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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 20042 Based on observation, interview, and record review the facility failed to ensure a resident's advanced directive was accurate for 1 of 1 resident (R153) reviewed for advanced directives in the sample of 33. The findings include: On 10/22/24 at 3:35 PM, R153's electronic medical record was reviewed and showed in the banner under his name that his advanced directive was DNR (Do Not Resuscitate). The Physician Orders for R153 showed on 4/17/24 and order for DNR; this was the only active code status order. The POLST (Practitioner Order For Life-Sustaining Treatment) form dated 9/13/24 for R153 showed he was a full code. The Face Sheet for R153 dated 10/23/24 showed, Advance Directive - Do Not Resuscitate. On 10/23/24 at 8:07 AM, V22 (LPN/Licensed Practical Nurse) stated she knows what a resident's code status is by looking at their wristband and MAR (Medication Administration Record). The wristband will tell you if the resident is a DNR. V22 stated in the resident's chart (electronic medical record) it says a residents code status at the top (by resident name). V22 stated she can also look at a resident's orders for the code status. V22 stated the physician orders and the POLST form are supposed to match. V22 opened R153's electronic medical record and stated he is a DNR. V22 looked at his POLST form dated 9/13/24 and it said full code. V22 stated what is documented in his chart and on the POLST form should match. On 10/23/24 at 9:29 AM, V2 (DON/Director of Nursing) reviewed R153's electronic medical record and stated his advanced directives showed he is a DNR. V2 reviewed R153's physician orders for code status and stated he had an order dated 4/17/24 for DNR. V2 reviewed R153's POLST form dated 9/13/24 and said the POLST form says he is a full code. V2 stated social services is to notify nursing when there is a change in code status. V2 stated the POLST form has to match the orders and what is listed as code status. (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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	145937	A. Building B. Wing	10/24/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directives policy (9/19) showed, it is the responsibility of the resident, or their representative, to notify attending physician of each advanced directive(s). An authorized facility employee shall provide assistance to the resident or their representative in communicating with the physician. A written physician's order is required in response to the resident's advanced directive(s). Orders regarding life-sustaining measures will be reviewed and re-signed by the attending physician at the time of the periodic review of orders. A resident, their legal representative or authorized health care representative may rescind their advance directive(s) at any time, whole or in part, through oral statement or revocation, and /or signed and dated written notice to a licensed nurse, licensed administrator, or attending physician. The facility shall honor such revocations upon facility and physician notification of the revocation action.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure treatment orders were in place for a resident with a new drain site, failed to ensure the ordered dressings were in place for a resident with wounds, and failed to do initial wound assessments for a resident for 2 of 2 residents (R521, R45) reviewed for wounds in the sample of 33. The findings include: 1. R521's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include bipolar disorder, pleural effusion, anxiety disorder, insomnia, ileostomy, and major depressive disorder. R521's complete care plan was reviewed and showed no evidence of R521's accordion drain for her liver abscess. R521's care plan initiated 10/4/24 showed, . Change midline dressing every Friday . On 10/22/24 at 2:08 PM, R521 was lying in her bed. R521 showed this surveyor her liver drainage site to her right upper abdomen. There was an undated dressing over the site. R521 said the dressing was placed at the hospital and has not been changed here at the facility. R521's Acute Care Hospital Discharge Instructions dated 10/4/24 showed, . Right upper quadrant drain care . Midline care per policy . R521's October 2024 Physician Order Sheet showed an order dated 10/4/24, 12 French Closed/Suction Accordion Drain to RUQ (right upper quadrant) . R521's Physician Order Sheet showed no evidence of monitoring the drainage site or changing the dressing to the liver drain. The same physician order sheet showed an order dated 10/4/24, PICC (peripherally inserted central catheter) dressing change, luer lock cap change, and measurements every Friday . R521's October 2024 eMAR (electronic Medication Administration Record) showed R521's PICC line dressing change documented as NA on 10/11/24 and left blank on 10/18/24. R521's October eMAR and eTAR (electronic Treatment Administration Record) showed no evidence of dressing changes to her liver drain site. R521's 10/18/24 Nursing Progress Note entered at 8:50 PM showed, Zero supply of PICC line dressing change kits, [pharmacy] called and ordered . On 10/24/24 at 10:00 AM, V19 (LPN/Licensed Practical Nurse) said they have to flush the liver drain once a shift and empty the bag. V19 said she is not sure if the drain site should have dressing changes. V19 said V25 (Wound Care Nurse) would know if there should be dressing changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 10:08 AM, V2 (DON/Director of Nursing) said R521 was readmitted to the hospital with abdominal pain. V2 said R521 came back to the facility on IV antibiotics and with the liver drain in place. V2 said R521 has an accordion drain in place that is emptied every shift. V2 said there aren't dressing changes to the site and that she has a gauze dressing on it and that was it. V2 said V25 (Wound Care Nurse) would be following R521 and the surveyor should follow up with V25 regarding treatments for R521. On 10/24/24 at 11:26 AM, V25 (Wound Care Nurse) said, I don't do anything with her drains, the bedside nurse does stuff like flush it every shift but there are no dressing changes. We had no PICC dressing change kits in the facility. I asked her and she said it had recently been changed. On 10/24/24 at 11:45 AM, V2 (DON) said she has no answer regarding how R521's drainage site is being monitored if the dressing is not being changed. V2 said V25 was notified of the drains and he should be following that. The facility's policy and procedure with issue date of February 2016 showed, . Post Operative Drains . Purpose: To establish guidelines for the management of post operative drainsto prevent complications, promote patient safety, and ensure effective drainage post operatively . 1. Assessment . Assess the surgical site and surrounding tissue for signs of infection, swelling, or increased pain . Clean the insertion site with an antiseptic solution as per facility protocol . Apply a dressing if indicated . The facility's policy and procedure with revision date of January 2012 showed, . Dressing change, Peripherally Inserted Central Catheter . The catheter insertion site is a potential entry site for bacteria that may cause catheter related infection . Dressing changes using transparent dressings are performed . every 7 days . 35175 2. R45's face sheet showed a [AGE] year-old female with diagnosis of mild intellectual disabilities, attention deficit hyperactivity disorder, anxiety disorder, schizoaffective disorder, bipolar type. On 10/22/24 at 11:54 AM, R45 had a white gauze dressing wrapped around her left second toe. On 10/23/24 at 8:57 AM, V25 (Wound Care Nurse) removed R45's open toed shoes and nonskid socks. R45 did not have any dressings covering the wound to the left second toe or the right dorsal foot wound. V25 said both wounds were skin tears, and he was not sure how she got them. V25 said the wounds were healed after the wound doctor treated them and recently reopened. The wounds were classified by the wound doctor as due to an injury or trauma. V25 said R45's current left toe dressing order was for a hydrocolloid not a gauze dressing. V25 said it's important to have wound dressings in place to help manage the wound and promote healing. If dressings come off the nurse should be replacing them. On 10/23/24 at 8:57 AM, R45 sat on the side of her bed. R45 was pale and said diabetes runs in her family but was otherwise not interviewable and talked to herself. R45's left second toe had a small circular open area to the top surface. There was no drainage or odor. The wound itself was light pink and the surrounding tissues were fleshtone. R45's wound to the dorsum (top) of her right foot was circular, pink in color and without redness, drainage or odor. (continued on next page)

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	145937	A. Building B. Wing	10/24/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 8:41 AM, V25 said R45's toe and foot wounds reopened one to two weeks ago. V25 said I never did an assessment on the right dorsal foot. You're supposed to do a wound assessment when a new wound is found. At 9:16 AM, V2 (DON) said if wound dressings are ordered, there should be dressings on the wounds. This is important to promote wound healing, for infection control, and to prevent worsening of the wound. A wound assessment should be done so you have a baseline for comparison to measure improvement or worsening. R45's 8/1/24 facility assessment showed severely impaired cognitive skills for daily decision making. R45's 10/14/24 physician order sheet showed to cleanse both wounds with wound cleanser, apply a yellow occlusive dressing, and cover with a gauze island dressing daily. R45's initial wound assessments were requested. Wound assessments dated 10/23/24 were received. R45's right dorsal foot wound was described as a skin tear which measured 0.4 centimeters (cm) X 0.3 cm X 0.1. R45's left second toe wound was described as a skin tear measuring 0.5 X 0.4 cm X 0.2. R45's care plan does not address her history of a right dorsal foot wound or the left second toe foot wound. The facility's 7/2022 Wound Policy showed the purpose was to identify factors that places the residents at risk for the development of pressure ulcers and to implement appropriate interventions to prevent the development of clinically avoidable wounds; to promote a systematic approach and monitoring process for care of residents with existing wounds and for those who are at risk for skin breakdown; and to promote healing of existing pressure and non-pressure ulcers. Upon identification of the development of a wound, the wound assessment will be documented. Documentation should cover all pertinent characteristics of existing ulcers, including location, size depth, maceration, color of the ulcer and surrounding tissues, and a brief description of any drainage, eschar, necrosis, odor, tunneling, or undermining, if warranted.

