

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 10/31/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35178</p> <p>Based on interview and record review the facility failed to report an allegation of abuse to the administrator of the facility for 1 of 3 residents (R1) reviewed for abuse in the sample of 9.</p> <p>The findings include:</p> <p>On 10/30/24 at 10:00AM, V1 Administrator said, I was not informed about an alleged incident between R1 and V3 CNA-Certified Nursing Assistant, I will investigate the allegation immediately.</p> <p>On 10/30/24 at 2:27PM, V5 Scheduler said, I received a report from R1's daughter that R1 received a ham sandwich. She reported that someone pushed her. I did not tell V1.</p> <p>On 10/30/24 at 1:00PM, V1 stated he reviewed the video footage regarding the alleged incident. V3 made no contact with R1.</p> <p>On 10/30/24 at 12:07PM, V3 CNA said, if an abuse like allegation was reported to me, I would contact V1 Administrator immediately, I would not worry about chain of command. I would report to my nurse also but V1 first.</p> <p>The facility's Abuse Prevention policy dated 11/18/2016 shows, employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about or suspect to the administrator immediately .</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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