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 02/06/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed complete a thorough, initial skin assessment and ongoing skin assessments for a resident at risk for skin breakdown with redness to her buttocks and peri-area for 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 5.The findings include:R1's Face sheet dated 2/5/26 showed diagnoses to include, but not limited to diabetes, atherosclerosis (hardening and narrowing) of the aorta, asthma, hypothyroidism, gastro-esophageal reflux disease (GERD), cataracts, dysphagia (difficulty swallowing), lack of coordination, and abnormalities of gait/mobility. R1's facility assessment dated [DATE] showed she had moderate cognitive impairment; was dependent on staff for toilet hygiene; required substantial to maximal assistance for personal hygiene; and required supervision for bed mobility. R1's Physician Order Sheet showed on 12/16/25 there was an order for Zinc Barrier Cream to buttocks twice a day for incontinence and as needed.R1's Care Plan initiated 12/16/25 showed R1 had impaired skin integrity related to exposure to moisture and irritants secondary to incontinence as evidenced by erythema, excoriation, and skin breakdown to peri-area and buttocks. R1's Electronic Medical Record did not contain an assessment of R1's buttocks from 12/16/25 until she was transferred on 1/16/26. R1's Progress Note dated 12/25/25 showed Zinc barrier cream to buttocks and perineal area continues as part of incontinence care. Area remains stable. Will continue treatment and monitor for changes. R1's Shower Sheet dated 1/6/26 showed she had redness to her buttocks. R1's Electronic Medical Record did not include a skin assessment (including wound classification, size, description of tissue, and presence of drainage) performed by a nurse related to R1's redness (skin issue). R1's Hospital Emergency Department Encounter dated 1/16/26 showed R1 had a sacral ulcer.On 2/4/26 at 1:34 PM, V6 (Certified Nursing Assistant - CNA) said she was familiar with R1 and was regularly assigned to R1's hall. V6 said R1 had a real red area on her butt and they were putting barrier cream on it after providing care. V6 said she didn't remember R1 having an open area or dressing to her butt. V6 said she wasn't working 1/16/26 (when R1 was sent to the hospital). V6 said the CNAs report any skin issues to the nurse.On 2/4/26 at 1:54 PM, V9 (Registered Nure - RN) said she was the nurse that sent R1 to the hospital on 1/16/25 for abnormal labs. V9 said R1 was stable when she was sent to the hospital. V9 said she didn't inspect R1's skin before sending her to the hospital. V9 said the last time she saw R1's bottom was 3-4 days prior to her transfer to the hospital. V9 said R1 did have redness and irritation to her buttocks. V9 said they were putting barrier cream on the area and just monitoring the redness. V9 said she didn't document any skin assessments. V9 said the nurse just documents the barrier cream on the Treatment Administration Record, but did not chart the size or description of the wound. The surveyor asked how the nurses track the progress of R1's wound if there are no assessments with size, appearance, and location of the wound. V9 replied, I can see what you're saying. V9 said she saw R1's redness when she moved to V9's hall. V9 said R1 was at risk for skin breakdown because she stopped eating as much, was very thin, and didn't like to get out of bed. (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

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 02/06/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked V9 to review R1's record for a Skin Assessment. V9 said the only skin assessment she saw was R1's Initial Skin Assessment (done on admission 7/8/25). On 2/4/26 at 3:22 PM, V2 (Director of Nursing - DON) said she didn't see any skin/wound assessments for R1 since 12/16/25, except a skin/wound note dated 12/25/25 that showed Area remains stable. The surveyor asked V2 what stable means. V2 replied, I'm going to assume not open. I'm guessing just redness and not open. The surveyor asked what V2 would expect to be charted. V2 said she would expect the location of the area, appearance, and size would be included in an assessment. V2 said wound assessments are important to track the progress or decline in a wound. On 2/5/26 at 8:56 AM, V11 (Wound Care Nurse) said this was her first role as a Wound Care Nurse and she had been at the facility since July 2025. The surveyor asked V11 what she does when a resident has a new skin issue. V11 replied it depends on the wound. V11 said for certain things she knows what the wound doctor will want her