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F 0686 Level of Harm - 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** 31615 Based on observation, interview and record review the facility failed to follow up a report of a stage 1 pressure injury resulting in the progression of the injury,and not being identified and treated until it became a stage 3, and failed to implement interventions to prevent the development of a pressure injury for 2 of 3 residents (R90, R122) reviewed for pressure injuries in the sample of 33. The findings include: 1. R90's admission record shows he was admitted to the facility on [DATE]. The 9/30/24 resident assessment and care screening documents R90 to have severe cognitive impairment and is dependant on staff for his personal hygiene needs and mobility. The same assessment shows he is at risk of developing pressure ulcers/injuries and had one stage 4 pressure injury present. The bowel and bladder assessment shows he is always incontinent. The October 2024 bath and shower sheet shows on 10/10/24 a reddened area was noted by V31 (CNA/Certified Nursing Assistant) during his bed bath. The nursing progress notes were reviewed for skin check and assessment related to the reddened area and none were found. On 10/23/24 at 9:30 AM, R90 was observed in bed, he had a dressing to his right hip. The wound on his right hip was noted to be irregular in shape and just larger than a quarter. The surface of the wound was covered with white tissue and the edges were slightly reddened. R90 was not able to provide any information or voice concerns due to his cognitive status. On 10/23/24 at 10:00 AM, V25 (RN/Registered Nurse) said (R90) acquired the pressure wound to the right hip in the facility. He said the new wound was initially identified at a stage 3 after it was reported by a CNA about 2 weeks ago. V25 said it is ideal to find wounds prior to becoming stage 3. He said he completed an assessment after it was reported to him. The wound and skin alteration reviews for October 2024 show on 10/9/24, R90 had wounds to his sacrum and right buttocks. The 10/16/24 weekly skin assessment completed by V25, shows a stage 3 pressure injury measuring 3.0 x 2.0 x 0.2 cm (centimeters) on the right hip. The area was documented as a new wound. The actions taken were orders received and carried out. The family notification was not marked and not documented in the comments of the report or in the nursing progress notes. On 10/24/24 at 10:29 AM, V30 (CNA) said residents get showers twice a week and if they refuse it is reported to the nurse. When residents are incontinent they are changed and care is provided every 2 hours, and skin is checked at that time. V30 said (R90) does refuse his showers and gets bed baths. He is also incontinent of bowel and bladder so staff has to change him every 2 hours and do his skin checks. If there is any reddened areas or spots, they are reported to the nurse and V25. If found during a bath, it is marked on the shower sheet by circling the area. V30 said the shower sheets are then turned into the Director of Nursing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 9:39 AM, V16 (LPN/Licensed Practical Nurse) and former wound nurse said skin checks done with showers twice weekly. If they refuse showers we will just ask to see their skin. It is important to make sure there is no skin breakdown if any skin breakdown is starting it is important to get interventions started to prevent any further breakdown. If a CNA finds reddened areas, it should be reported to the floor nurse and the wound nurse. Nurses should be documenting in the progress notes when any skin issue is identified or reported. The initial assessment should be completed by whoever finds it and include measurements and location of the skin issue. She said notifications are done to the wound physician, V2 (DON/Director of Nursing), V25, and the POA (Power of Attorney)/Guardian. and NP (Nurse Practitioner). V16 said skin breakdown/wounds should be identified prior to becoming a stage 3. She said there would be signs such as redness before it becomes a stage 3. The facility 7/2022 policy for wounds shows 3. Upon identification of the development of a wound, the wound assessment will be documented. 5. Residents should be examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers. 6. Nurse Aides should complete a shower sheet on all residents when they are bathed or showered and given to the charge nurse. b. After review by the charge nurse, the shower sheet should be given to the wound nurse, or designee for appropriate follow up. The 2/1/22 policy for change in resident's condition documents it is the policy of the facility, except in a medical emergency, to alert the resident's physician/NP (Nurse Practitioner) and resident's responsible party of a change in condition. 