Registered Dietician if there is a 5% weight loss over 30 days. There have been no care plan interventions in 2024 to increase caloric intake, improve diet compliance, increase appetite, or encourage oral intake. R103's medication administration record (MAR) showed V19 (Licensed Practical Nurse/LPN) provided nutritional approach 18 times (as indicated by her initials). R103's restorative notes showed monthly weights were refused in May, June, August, and September 2024. There were no documented refusals for February, March, April, July, or October 2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R103's 1/15/24 dietitian note showed to add resident to weekly weights and perform a medication review for appropriateness of an appetite stimulant. This note showed a 7.8-pound weight loss in one month and recent significant weight loss months prior. The facility's 1/2024 Weight Assessment and Interventions Policy showed the purpose was to ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner. Weigh the resident upon admission and weekly for a total of four weeks. Monthly weights will be done thereafter if no issues are identified. Weights will be entered in the resident's medical record. The dietician will review the weight record to identify and address weight issues. Significant weight changes are defined as 5% weight gain/loss in 30 days. The dietician will document desirable and undesirable weight changes and will discuss with the interdisciplinary team to identify possible approaches/interventions. If a resident refuses to participate in weight interventions, the dietician will document the resident's wishes.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on interview, and record review the facility failed to ensure a resident with a history of embolic strokes (R167) received physician ordered anticoagulants. This failure resulted in R167 requiring emergency transport to the hospital for an acute embolic stroke. R167 was hospitalized until [DATE], when he passed away. The facility also failed to ensure an anticoagulant medication was administered as ordered for R116 for 2 of 8 residents (R167 & R116) reviewed for significant medication error in the sample of 33. The Immediate Jeopardy began on [DATE] when R167 was readmitted to the facility and the facility failed to ensure the physician prescribed anticoagulant medication was obtained from pharmacy. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 1:02 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the process changes and in-service training. The findings include: 1. R167's Facesheet dated [DATE] showed diagnoses to include, but not limited to: stroke due to embolism, nicotine dependence, encephalopathy, hypertension, deep vein thrombosis, chronic obstructive pulmonary disease, unsteadiness on feet, repeated falls, weakness, and long-term use of anticoagulants and antithrombotics/antiplatelets. This document showed R167's original admission to the facility was [DATE]. R167's Physician Order Sheet printed [DATE] showed an order for Xarelto 15 mg (milligrams) twice a day for stroke due to embolism. This order was entered on [DATE]. R167's MAR (Medication Administration Record) showed he R167's was scheduled to received Xarelto 15 mg in the morning and the evening, starting [DATE]. R167's MAR showed there were entries for [DATE], [DATE] and [DATE] that showed the medication was on order from pharmacy or a progress note was entered. (According to pharmacy, R167's Xarelto was delivered to the facility on [DATE]. R167's should have received 6 doses of the medication during that time.) R167's Progress Note dated [DATE] at 4:02 PM, showed R167 had returned to the facility from a facility initiated transfer. R167's Progress Note [DATE] at 11:05 PM, showed This writer just spoke with [consulting pharmacist] regarding the status of atorvastatin and xarelto. Atorvastatin will be delivered tonight. Xarelto is not covered by resident's insurance. Asked pharmacist what would be covered as an alternative and he reports it is not in the notes, billing department will know that and they will be in tomorrow morning at 0600. [V12-NP] informed. R167's Progress Note dated [DATE] showed he lost his balance, pushing his wheelchair and fell on the dining room floor. There were no injuries noted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R167's Progress Notes dated [DATE] at 9:15 PM, showed, Residents family have been here with resident most of the PM shift. Resident has had no changes in baseline mental status. Resident's niece states at 9:10 PM, I'm scared my uncle might have had a stroke earlier when we were taking to him, but I really don't know. CNA [Certified Nursing Assistant] reports she just assisted resident back to bed and that his behavior was fine, he was speaking to her, and had no abnormalities. This RN [Registered Nurse] did neuro assessment and no signs that resident had a stroke . R167's Progress Notes dated [DATE] at 5:50 PM, showed At approximately 5:50 PM resident started having seizure in the dining room that lasted 2 minutes. Staff immediately notified nursing - accucheck 168. Pulse oximetry 73% on room air . 911 called while nursing helped resident in the dining room . 