to do. V11 said if she is unsure then she will call the wound doctor. V11 said if it's redness for incontinence she knows to order zinc barrier cream and leave it open to air. The surveyor asked V11 what kind of assessment she would document. V11 replied just what I saw visually, if I received orders and that I will continue to monitor. V11 said she thinks she documented an assessment for R1. The surveyor asked how the facility monitors a wound without wound assessment documentation. V11 replied, I know what it looks like and I'll go in every other day to see what it looks like and see if there are any new interventions that need to be placed. The surveyor asked how often a skin assessment should be documented. V11 replied, It just kind of depends. Sometimes weekly, sometimes every other. V11 said wound assessments allow us to track the progress or decline of a wound and prevent deterioration of a wound. V11 said R1 had redness to her peri-area and buttocks. V11 said the facility was trying zinc to clear it up, but nothing was really working. V11 said R1 stopped eating as much before she went to the hospital. V11 said lack of proper nutrition and R1 not getting out of bed can contribute to skin breakdown. V11 said the last time she saw R1's buttocks was a couple days before she went to the hospital. V11 said it's possible that R1's wound opened up. On 2/6/26 at 9:39 AM, V15 (Nurse Practitioner) said R1 was admitted to the facility with a failure to thrive and experienced a gradual decline throughout her stay at the facility. V15 said R1 was at risk for pressure ulcer development due to her thin body habitus and decreased nutritional intake. V15 said if R1 had redness it could deteriorate over the bony prominences like the butt into a pressure ulcer. The facility's Wound Policy revised 11/2022 showed the purpose was to identify factors that place the resident at risk for development of pressure ulcers and to implement appropriate interventions to prevent the development of clinically avoidable wounds; promote a systemic approach and monitoring process for the care of residents with existing wounds and those who are at risk for skin breakdown; and to promote healing of existing pressure and non-pressure ulcers. The policy showed any skin impairments, including pressure ulcers, non-pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc, should be assessed and documented weekly by the Wound Nurse or designee.

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NAME OF PROVIDER OR SUPPLIER Forest City Rehab & Nrsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on interview and record review the facility failed to identify, document, and update dietary interventions for a resident with a history of weight loss and a recent change in food intake for 1 of 3 residents (R1) reviewed for weight loss in the sample of 5. These failures resulted in a severe weight loss of 29% for R1 from 1/6/26 until 1/16/26.The findings include:R1's Face sheet dated 2/5/26 showed diagnoses to include, but not limited to diabetes, atherosclerosis (hardening and narrowing) of the aorta, asthma, hypothyroidism, gastro-esophageal reflux disease (GERD), cataracts, dysphagia (difficulty swallowing), lack of coordination, and abnormalities of gait/mobility. R1's facility assessment dated [DATE] showed she had moderate cognitive impairment and required supervision to eat. R1's Care Plan initiated 7/9/25 showed R1 was at risk for weight gain/loss related to diabetes and hypothyroidism. The interventions included monitor and document % (percentage of food) consumed at all three meals and make referral to doctor/dietician if there is a 5 % weight loss over 30 days or 10% loss over 180 days. R1's Weight Summary showed on 7/8/25 her weight was 128 pounds. This document showed the last weight documented by the facility on 1/6/26 was 113.6 pounds. R1's Hospitalist Initial admission Note dated 1/16/26 showed R1 was admitted to the hospital for acute cystitis, hyponatremia and metabolic acidosis. This note showed R1 had severe protein-calorie malnutrition and her weight was 80 pounds (demonstrates a severe weight loss of 29% since the facility's most recent weight on 1/6/26). The hospital record showed R1 appeared frail and cachectic.R1's Nutrition Support dated 1/17/26 showed she was referred for unintentional weight loss. This document showed on 1/17/26 R1 weighed 87 pounds. This document showed she had severe protein-malnutrition in the context of chronic disease. This document showed R1 appears thin and frail. R1's son at bedside and provided most of the information. R1's son stated her intake has steadily declined over the past 6 months and she's