20042 2. On 10/23/24 at 9:13 AM, V25 (RN/Registered Nurse/Wound Care Nurse) and V22 (LPN/Licensed Practical Nurse) went into R122's room to provide care and dressing change for her pressure injuries. R122 was laying on her back in bed. V25 removed the blanket from R122's legs and feet. R122's off loading boot was not in place to her right foot. V25 stated he did not remove R122's offloading boot before coming in to provide wound care. V25 stated R122 has a deep tissue injury to her right heel and came back from the hospital with the wounds. V25 had gloves on and applied skin prep to R122's right heel. The right heel had a large dark purple/black area present. The Wound Care Physician's Initial Wound Evaluation & Management Summary dated 10/15/24 for R122 showed, deep tissue injury of the right heel. Float heels in bed; off-load wound; reposition per facility protocol; turn side to side every 1-2 hours if able. The Care Plan dated 10/18/24 for R122 showed, documented pressure ulcer to right heel and left lateral foot, unstageable deep tissue injuries related to mechanical forces, pressure over bony prominence's, impaired circulation, and psychogenetic factors manifested by being dependent for activities of daily living/mobility, generalized weakness, diagnoses of dementia, epilepsy, and subdural hemorrhage. Right heel measures 3.5 x 5.7 cm. Maintain off-loading heel boots. The Face Sheet dated 10/23/24 for R122 showed diagnoses including transient cerebral ischemic attack, dementia, cardiac arrhythmia, hypertension, traumatic subdural hemorrhage, hyperlipidemia, and epilepsy. (continued on next page)

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	145937	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer and Skin Condition Assessment policy (10/2011) showed, the resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. The policy did not address pressure ulcer prevention.

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	145937	A. Building B. Wing	10/24/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 20042 Based on observation, interview, and record review the facility failed to ensure a resident had a catheter secure device in place for 1 of 3 residents (R49) reviewed for indwelling urinary catheters in the sample of 33. The findings include: On 10/24/24 at 9:34 AM, R49 was laying on his back in bed. V28 (CNA/Certified Nursing Assistant) and V29 (CNA) were giving R49 a bed bath. R49 did not have catheter secure device in place for his catheter tubing. R49's catheter tubing was pulled tightly to the left and his drainage bag was secured to the lower part of the bed frame. V28 and V29 stated they did not realize he did not have a catheter secure device in place. V28 stated she wasn't aware of R49's catheter coming out. R49 nodded yes that his catheter has come out and put up two fingers. R49 was asked if his catheter came out twice and he nodded yes to confirm. R49 is able to make hand gestures and nod yes/no for communication. R49 was asked if he would let the facility put a device on to hold his catheter tubing in place to try and prevent any trauma and he nodded yes. On 10/24/24 at 9:39 AM, V2 (DON/Director of Nursing) stated the facility uses catheter secure devices to secure catheter tubing. V2 stated the deices should be offered for all residents with catheters. V2 stated some residents have irritation from the catheter secure device and when that happens staff can use paper tape or a band to keep the tubing secure. The Physician Orders dated 10/24/24 for R49 showed catheter care every shift. The Face Sheet dated 10/24/24 for R49 showed diagnoses including hemiplegia and hemiparesis of right side, dysphagia, morbid obesity, peripheral vascular disease, retention of urine, benign prostatic hyperplasia, hypertension, anxiety, bipolar disorder, major depressive disorder, neuromuscular dysfunction of bladder, and edema. The Care Plan dated 9/17/24 for R49 showed, R49 is at risk for complications related to catheter use. The catheter size is 18 with 5 mm balloon. Render catheter care every shift. Good peri care - being careful not to pull tubing. The care plan did not show the use of a catheter secure device or refusal of use of the device. The facility's Catheter Care policy and procedure (10/31/18) showed indwelling catheter will be secured to prevent trauma and tension.

