

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001135	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2021
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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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S 000	Initial Comments Annual Licensure and Certification survey. F689G & F695G Cited	S 000		
S9999	<p>Final Observations</p> <p>1) Statement of Licensure Violations:</p> <p>300.610a) 300.1210a) 300.1210b) 300.1210c)2)3) 300.1210d)6) 300.1220b)2)3) 300.3220f) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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S9999	<p>Continued From page 1</p> <p>the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>made by nursing staff and recorded in the resident's medical record.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities,</p> <p>Section 300.3220 Medical Care</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with severe sleep apnea received continuous positive airway pressure (CPAP) treatment; failed to ensure transcribe a physician order for CPAP treatment; and failed to identify, assess, monitor, and provide interventions for a resident requiring CPAP treatment one resident (R225). These failures resulted in R225 being transferred to the hospital via ambulance on 5/27/21 in respiratory distress.</p> <p>The findings include:</p> <p>On 5/25/21 at 12:45 PM, R225 walked from her bathroom, across her room, and sat on the edge of her bed. R225 was wearing oxygen via nasal cannula. R225 was short of breath and unable to answer more than one word without having difficulty breathing. R225 stated, "I need a minute." After several minutes, R225 was able to answer questions with short phrases. R225 had a CPAP machine with a hose lying on the floor of</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>her room, near the head of the bed. R225's CPAP hose did not have a mask attached to it. R225 said she is supposed to wear the CPAP at night, but hasn't been able to because she hasn't had a mask. R225 said she hasn't been wearing the mask since she got to the facility. R225 said she needs the part that she puts on her face and she gets anxious with the full face mask. R225 said she needs the mask that only covers her nose. R225 said she's told the staff about it, but no one has brought me a mask. R225 said she was admitted to the facility after being in the hospital, on a ventilator, in a medically induced coma for 28 days. R225 stated, "I'm not sure who takes care of the masks here, but it would be nice if they would." R225 said she has just been wearing the oxygen all the time. During this interview, several short breaks had to be taken to allow resident time to calm her breathing.</p> <p>On 5/26/21 at 9:20 AM, R225 was sitting up on the side of her bed with her oxygen on. The CPAP machine and hose remained on R225's floor and there was no mask visible in her room.</p> <p>On 5/27/21 at 09:26 AM, V14 (Licensed Practical Nurse - LPN) said she was the nurse for R225. V14 said she heard R225 snoring this morning and wondered why she wasn't using her CPAP, that was sitting on the floor. V14 stated, "I didn't even know she needed a CPAP until this morning." V14 said when I asked her why she wasn't using it, she pointed down and said, "I didn't have a mask for it." V14 said when a resident is admitted the nurse receiving the resident will review the orders and enter them into the computer. At 9:30 AM, V15 (Admissions Director) approached V14 and stated, "[R225] was trying to come out of her room, she's short of breath, on the phone with her doctor's office, and</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>says she wants to go to the hospital." V15 stated, "She is on the phone with someone that wants to talk to the nurse, [R225] said she was talking to her doctor." V14 went to R225's room. At 9:35 AM, V14 (LPN) returned to the nurses station and said R225 was talking to V18's office (R225's Pulmonologist). V14 said R225 was up walking and is short of breath and V18's office wants R225 sent to the emergency room for evaluation. At 9:49 AM, V14 (LPN) called 911 and reported R225 needed transport to the hospital for an exacerbation of COPD (Chronic Obstructive Pulmonary Disease). V14 said R225's oxygen saturation was 80% on 3 liters of oxygen, via nasal cannula. At 9:59 AM, R225 was transported via ambulance stretcher. R225 had visible intercostal retractions, was short of breath, pale, and wearing a non-rebreather oxygen mask. The CPAP machine was not transported with the resident to the hospital.