somewhat of a picky eater. R1's Facility Amount Eaten showed 1/6/26 R1 consumed 0-25% for breakfast and lunch, but there was no entry for the evening meal. There was no amount eaten documented for R1 1/7-1/10/26. This document showed R1 refused to eat 1/11, 1/13, and 1/15. This document showed R1 ate 0-25% on 1/12 at the breakfast and lunch meals, but there was no entry for the evening meal. R1's Psychiatry Note dated 1/15/26 showed, Per staff, patient has not been eating. This note showed that staff reported the resident was spending approximately $600/week on [a food delivery app], and after her family placed a spending limit on her card, she had reportedly not been eating. R1's Dietary Progress Note dated 1/15/26 showed R1's intakes had been poor, and she does require 1:1 supervision with meals. This note showed R1 continued on an appetite stimulating medication and had multiple interventions in place to aid weight maintenance, including super cereal at breakfast, ice cream twice a day and health shakes three times a day. This note showed R1 used to order food (on a food delivery app) a lot but has been unable to order as much as she used to and may have contributed to some weight loss. This note included R1's weight from 1/6/26. The facility did not obtain a new weight for R1 related to her changes in appetite. (During interview with V5 (Dietician) she said this note was based on a chart review and she did not see R1 in person).R1's progress notes do not show that the nursing staff notified R1's Provider or the Dietician of her change in intake from 1/6/26 to 1/15/26. These notes did not show that weight frequency was increased, or nutritional interventions were updated between 1/6/26 and 1/15/26. On 2/4/26 at 1:34 PM, V6 (Certified Nursing Assistant - CNA) said she was regularly assigned to R1. V6 said R1 didn't like the food at the facility. V6 said she would offer a substitute and usually she'd refuse it. V6 said R1 liked the health shakes, milk and occasionally she could get her to eat grilled cheese. V6 said R1's POA provided her with a card to order from a food delivery app. V6 said R1 ordered a lot of food, but (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	when the amount she could spend on the food delivery app was decreased R1 stopped eating. V6 said she told the nurse that R1 wasn't eating. V6 said she wouldn't know about R1's weight and said to ask the nurse. V6 said the CNAs should document amount eaten after each meal. On 2/4/26 at 1:49 PM, V7 (CNA) said R1 was a little one. V7 said R1 ordered food out because she didn't like the facility's food. V7 said she ordered a lot of food, but then the family stopped the ordering, and she stopped eating. V7 said it looked like she was losing weight after she stopped getting the food delivered. V7 said we reported it to the nurse. On 2/4/26 at 1:54 PM V8 (Licensed Practical Nurse - LPN) said if a resident stops eating, then the facility should obtain a weight to see where they are at. V8 said she remembered R1 had a lot of food delivered. V8 stated, Food was coming in every day, all day. She was eating well when she ordered the food. V8 said if there is a concern with weight loss and lack of intake then the nurse should notify the provider and the dietician.On 2/4/26 at 2:05 PM, V9 (Registered Nurse - RN) said she was familiar with R1 and assigned to R1's hall. V9 said R1 stopped eating when R1's family cut off her card for ordering food deliveries. V9 said R1 didn't completely stop ordering, but it was very decreased. V9 said R1 would eat the delivery food, but not the facility's food. V9 said R1 would take health shakes and eat anything brought from outside. V9 said when R1 stopped eating, she did notice that R1 had lost some weight, but R1 was always pretty tiny. V9 said when R1 stopped eating regularly, the facility probably should have obtained a weight to establish a baseline and/or compare to her previous weights. V9 said she did not see a facility weight entered after 1/6/26. The surveyor asked if R1 weighed 80 pounds at the hospital would that be concerning? V9 replied, Yes, that would be a very significant weight loss. V9 said the CNAs should be documenting meal intakes at every meal. This surveyor reviewed R1's intakes for the last 30 days with V9. V9 said R1 had no documented intakes from the evening of 1/7/26 to 1/11/26. V9 said the purpose of documenting intakes is to ensure the residents are eating enough. V9 said R1 was definitely at risk for weight loss. On 2/4/26 at 2:25 PM, V4 (Dietary Manager) said she the facility has a Nutritional at Risk meeting weekly. V4 said they discuss residents that triggered for weight loss and any new concerns