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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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	145937	A. Building B. Wing	10/24/2024

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review the facility failed to store respiratory equipment in a manner to prevent contamination and failed to date respiratory equipment when changed for 2 of 2 residents (R144, R126) reviewed for oxygen in the sample of 33. The findings include: 1. R144's face sheet showed a [AGE] year-old male with diagnosis of chronic obstructive pulmonary disease, acute and chronic respiratory failure, anxiety disorder, and hypertension. On 10/22/24 at 11:02 AM, R144 was in his room in a wheelchair. R144 was alert and oriented X3 and had oxygen running at 2 liters per nasal cannula via a portable oxygen concentrator. There were no markings on the oxygen tubing to indicate when it was started. At 11:17 AM, there was an oxygen concentrator in the room turned on and running. There was oxygen tubing in contact with the floor and the end of the cannula was on the bed. There was a CPAP (continuous positive airway pressure) mask connected to a machine on the bedside table. The facemask was hanging from a knob of a drawer on the table. The concentrator tubing and the CPAP tubing were uncovered and had no markings to indicate when they were initiated. On 10/24/24 at 9:16 AM, V2 (Director of Nursing/DON) said, Respiratory masks and tubing should be stored in a baggie when not in use. It's important so the equipment does not become contaminated. We change our tubing weekly on Sunday night and prn (as needed). Tubing changes are documented in the TAR (Treatment Administration Record) for night shift. If our policy showed respiratory equipment should be dated, then it should be dated. It should be change to make sure it doesn't grow a bunch of bacteria, it's moist. It could cause an infection if grew bacteria. R144's physician orders had no orders for the CPAP machine or care of the equipment orders. The facility's 8/2014 Oxygen Equipment Policy showed the policy objective was to administer oxygen in conditions in which infection control is maintained. The facility will use disposable nasal cannula and facemasks. Equipment will be changed weekly and prn (as needed) and dated. Oxygen tubing/nebulizer masks will be changed and dated weekly and prn. Oxygen tubing/nebulizer masks will be covered when not in use. 2. R126's face sheet showed a [AGE] year-old male with diagnosis of chronic obstructive pulmonary disease, obstructive sleep apnea, schizoaffective disorder, hallucinations, and hypertension. On 10/22/24 at 11:24 AM, R126 was sitting on the edge of his bed receiving a breathing treatment via a nebulizer machine. The nebulizer mask and tubing had no markings to indicate how old the equipment was. There was a CPAP facemask, tubing, and machine on the bedside table. The face mask was uncovered and on top of the machine. R126 was alert and oriented X3. His color was fleshtone and he was in no distress. On 10/24/24 at 9:16 AM, V2 (DON) reviewed R126's medical record. V2 said there were no orders to change his tubings so there was no documentation it was done. (continued on next page)

