

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 06/23/2025
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review the facility failed to follow their abuse policy by not immediately reporting, investigating and protect residents while and investigation is underway for 1 of 3 residents (R1) reviewed for abuse in the sample of 9.</p> <p>The findings include:</p> <p>The facility's Abuse Prevention Program Facility Policy and Procedure dated 10/2023 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 or to an immediate supervisor who must then immediately report it to the administrator .Upon learning of the report, the administrator or a designee shall initiate an incident investigation .The facility will take steps to prevent potential abuse while the investigation is underway Employees of the facility who have been accused of abuse will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator .The investigator will attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable When an allegation of abuse .has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax .This report shall be made immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse</p> <p>On 6/23/25 at 11:35 AM, V1 (Administrator/Abuse Coordinator) said that the facility follows their Abuse Prevention Policy. V1 said that all allegations should be reported to him immediately and he then sends an initial report to IDPH within two hours. V1 said that if a staff member is an alleged perpetrator, they are immediately sent home until the investigation is completed. V1 said that an investigation is started and the resident, any involved witnesses, other staff and other residents are interviewed to try and determine if abuse occurred. V1 said that he did not hear about R1's allegations of assault until he came in on the morning of 6/16/25. V1 said that the nurse did text him but she should have called him to report the allegation. V1 said that he did start an investigation that day by talking with V15 (Licensed Practical nurse) about the incident and asking who, where, when but V15 was unable to provide any additional information. V1 said that he did not speak to R1 about the incident. V1 said that the day got busy and he knew he was already late for reporting to IDPH so he did not send in a report on 6/16/25. V1 said that he heard later in the day that V11 (Certified Nursing Assistant) was the alleged perpetrator and was sent home.</p> <p>R1's Care Plan shows, [R1] is at risk for abuse and/or neglect due to her mental illness and hx (history) of abuse .Follow facility policy for all suspected or reported instances of abuse and/or neglect. Take all reports seriously .</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Hospital After Visit Summary dated 6/15/25 shows, Patient does not like this facility and she keeps trying to elope. She stated that staff started to restrain and fight with her so she fought back .Adult Protective Services being notified .</p> <p>R1's Nursing Notes dated 6/15/25 at 11:47 PM shows, Resident returned via stretcher accompanied per [Ambulance Company] Attendants(2) while taking resident to bedroom,resident replied,Look my favorite person,the one that assaulted me. [Attendant's Name] intervened/re-directed.false belief</p> <p>On 6/17/25 at 10:50 AM, V11, Certified Nursing Assistant (CNA) said that R1 returned from the hospital around 11:30 PM on 6/15/25. V11 said that upon her return, R1 looked at her and said, That is my favorite person who assaulted me. V11 said that upon R1's return the nurse told her to keep an eye on R1 due to her behaviors of trying to elope prior to going to the hospital. V11 said that she got a table and chair and sat in front of R1's doorway from the time that she returned from the hospital until about 1:10 AM. V11 said that R1 came out of her room one time asking for a bag of chips but did not have enough money so she returned to her room. V11 said that the nurse wanted her to stay until 4:00 AM but R1 was sleeping around 1:00 AM so she felt it was ok to leave.</p> <p>V11's Time Card printed on 6/17/25 shows that she worked on 6/15/25 from 1:14 PM to 1:15 AM and worked again on 6/16/25 from 9:08 PM to 5:52 AM.</p> <p>On 6/18/25 at 8:18 AM, V15 (Licensed Practical Nurse) said that upon R1's return from the hospital, V11 told her that R1 stated, You're the one that assaulted me. V15 said that she did not hear R1 make the statement but she was told by V11 about it about 5 minutes after R1 readmitted . V15 said that she then text V1 (Administrator/Abuse Coordinator) around 12:30 AM to let him know but V1 did not respond to her. V15 said that she did not interview R1 to get additional details about what she had said.</p> <p>R1's Initial Abuse Investigation Report was sent to IDPH on 6/17/25 and the Final Abuse Investigation Report was sent on 6/20/25.</p>		

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<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>Based on interview and record review the facility failed to immediately report an allegation on abuse to the state survey agency for 1 of 3 residents (R1) reviewed for abuse reporting in the sample of 9.</p> <p>The findings include:</p> <p>R1's Care Plan shows, [R1] is at risk for abuse and/or neglect due to her mental illness and hx (history) of abuse .Follow facility policy for all suspected or reported instances of abuse and/or neglect. Take all reports seriously .</p> <p>R1's Hospital After Visit Summary dated 6/15/25 shows, Patient does not like this facility and she keeps trying to elope. She stated that staff started to restrain and fight with her so she fought back .Adult Protective Services being notified .</p> <p>R1's Nursing Notes dated 6/15/25 at 11:47 PM shows, Resident returned via stretcher accompanied per [Ambulance Company] Attendants(2) while taking resident to bedroom,resident replied,Look my favorite person,the one that assaulted me. [Attendant's Name] intervened/re-directed.false belief</p> <p>On 6/17/25 at 10:50 AM, V11, Certified Nursing Assistant (CNA) said that R1 returned from the hospital around 11:30 PM on 6/15/25. V11 said that upon her return, R1 looked at her and said, That is my favorite person who assaulted me.