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	05/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect a resident's dignity during an activity. This applies to one of four residents (R1) reviewed for dignity in the sample of four.The findings include:The facility face sheet for R1 shows she was admitted to the facility with diagnoses to include anxiety, conversion disorder with seizures, encephalopathy and alcohol dependence. The facility assessment dated [DATE] shows her to be cognitively intact and requires supervision for her activities of daily living.On 5/14/26 at 10:04 AM, R3 said he was playing cards with some of his peers and R1 had left the game to go shower. R3 said R2 then came and joined the game but later left to go use the bathroom. R3 said while R2 was in the bathroom, R1 came back to the game to play and sat in the chair R2 was in. R3 said when R2 came back he told R1 to move, and she refused. R3 said R2 picked up the back of R1's chair and forced her to stand up.On 5/14/26 at 10:14 AM, R2 said he had joined a game of cards in the dayroom that night, but he had to use the bathroom after playing for a while. R2 said when he came back, R1 was in his chair. R2 said he asked R1 to get up, but she refused. R2 said he lost his patience with R1 and forced her to get off the chair by picking up the back legs of the chair.On 5/14/26 at 10:24 AM, R4 said he was playing cards with some peers. R4 said R1 was playing cards with them but then left to go take a shower. R4 said R2 came and joined the game but left for a short time to use the bathroom. R4 said while R2 was in the bathroom, R1 came back and sat in the chair. R4 said when R2 came back and saw R1 in his chair he got mad and forced R1 to get out of the chair by picking up the back legs of the chair.On 5/14/26 at 10:36 AM, R1 said she was playing cards with some of her peers and another resident came to join the game and said she was in his seat. R1 said she refused to get up and this other resident (R2) picked up the back of her chair, forcing her to stand up. R1 said she was so mad and felt embarrassed about it. R1 said she nearly fell to the floor.On 5/14/26 at 11:12 AM, V4 (Registered Nurse) said she was working the night R2 forced R1 to get off a chair. V4 said the residents play cards nearly every night. V4 said she heard yelling between the group of residents, and she told them to settle down. V4 said she then saw R2 pick up the back of the chair R1 was sitting in and forced R1 to stand up. On 5/14/26 at 9:25 AM, V1 (Administrator) said an incident happened during a card game between some residents on 5/3/26 around 10:00 PM. V1 said he completed an investigation into the incident, and it was proven that R2 did pick up the back of R1's chair and forced her to stand up and get out of a chair. V1 said these residents play cards nightly and residents will come and go from the game. V1 said R1 had left the game to go shower and R2 joined the game. V1 said R2 left the game to go to use the bathroom and when he got back to the game R1 was in his chair.The facility final investigation into the incident shows after review of the video footage, it was observed that R2 picked up the back of the chair R1 was sitting in and forced her to stand up. The findings of the incident shows confirmation of inappropriate behavior by tipping the chair forward during a verbal dispute. The conclusion shows that a verbal disagreement escalated and R2 inappropriately tipped R1's chair during the dispute. No injuries resulted from the incident. Facility staff were reminded to promptly intervene during escalating resident disagreements to prevent further incident.The facility face sheet for R2 shows he (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was admitted to the facility with diagnoses to include low back pain, myopia and lipoma. The facility assessments dated 2/9/26 shows him to be cognitively intact and requires supervision for his activities of daily living.The facility policy with a revision date of 1/2025 for dignity shows the purpose is to protect the residents right to be treated with dignity and respect. 1. Residents should be treated with dignity and respect. 2. Residents will be assisted in maintaining and enhancing his/her self-esteem and self-worth.