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	145937	A. Building B. Wing	10/24/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R126's 10/10/24 physician's order showed to administer a medicated nebulizer treatment every 8 hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to administer an injectable medication per manufacturer instructions and failed to ensure a medication was available for 2 of 2 residents (R62, R153) reviewed for medications in the sample of 33. The findings include: 1. R62's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include anxiety disorder, Type 2 Diabetes, emphysema, bipolar disorder, and hypertension. R62's facility assessment dated [DATE] showed she has no cognitive impairment. R62's Physician Order Sheet showed an order started 5/15/24 for Dulaglutide Subcutaneous Solution Pen-Injector 0.75 mg (milligrams)/0.5ml (milliliters) (Trulicity) to be administered once weekly on Wednesdays. On 10/22/24 at 12:53 PM, R62 said she was out of her diabetic medication, Trulicity, in September and missed several doses. R62's September 2024 eMAR (electronic Medication Administration Record) showed she did not receive her Trulicity as scheduled on 10/18/24 or 10/25/24 due to it not being sent by pharmacy. On 10/24/24 at 12:37 PM, V38 (LPN/Licensed Practical Nurse) said if a medication is not available for administration they should call the pharmacy to check to see what the reason is that they didn't send it. V38 said they should call the doctor if its an insurance issue they should call the doctor to see if a partial prescription can be sent into the local pharmacy. On 10/24/24 at 10:18 AM, V2 (DON/Director of Nursing) said R62's Trulicity is being ordered today. R62 said she let R62's physician know and he said to give it when it comes in from pharmacy. V2 said she was not aware that R62 missed her Trulicity in September. 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 . 39543 2. R153's Admission Record (Face Sheet) showed he was type 2 diabetic. R153's Order Summary Report (dated 10/23/24) showed an active order for fast acting insulin to be given four times a day. The order showed the insulin dosage was based on blood sugar levels. The order showed 8 units of insulin should be given for a blood sugar reading between 301 and 350. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 10:54 AM, V6 (Licensed Practical Nurse/LPN) measured R153's blood sugar to be 338. V6 then attached a needle to R153's fast acting pre-filled insulin pen. V6 dialed in 8 units of insulin, entered R153's room, and wiped the back of his right arm with an alcohol wipe. V6 then pressed the needle into R153's arm, depressed the plunger button, and held the button for less than 3 seconds. V6 did not wipe the pen tip with alcohol prior to attaching the needle and she did not prime the insulin pen. On 10/23/24 at 12:57 PM, V2 (Director of Nursing) stated, V6 should have wiped the tip of the insulin pen prior with alcohol prior to attaching the needle to prevent cross-contamination. V2 stated, V6 should have also primed the insulin pen prior to injecting the insulin. V2 stated the purpose of priming the insulin pen is to fill the needle with insulin so the resident receives the full dose of insulin. V2 stated failure to prime the needle would mean less insulin was given than ordered. V2 stated V6 should have also held the plunger button, while the need was inserted in R153, for several seconds. V2 said holding the plunger ensures the full dose of insulin is injected. V2 said the facility and nurses follow manufacturer's instructions for insulin pens. The manufacturer's instructions for the quick acting insulin show the rubber tip should be wiped with alcohol prior to attaching the needle, the pen should be primed with 2 units of insulin, and after the needle is inserted into the skin the button should be held for a slow 5 count.