that she becomes aware of. V4 said R1 hadn't been discussed in the meetings held between 1/6/26 and 1/16/26. V4 said she had met with R1 but she was refusing the facility meals and ordering a lot of food delivery. V4 said R1 was non-compliant with her modified diet and was provided education but continued to refuse. V4 said towards the end of R1's stay at the facility she wasn't able to purchase as much from the food delivery app. V4 said the CNAs are usually pretty good about reporting any food issues. V4 said they did tell me that she wasn't getting the food delivery as much and was eating 26-50%. The surveyor asked V4 to review R1's meal intakes. V4 replied there isn't much charted. V4 said there should be a documented food intake for each meal and R1's records did not reflect that. V4 said based on no meal intake documented 1/6/26 evening meal to 1/11/26 she should have requested a weight and notified the dietician. V4 said she would have expected the staff to report that R1 wasn't eating or was minimally eating for several days. On 2/4/26 at 2:45 PM, V5 (Dietician) said she had seen R1, and she had history of weight loss during her stay at the facility. V5 said R1 had gained 1.6 pounds between 12/4/25 and 1/6/26 weights. V5 said she performed a chart review on 1/15/26 but did not physically see R1. V5 said she knew R1 was ordering a lot from a food delivery app, but her family had decreased the amount she could spend. V5 said she was not aware that R1's meal intakes were not documented or were 0-25%. V5 said she was not notified that the resident was refusing to eat or had low intakes. V5 said if she had known, then she would have had the facility to obtain a weight. V5 said if the weight showed weight loss, then she would have talked to the Dietary Manager to discuss food preferences with the resident and review additional interventions to prevent further (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	weight loss. V5 said she believed some of the weight loss was attributed to eating less fast food. V5 said if the resident weighed 80 pounds at the hospital, that would be a significant change. On 2/4/26 at 3:22 PM, V2 (Director of Nursing) reviewed R1's amount eaten for the last 30 days. V2 said this charting was completely unacceptable. V2 said the CNAs know that are supposed to document every meal. V2 said it's a standard of care to document meal intakes. V2 said this documentation is important to monitor if a resident is eating enough and getting their nutritional needs met. V2 said if a resident was not eating or had decreased intakes, then I would expect the staff to obtain a weight and call the Provider or Dietician. V2 said the weight frequency should be increased until the weight stabilized. V2 said that R1's last weight obtained by the facility was 1/6/26.On 2/6/26 at 9:39 PM, V15 (Nurse Practitioner - NP) said she was familiar with R1. V15 said R1 had been admitted to the facility for failure to thrive and had a slow decline in her health throughout her stay. V15 said she saw R1 in November 2025 and again on 1/5/26. V15 said R1 did appear thinner to her on the 1/5/26 visit, but R1 had experienced a weight loss since November. V15 said R1 was on a medication to stimulate her appetite and had nutritional supplements in place. V15 said R1 had a poor appetite and didn't like the facility food. V15 said R1 was ordering out a lot but thought that had decreased. V15 said she didn't know R1 was refusing to eat or that her intakes were less than 25%. V15 said she would expect the facility to notify her of that. V15 said if she was aware of refusal to eat and/or low intake then she would order a weight to see where she was and increase the frequency of the weights. V15 said if R1 continued to lose weight then she would talk to R1's family about other alternatives and possible placement of a feeding tube or hospice referral. V15 said she didn't think R1 was neglected, but the facility could have done weekly weights for better tracking. V15 said she doesn't see how R1 could have gone from 113.6 on 1/6/26 to 80 on 1/16/26. V15 stated, That doesn't seem right. V15 said R1 likely did lose weight, but that seemed drastic. V15 said R1 had been slowly losing weight and her co-morbidities likely contributed to the slow decline in weight and overall health. The facility's Weight Policy dated 9/2018 showed the facility will have a systematic interdisciplinary effort to identify, track, intervene, and monitor residents that are at high risk for weight loss, dehydration and pressure ulcers. Residents reviewed are based on criteria including significant change in appetite and decreased oral intake in the last 7 days.