</p> <p>On 6/18/25 at 8:18 AM, V15 (Licensed Practical Nurse) said that upon R1's return from the hospital, V11 told her that R1 stated, You're the one that assaulted me. V15 said that she did not hear R1 make the statement but she was told by V11 about it about 5 minutes after R1 readmitted . V15 said that she then text V1 (Administrator/Abuse Coordinator) around 12:30 AM to let him know but V1 did not respond to her.</p> <p>On 6/23/25 at 11:35 AM, V1 (Administrator) said that when he arrived to work on 6/16/25, V15 came to him and notified him of an allegation of abuse involving R1. V1 said that V15 should have called him immediately after she heard of the allegation. V1 said that V15 should not have just text him in the middle of the night. V1 said that the day got busy and he knew he was already late on reporting so it was not reported that day. V1 said that all allegations of abuse should be reported to him immediately via phone call if he is not in the building and an initial report should be sent to Illinois Department of Public Health (IDPH) within 2 hours of the allegation.</p> <p>On 6/17/25 at 11:10 AM, V2 (Director of Nursing) said that she can not find that a report was sent to IDPH regarding R1's allegation of assault. At 12:16 PM, V2 said that they are sending the initial report right now and she is not sure why it was not sent earlier.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately investigate an allegation of abuse and failed to immediately suspend the alleged perpetrator while the investigation was in process for 1 of 3 residents (R1) reviewed for abuse in the sample of 9.</p> <p>The findings include:</p> <p>R1's Hospital After Visit Summary dated 6/15/25 shows, Patient does not like this facility and she keeps trying to elope. She stated that staff started to restrain and fight with her so she fought back .Adult Protective Services being notified .</p> <p>R1's Nursing Notes dated 6/15/25 at 11:47 PM shows, Resident returned via stretcher accompanied per [Ambulance Company] Attendants(2) while taking resident to bedroom,resident replied,Look my favorite person,the one that assaulted me. [Attendant's Name] intervened/re-directed.false belief</p> <p>On 6/17/25 at 10:50 AM, V11, Certified Nursing Assistant (CNA) said that R1 returned from the hospital around 11:30 PM on 6/15/25. V11 said that upon her return, R1 looked at her and said, That is my favorite person who assaulted me. V11 said that upon R1's return the nurse told her to keep an eye on R1 due to her behaviors of trying to elope prior to going to the hospital. V11 said that she got a table and chair and sat in front of R1's doorway from the time that she returned from the hospital until about 1:10 AM. V11 said that R1 came out of her room one time asking for a bag of chips but did not have enough money so she returned to her room. V11 said that the nurse wanted her to stay until 4:00 AM but R1 was sleeping around 1:00 AM so she felt it was ok to leave. V11 said that before she left, she wrote a statement of what R1 had said earlier in the evening and gave it to the nurse and told her to make sure that she charted what happened.</p> <p>V11's Time Card printed on 6/17/25 shows that she worked on 6/15/25 from 1:14 PM to 1:15 AM and worked again on 6/16/25 from 9:08 PM to 5:52 AM.</p> <p>V11's Written Statement shows, [R1] was trying to leave out the facility. I saw V14 (LPN) helping I helped her keep the young lady from going outside, she didn't like that I was in front of her, and that she told me not to touch her as I went to go outside and have a smoke break she followed me. V12 (CNA) and V14 came out with me got her back in me and V12 had her stay in her room until [local hospital] came and got her she kept charging at us to get out the door and me and V12 asked her not to touch us and we moved her back from being against us. She hit us threw food at us and V14 and V17 (RN) came walking down there as she was pushing against us, and then [local hospital] showed up. She believes we assaulted her and wouldn't let her leave she stated that as the paramedics brought her back as I was still down 400 hall and [NAME] that bout me.</p> <p>On 6/18/25 at 8:18 AM, V15 (Licensed Practical Nurse) said that upon R1's return from the hospital, V11 told her that R1 stated, You're the one that assaulted me. V15 said that she did not hear R1 make the statement but she was told by V11 about it about 5 minutes after R1 readmitted . V15 said that she then text V1 (Administrator/Abuse Coordinator) around 12:30 AM to let him know but V1 did not respond to her. V15 said that she did not interview R1 to get additional details about what she had said.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/23/25 at 11:35 AM, V1 (Administrator) said that when he arrived to work on 6/16/25, V15 came to him and notified him of an allegation of abuse involving R1. V1 said that he started asking who, when, where questions but no one had any additional information. V1 said that he did not speak to R1 about the allegation. V1 said that he had learned later in the day that V11 was the alleged perpetrator and was sent home. V1 said that all allegations of abuse should be investigated immediately and the alleged perpetrator should be sent home pending the results of the allegation. V1 said that the resident, other residents and all staff involved are interviewed during an investigation</p> <p>On 6/17/25 at 11:10 AM, V2 (Director of Nursing) said that she had no involvement with R1's allegation of abuse and it was all done by V1. V2 said that all allegations of abuse are immediately investigated. V2 said that if there is an alleged staff member, they are sent home immediately until the investigation is complete. V2 said that it is important to investigate all allegations of abuse to make sure that all residents are safe.</p> <p>R1's Care Plan shows, [R1] is at risk for abuse and/or neglect due to her mental illness and hx (history) of abuse .Follow facility policy for all suspected or reported instances of abuse and/or neglect. Take all reports seriously .</p> <p>R1's Initial Abuse Allegation Investigation was sent to IDPH on 6/17/25 and Final Abuse Allegation Investigation was sent to IDPH on 6/20/25.</p>		