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	145937	A. Building B. Wing	10/24/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39543 Based on observation, interview, and record review the facility failed to date opened insulin pens. This applies to 2 of 2 residents (R153, R166) reviewed for medication storage in the sample of 33. The findings include: 1. On 10/24/24 at 10:45 AM, The 200-hall medication cart was reviewed with V9 (Licensed Practical Nurse/LPN). R153's fast-acting insulin pen had a yellow sticker with three areas for documentation. The areas were Date Open, Date Expire, and Initials; all three areas were blank. R153's insulin pen showed no handwritten dates elsewhere on the pen. The pen had a red tamper seal around the pen cap, which was damaged, indicating the pen had been opened. R153's fast-acting insulin pen also had coarse milliliter graduations which showed some insulin had been dispensed. V9 stated she had given R153 insulin from that pen earlier in her shift. V9 said whoever opens the pen is supposed to date the pen. R153's Order Summary Report (dated 10/23/24) showed an active order for fast-acting insulin to be given four times a day. On 10/24/24 at 11:16 AM, V2 (Director of Nursing/DON) stated the insulin pens are supposed to be dated when they are opened. V2 said after 28 days the potency of the insulin begins to degrade. V2 said, I just in-serviced the staff on this (dating and labeling insulin pens and vials). The facility's in-service showed all open insulin pens expire after 28 days. 2. On 10/24/24 at 10:45 AM, the 200-hall medication cart was reviewed with V9 (LPN). R166's long acting and fast-acting insulin pens had a yellow sticker with three areas for documentation. The areas were Date Open, Date Expire, and Initials; all three areas were blank. The two insulin pens had no other dates documented on the pen indicating either an open or expiration date. The insulin pens had tape covering the seals between the pen cap and the pen, which were damaged, indicating the pens had been opened. V9 stated she had given R166 his long-acting insulin that day from the undated pen. V9 stated the pens should have been dated when they were opened. R166's Order Summary Report (dated 10/24/24) showed and active order to inject 15 units of fast-acting insulin three times a day and to inject 44 units of long-acting insulin once a day. On 10/24/24 at 11:16 AM, V2 (DON) stated the insulin pens are supposed to be dated when they are opened. V2 said after 28 days the potency of the insulin begins to degrade. V2 said, I just in-serviced the staff on this (dating and labeling insulin pens and vials). The facility's in-service showed all open insulin pens expire after 28 days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39543 Based on observation, interview, and record review the facility failed to handle food in a manner to prevent cross-contamination. This failure has the potential to affects all residents residing on the first floor. The findings include: The facility resident census, provided on 10/22/24, showed 81 residents out of 164 residents, reside on the first floor. On 10/22/24 at 9:49 AM, V32 (Dietary Manager) stated the noon meal was open face turkey sandwich and alternatives included but not limited to hamburgers, grilled cheese sandwiches, and cold meat sandwiches. On 10/22/24 at 11:37 AM, V33 (Cook) began lunch service on the first floor. During the lunch service, V33 grabbed the hamburger patties from the container with her gloved hand after she had touched potentially contaminated surfaces such as handles, bags, food containers, and horizontal surfaces. V33's did not change gloves and her gloves developed a layer of grease on them. V33 would then grab a slice of bread for the open face turkey sandwich with the same greasy glove. V33's fingers also contacted the top of the plates leaving a grease streak on the plate. This process of alternating between hamburgers and the open face turkey sandwiches continued for the entire lunch service; V33 did not change her gloves. On 10/23/24 at 2:09 PM, V32 stated V33 should have used tongs or changed her gloves prior to and after handling the hamburger patties, especially after touching potentially contaminated surfaces. V32 said this to prevent cross-contamination. The facility Food Safety and Sanitation policy: Glove Use (revised 9/20/23) showed, The facility will practice safe food handling and avoid cross contamination through proper use of gloves. The Food and Nutrition Department Manager or designee will ensure that employees practice proper use of gloves .Single use gloves need to be changed: As soon as they become dirty or torn. Before beginning a different task .