</p> <p>R225's Facesheet printed 5/27/21 showed diagnoses to include: chronic obstructive pulmonary disease, lack of coordination, cognitive communication deficit, polyneuropathy, hyperlipidemia, bacterial pneumonia, edema, major depressive disorder, anxiety disorder, and hypertension. This document showed R225 was admitted to the facility on 5/17/21.</p> <p>R225's Hospital Records dated 5/13/21 showed R225 was admitted to the hospital on 4/4/21 and discharged on 4/30/21. This document showed R225's Plan was, "...3. Ref (referral) to Pulmonary Rehab...6. Pulmonary/sleep appointment... Visit Diagnoses: Acute on chronic respiratory failure with hypoxia and hypercapnia, anxiety, COPD with acute exacerbation, obstructive sleep apnea, morbid obesity, tobacco abuse disorder..."</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>R225's Pulmonary Medicine Clinic Department of [a local hospital] order dated 5/17/21 showed R225 had diagnoses of obstructive sleep apnea and COPD. This document showed an order for "oxygen 1 lpm (liter per minute) at rest, then 2 lpm with ambulation. autopap 8-12 cmh20 (CPAP settings) with 2 lpm oxygen while sleeping." There are handwritten notes on the bottom of this document that stated, "See prog (progress) note. She requires a CPAP not BiPAP! Will need to call..."</p> <p>R225's Physician Order Sheets were reviewed. There were no orders entered for CPAP therapy.</p> <p>R225's Progress Notes were reviewed from admission (5/17/21) to 5/26/21. There were no entries related to R225 needing, using, or refusing to use the CPAP.</p> <p>R225's Care Plan was reviewed on 5/26/21 and there was no mention R225 requiring a CPAP.</p> <p>On 5/27/21 at 09:32 AM, V2 (Director of Nursing - DON) reviewed R225's Electronic Medical Record (EMR) with this surveyor. V2 said I saw the order for R225 to have the CPAP, scanned under the Miscellaneous tab, but I don't see an order for it. V2 said that order should have been entered by the admitting nurse. V2 said V19 (Assistant Director of Nursing - ADON) is supposed to audit new admissions and should have caught this. V2 said the admission audits are a double check to make sure we have everything done correctly. V2 said R225 not having the CPAP in place could lead to respiratory distress. V2 said R225 should have a face attachment. V2 said V16 (LPN) would have ordered it.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>On 5/27/21 at 9:44 AM, V16 (LPN) stated, " I do not order CPAP supplies. [V17, Housekeeping Director] does that, he places the orders. I haven't heard anything about [R225] needing supplies for a CPAP. The CPAP shouldn't be on the floor. I don't know where the facial attachment (mask) is."</p> <p>On 5/27/21 9:57 AM, V17 (Housekeeping Director) stated, "I'm not sure where we got [R225's] CPAP. Usually I order the mask and tubing when V16 (LPN) tells me. I have not ordered any masks for her. I wasn't aware that she needed one."</p> <p>On 5/27/21 at 10:19 AM, V19 (ADON) stated, "I just searched the room and didn't find a mask. It was just the box (CPAP) and the hose. "</p> <p>On 5/27/21 at 11:48 PM, V20 (V18's Office Nurse) said she was familiar with R225. V20 said she talked to R225 this morning and she was very short of breath. V20 stated, "[R225] was so short of breath she couldn't finish her sentences." V20 said she asked to speak with the nurse at the facility and told the nurse to send R225 to the emergency room. V20 stated, "I believe [R225] is admitted to the hospital now.</p> <p>On 5/27/21 at 12:04 PM, V18 (R225's Pulmonologist) said the last time R225 was in the office was September 2020, but she had recently been hospitalized and he provided the facility with an order for her CPAP treatment. V18 said R225 should be using the CPAP every night, as ordered. V18 said R225 has several co-morbidities that contribute to her breathing difficulties including: obesity, smoking, COPD, and severe sleep apnea. V18 stated, "Not using her CPAP every night would have contributed to</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>her breathing difficulties that caused her to have to go to the hospital today."</p> <p>The facility's Physician Orders Policy and Procedure (1/2020) showed, "Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Policy: ...2. Orders must be recorded in the medical record by a licensed nurse authorized to transcribe such orders... 5. The Physician Order Sheet (POS) will be maintained with current orders as new orders are received.</p> <p>The facility's CPAP/BiPAP Use Policy (1/1/20) showed, "Policy: To provide guidelines for use of CPAP/BiPAP therapy for treatment of the following conditions: Obstructive sleep apnea... history of respiratory failure. Procedure 1. Resident using CPAP/BiPAP will require a physician's order to include approved order setting, duration of use, and use of humidifier..."