23:00PM resident admitted with stroke diagnosis. R167's Xarelto prescription dated [DATE] showed the medication was to be administered twice a day. R167's Xarelto Manifest showed it was delivered to the facility on [DATE] at 8:00 PM. R167's emergency room records dated [DATE] showed he had a history of strokes, had a seizure prior to arrival. The facility reported the patient had a two minute seizure in the dining room. The records showed the family reported an episode of aphasia yesterday, which as resolved. These notes showed R167's was admitted to the hospital on [DATE] for an embolic stroke. R167's Neurology Progress Note dated [DATE] showed R167 had recurrent bi-hemispheric embolic strokes. R167's Hospital Discharge Summary dated [DATE] showed R167 died . R167's Death Certificate showed he died on [DATE] and the primary cause was recurrent emobilic strokes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:15 PM V2 (Director of Nursing/DON) said when a resident is admitted from the hospital the discharge medication list is used to order the resident's medications at the facility. V2 said the nurse will enter the orders when the resident is admitted . V2 said when the order is entered, the order is sent to pharmacy to fill the medication. V2 said sometimes there is an issue with the insurance and pharmacy will send an authorization notice. V2 said if the medication isn't available for more than a shift and a half, then I get involved. V2 said she expects the nurses to report any medication that has not been received from pharmacy to her. V2 stated, I know I was in contact with the pharmacy about [R167's Xarelto]. I told them to send it. V2 said she isn't sure if Xarelto is in the automated medication dispensing system, but stated, It should be. V2 said she thought the issue was taken care of because the nurses hadn't reported any issues to her. V2 said she doesn't know if R167 received his scheduled Xarelto prior to [DATE]. V2 said she doesn't know why the Xarelto was documented as administered by some nurses. V2 said she had no idea how a nurse would give a medication that wasn't available because they aren't supposed to borrow medications from another resident. (R167's Xarelto was delivered on [DATE] at 8:00 PM.) V2 said the automated medication dispensing system was changed six months ago and there are a few nurses that still don't have access to it. V2 said Xarelto is a blood thinner and is used to prevent clot formation and decrease the risk for stroke. V2 said she wasn't sure what happened to R167. V2 reviewed R167's Electronic Medical Record (EMR) and said it looked like he had seizure activity and was sent to the emergency room . At 3:28 PM, V2 accessed the automated medication dispensing system. The automated medication dispensing system was small, the size of a mini-refrigerator and across the room there was a plastic storage container, with a padlock affixed to it. V2 said if the medication isn't inside the smaller automated medication dispensing system, then a key will be obtained to open the lock on the plastic container. V2 checked for Xarelto and was unable to obtain it from the automatic dispensing system. V2 stated, I'll have to sign out the key and check over there. V2 signed out the key and opened the plastic storage container to expose multiple small, divided containers. V2 picked up a small plastic container and stated, Look at this. There isn't even a label on this to tell me what is inside. I just have to look at each separate medication. This system is ridiculous. I hate it. V2 stopped and stated, This will take forever. Do we have to go through each one? Can I just get the list from pharmacy that shows what medications are available. V2 locked the cabinet and returned the keys to the automated dispensing system. On [DATE] at 1:10 PM, V6 (Licensed Practical Nurse/LPN) said she wasn't sure if Xarelto was available in the automated medication dispensing system. V6 said she didn't have access to the system. V6 said the system was changed about 6 months ago and there were still nurses that didn't have access. On [DATE] at 4:03 PM, V9 (LPN) said she doesn't remember R167 or any specific information regarding him. V9 said she does not have access to the facility's automated medication dispensing system. V9 said she would have to ask another nurse to access, but stated, She hasn't come across anyone that had access to it while I was working. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:59 AM, V12 (Nurse Practitioner/NP) said R167 was admitted from the hospital after he had a stroke. V12 said the nurse reviews the medications and enters the orders into the EMR. V12 said she expects the medications to be administered as ordered. V12 said R167 was on Xarelto because he had a stroke caused by a blood clot. V12 said it was important R167 received the medication as it was ordered to prevent blood clot development and reduce the risk of stroke. V12 said missing 6 doses of the Xarelto could have contributed to R167 having an acute embolic stroke on [DATE]. V12 said she didn't order an alternative blood thinner because she was under the understanding that insurance issue was addressed promptly. V12 said she would expect the facility to obtain R167's medications in a timely manner. On [DATE] at 9:08 AM, V11 (Pharmacy Consultant) said Xarelto is an anticoagulant medication that is prescribed to prevent blood clots and strokes. V11 said R167 could be at an increased risk of stroke if multiple doses were missed. V11 said Xarelto was not a medication stocked in the automated medication dispensing system. V11 stated, Today [V2-DON] called and we will be adding Xarelto to the stock. At 10:34 AM, V11 said R167's Xarelto order was entered on [DATE] at 11:48 PM; the pharmacy sent a message to the facility that authorization was needed on [DATE] at 7:49 AM; the facility responded to the authorization message on [DATE] at 8:17 AM; and the medication was delivered to the facility on [DATE] (at 8:00 PM). 2. R116's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include chronic systolic congestive heart failure, atrial flutter, stage 3 chronic kidney disease, cardiomyopathy, anemia in chronic kidney disease, and cirrhosis of liver. R116's [DATE] Physician Order Sheet showed an order for an anticoagulant dated [DATE] for Rivaroxaban (Xarelto) 20 mg daily for atrial flutter. R116's [DATE] eMAR (electronic Medication Administration Record) showed an order for warfarin (anticoagulant) was discontinued [DATE] and a new order for Rivaroxaban (anticoagulant) was started [DATE]. R116's eMAR showed his warfarin was not administered [DATE] or [DATE] due to being on order with pharmacy. The same eMAR showed R116's Rivaroxaban was not administered [DATE], [DATE], and [DATE] due to not being delivered by pharmacy. R116 went without an anticoagulant for a 5 days. R116's Late Entry Nursing Note entered on [DATE] at 1:18 PM (after an Immediate Jeopardy was declared related to anticoagulant therapy not being administered) but dated for [DATE] at 5:15 PM showed, Received new order from [R116's Physician]. New order processed for Xarelto (Rivaroxaban) d/t abnormal EKG for Atrial flutter. Ok to start when arrives from pharmacy. The facility provided a list of medications available in the automated medication dispensing system on [DATE]. Xarelto was not a medication listed. There was a handwritten note attached to the list that stated, Have already requested that Xarelto be stocked in the cubex. The facility's Administering Medications Policy and Procedure dated [DATE] showed, To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure: .3. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity 6. Medications should be administered within one hour of the prescribed times . (continued on next page)