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 20042 Based on observation, interview, and record review the facility failed to ensure enhanced barrier precautions were in place for a resident with a pressure injury. The facility failed to ensure soiled linen was not discarded on the floor and gloves were changed after care and before touching other contact surfaces to prevent cross contamination for 2 of 2 residents (R122 & R151) reviewed for infection control in the sample of 33. The findings include: 1. The Nurse's Notes dated 10/11/24 at 3:56 PM for R122 showed, resident admitted from the hospital via ambulance stage two on coccyx area at this time. The Nurse's Note dated 10/18/24 at 1:13 PM for R122 showed, R122 is alert, disoriented, but can follow simple instructions; has difficulty making needs known. R122 needs mechanical lift (2 person assist) for transfers, eating with total assistance, dressing/hygiene with total assist, and is incontinent of urine, is incontinent of bowel. Resident is non-verbal due to previous CVA (cerebral vascular accident), with hemiplegia, she is dependent on staff for all ADL's (activities of daily living) and her meals. She is dependent on staff for meals, turning and repositioning. She was admitted with pressure injury on her coccyx, and DTI's (deep tissue injuries) bilateral heels; treatment in place. On 10/22/24 at 2:25 PM, R122 was laying on her back in bed while V24 (Hospice CNA/Certified Nursing Assistant) was in the room giving R122 and bath and applying lotion to her skin. V24 had gloves on but did not have a gown on. V24 turned R122 onto her right side and R122 had a dressing in place to her coccyx. V24 stated she was told in report that R122 had a dressing to her coccyx but she did not know if the wound was open or not. There wasn't an enhanced barrier precaution sign on R122's door or an isolation cart in the hallway. On 10/23/24 at 9:13 AM, V25 (RN/Registered Nurse/Wound Care Nurse) was at R122's bedside to provide care to her pressure injuries. V25 removed the dressing from R122's coccyx and she had an open area present. V25 stated R122 had a stage III pressure injury to her coccyx. V25 stated R122 was on enhanced barrier precautions for her wounds. On 10/23/24 at 9:29 AM, V2 (DON/Director of Nursing) stated, EBP (enhanced barrier precautions) is for anyone with a catheter, wounds, infections, tubes etc. We post a sign on the door and put an isolation cart in hall. When care is provided staff should wear a gown and gloves. It is important so they don't contaminate themselves when providing care and so they don't spread anything to others. The Face Sheet dated 10/23/24 for R122 showed diagnoses including transient cerebral ischemic attack, dementia, cardiac arrhythmia, hypertension, traumatic subdural hemorrhage, hyperlipidemia, and epilepsy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Enhanced Barrier Precautions policy (8/15/24) showed, enhanced barrier precautions require the use of gown and glove during high contact resident care activities. High contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of an indwelling medical device Wound care: any skin opening requiring a dressing 2. On 10/22/24 at 11:19 AM, V23 (CNA) was providing incontinence care for F151. There was a soiled washcloth on the floor. V23 towel dried R151, removed the incontinence pad from under R151, and threw the linen on the floor. V23 removed R151's her pants that were at her ankles. V23 took R151's pants and grabbed the soiled linen from the floor. V23 went to the door, opened the door, and went into the hall with his gloves and gown on while carrying soiled the soiled linen. R151 pushed the door open more when he returned to the room with the gloves and gown still on. V23 assisted R151 out of bed and into her wheelchair. R151 then removed his gloves and gown. On 10/24/24 at 9:39 AM, V2 (DON) stated, Linen should be bagged up and there are bins for soiled linen. Dirty linen should not be on the floor for infection control reasons and it is disgusting. Gloves are to be changed after providing care. They should wash their hands and put on gloves before they touch anything else so they don't contaminate anything else. Its for infection control. R151's Face Sheet dated 10/23/24 showed diagnoses including Wernicke's encephalopathy, conversion disorders with seizures or convulsions, hepatic encephalopathy, cirrhosis of liver, and insomnia. The Care Plan dated 9/27/24 showed, R151 is frequently incontinent related to general weakness, requiring assistance with toileting, and due to the use of anticholinergics and diuretics. Staff will check and change resident per facility protocol and as needed for incontinence. The facility's Linen Handling policy (no date) showed, every effort will be made to ensure that soiled linens or clothing does not come in contact with uniforms, furniture, or other areas deemed clean. Soiled linen shall not be placed on the floor. Soiled linens shall be carefully removed from beds, rolled inward, and placed directly into plastic bag or soiled linen containers, at the location of use and not transported openly through corridors (unless in plastic bags). The facility's Perineal and Genital Care policy (no date) showed hands are to be washed and gloves put on before care. The procedure for incontinence care was given. The policy stated after providing the care, Assist resident to comfortable position. Empty basin, clean and dry. Place soiled cloths in linen hamper bag. Remove gloves and wash hands.