</p> <p>(B)</p> <p>2) Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.1210c) 300.1220b)2)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities,</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to provide adequate</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>supervision for a resident with a history of falls and failed to implement fall prevention measures for a resident for one resident (R82) reviewed for falls. This failure resulted in R82 sustaining a right humerus fracture from a fall.</p> <p>The findings include:</p> <p>On 5/25/21 at 10:46 AM, R82 was in bed, sleeping soundly. There was no scoop mattress, nor were any fall mats noted. At 10:59 AM, this surveyor was standing outside R82's room and observed him attempting to pull the blankets off himself. R82 sat up on the side of his bed, with his blanket still stuck on his right foot. R82 stood up, his right foot slipping on the blanket, walked out of the blanket and proceeded to pace around his room. R82 was not wearing shoes and had a shuffling gait.</p> <p>R82's Facesheet printed 5/27/21, showed he had diagnoses to include, but not limited to: nondisplaced fracture of the right humerus; abnormalities of gait and mobility; lack of coordination; unsteadiness on feet; chronic obstructive pulmonary disease; diabetes, obesity; and dementia.</p> <p>R82's facility assessment dated 3/26/21, showed R82 had short and long term memory problems; required extensive assistance of two or more staff members for bed mobility, transfers, toilet use, and personal hygiene; not steady and only able to stabilize with staff assist for moving from seated to standing position, walking, and turning around; had an impairment on one side of his upper extremity; was frequently incontinent of urine and bowel; and had fallen since admission.</p> <p>R82's Fall Care Plan (initiated 5/19/16) was</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>reviewed on 5/26/21. This care plan showed, "[R82] is at risk for falls r/t (related to) use of psychotropic medications, use of antihypertensives, use of hypoglycemics, history of falls, he has not been wearing shoes and/or socks..." This care plan included interventions of fall mats (initiated 4/24/21) and scoop mattress (initiated 4/24/21). The copy of the care plan provided by the facility was edited and these interventions were not printed.</p> <p>R82's fall list dated 11/26/20 to 5/26/21 showed 15 falls incidents. Handwritten on this note was, "March 13th Moved Downstairs." This list showed R82 fell on 12/7/20, 1/4/21, twice on 3/11/21 (once at 2:05 PM and a second time at 5:45 PM), and 11 more times. (The second fall on 3/11/21 resulted in R82 fracturing his right arm.)</p> <p>R82's Progress Note dated 3/11/21 at 2:05 PM showed, "This writer was called to resident room [by staff]. Resident observed lying on the floor on left side with head near back of toilet, back to the wall, legs in the front of the toilet. The call light was not in use, light was on, resident had urinated on the floor. Resident had shoes on. Resident stated, "I fell." Resident inspected for injuries, red area noted to back of head. No other injuries notes... Resident ambulated to bed with weakness and unsteady gait noted..."</p> <p>R82's Progress Note dated 3/11/21 at 5:45 PM showed, "This writer observed staff attempting to redirect resident due to resident attempting to walk to room with tray. Staff told resident they would bring his tray to his room due to res weakness and unsteady gait while ambulating. Resident started cussing at staff and attempting to take tray. Resident spilled his juice on his tray, resident then gave his tray to staff. Resident did</p>	S9999		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001135	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2021
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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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S9999	<p>Continued From page 13</p> <p>not have shoes on and staff was attempting to warn res that there was juice on the floor when resident slipped in juice, resulting in fall. Resident did not hit his head but attempted to catch him self with his right arm. Resident fall was witnessed by this writer and CNA. This writer inspected resident for injuries, abrasion noted to right knee, right shin. This writer assessed ROM when resident c/o (complained of) pain to right arm near shoulder. Resident was guarded and would not move shoulder, right elbow ROM WNL and all other ROM WNL... Notified [R82's physician], order for multiple x-rays to right arm..."</p> <p>R82's Progress Note dated 3/11/21 at 11:00 PM showed R82 was transferred to the emergency room.