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 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest City Rehab & Nrsg Ctr	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)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Physician's Order Policy dated ,d+[DATE] showed, All resident medications and treatments must be ordered by a licensed physician or nurse practitioner . The facility's undated Ordering Medications Policy showed, Policy: Medications and related products are ordered from [contracted pharmacy] on a timely basis. Procedure: New medication order requests can be faxed to the pharmacy's main fax number, sent via electronic health records, EHR system, electronically prescribed by the prescriber, and/or called in by the appropriate personnel according to State laws and regulations . The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. R167 no longer resides in the facility; expired in the hospital All licensed nursing staff have been re-educated to ensure residents admitted have medications available, are aware of the process in place to ensure commonly prescribed medications are readily available, are aware of the steps to take when medications are not available. Education includes an emphasis on the importance of securing medications, such as blood thinners/anticoagulants. Education conducted by Administrator/DON/MDS/or clinical management directors. The Administrator re-educated licensed clinical management nursing staff on the process to follow-up with pharmacy when authorization is required. This was completed on 10.23.2024 via in person education. - A system is in place to ensure commonly available medications are available through pharmacy, back up pharmacy and the backup medication dispensing system. - Education initiated 10.23.2024 and completed on 10.23.2024 - Re-education is completed by Administrator/DON/MDS/clinical management directors. All licensed nursing staff have been contacted via phone by the Administrator/DON/MDS/or clinical management directors and prior to the beginning of the next shift worked and will sign education sheets ensuring the licensed nursing staff was re-educated to ensure residents admitted have medications available, are aware of the process in place to ensure commonly prescribed medications are readily available, are aware of the steps to take when medications are not available. Education includes an emphasis on the importance of securing medications, such as blood thinners/anticoagulants. On 10.23.2024 a house audit was completed which consisted of the Director of Nursing ensuring that all residents prescribed blood thinners are receiving the prescribed medications, per physician orders. (continued on next page)

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Forest City Rehab & Nrsg 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)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	New licensed nursing staff hired on or after 10.23.2024 are educated to ensure residents admitted to the facility have medications available, are aware of the process in place to ensure commonly prescribed medications are readily available, are aware of the steps to take when medications are not available. Education includes an emphasis on the importance of securing medications, such as blood thinners/anticoagulants medication administration, medication availability and steps to take when medications are not available. The newly hired licensed nursing staff will sign that the education was completed. The Administrator/DON/MDS/or clinical management directors are conducting the education on hire, prior to the new licensed nursing staff member working the floor. On the spot education for licensed nursing staff is being conducted to ensure residents admitted have medications available, are aware of the process in place to ensure commonly prescribed medications are readily available, are aware of the steps to take when medications are not available. Education includes an emphasis on the importance of securing medications, such as blood thinners/anticoagulants. Education conducted by Administrator/DON/MDS/or clinical management directors. Education to be completed by the start of next scheduled shift. A weekly audit of 5 residents will continue for four months to ensure residents have all medications are available, including blood thinners and all medications are received in a timely manner, per physician orders. The DON or designee perform QAPI audits of 5 residents a week for 4 months to ensure medications are administered as prescribed. An analysis of the audits are presented through QAPI quarterly QAPI Audits are completed using direct observation, resident interview and medical record review . A root cause analysis was completed on [DATE] to determine process breakdown, barriers and process improvement. The root cause analysis was completed by the IDT which included the Administrator, clinical management licensed staff, pharmacy representation, corporate clinical staff and the medical director. All QAPI audits will be analyzed and reviewed in quarterly QAPI. This is overseen by the medical director and administrator. QAPI will determine if further audits will continue after the completion of 4 months. 38488