</p> <p>R82's Progress Note dated 3/12/21 at 8:20 AM, showed R82 returned from the local emergency room with a prescription for pain medication related to a right humerus fracture from a recent fall.</p> <p>R82's Physician Progress Note dated 3/26/21 at 1:57 PM showed, "...Rehabilitation follow-up for impaired ADLs and mobility related to right upper extremity myopathy and physical deconditioning related to right humeral neck fracture and recent hospitalization."</p> <p>On 5/27/21 at 11:05 PM, V11 (Restorative Nurse) said she is responsible for reviewing all the falls at the facility. V11 said the falls are discussed at the daily interdisciplinary meetings, the team brainstorms appropriate interventions, and those interventions are entered into the record. V11 reviewed R82's record during this interview and verified that R82 had interventions entered for a scoop mattress and fall mats. V11 said any</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>interventions on R82's care plan should be in place. V11 stated, "The team decided not to go with scoop mattress, but I forgot to take it out of the care plan. Thanks for catching that; I just deleted it." V11 said that V1 (Administrator) said he was going to order R82 fall mats at the IDT meeting on 4/24/21. V11 said she wasn't sure why R82 did not have the fall mats yet. V11 said fall interventions are put in place to prevent further falls and possible injuries to residents. V11 said preventative measures would include fall mats and a scoop mattress. V11 said R82 is not supposed to ambulate by himself, but she saw him doing so yesterday.</p> <p>On 05/27/21 at 12:05 PM, V4 (Certified Nursing Assistant - CNA) said we encourage R82 to stay in his wheelchair because he's unsteady on his feet. V4 said R82 is not supposed to be up walking alone. V4 said she wasn't sure what R82's fall interventions are because she has been too busy to look. V4 said she would refer to R82's care plan or ask the nurse if she wasn't sure. V4 said R82 is hard-headed and won't always ask for help. V4 stated, "We try to keep an eye on him, but it's not always possible."</p> <p>On 5/27/21 at 12:20 PM, R82 was in his room, lying in bed. There was no scoop mattress or fall mats in his room. R82's call light was hanging off the bed, out of reach of the resident. As the surveyor exit the room, R82 started yelling out, "light,light." The surveyor returned to R82's room and he was sitting on the edge of his bed. R82 was unsteady and had his blanket wrapped around his foot. R82's wheelchair was parked at the foot of the bed, away from the resident. The resident was instructed to wait for staff to assist him with the transfer and he said he would wait.</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>On 5/27/21 at 12:46 PM, V1 (Administrator) stated, "I can't recall ordering a scoop mattress for him. I know he's fallen a bunch and we've done a bunch of things." V1 stated, "I can't clearly give you an answer as to why he keeps falling, he has no safety awareness. Earlier today he was in my office walking around, asking me to buy him a pizza. V1 said R82 did fall and break his arm in March and he did report it. V1 stated, "I don't have an excuse as to why the fall interventions are not in place."</p> <p>On 5/27/21 at 1:41 PM, V12 (Registered Nurse - RN) said she was working on the second floor the night R82 fell and broke his arm (3/11/21). V12 said R82 had fallen in his room earlier in the day and he was having weakness. V12 said later that night R82 walked to the dining room to get his dinner tray. V12 stated, "He was unsteady so we were trying to get him back to his room to lay down. He's very hard of hearing and was having weakness. The CNA and I were trying to tell him we would bring him is tray and he was getting agitated. The CNA was carrying the tray, he turned to grab the tray from her, and he fell. When he fell he landed on his arm. When I assessed him, he said his arm was hurting. I called the doctor and we sent him to the emergency room. When he came back from the hospital they moved him downstairs. I guess he broke his arm and was in a sling. He had COVID and it seemed like for a while he was just declining. He was unsteady on his feet, weak, and short of breath with ambulation."</p> <p>The facility's Fall Prevention Program (2/28/2014) showed, "Policy: It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility... The program will include measures which determine the</p>	S9999		

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S9999	Continued From page 16 individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistance devices are utilized... (B)	S9999		