STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	**1920 NORTH MAIN STREET ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1012500/ IL 48088 F165, F223, F225, F248, F249, R252, F258, F312, F490 Complaint Investigation 1012635/ IL 48252 F312, F328 A Partial Extended Survey was conducted.	F 000		
F 165 SS=F	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that staff and residents feel that they can report concerns to the facility without fear of retaliation. The facility also failed to ensure residents that their grievances will be acted upon and they will be kept aware of the progress the facility is making toward a resolution. This has the potential to affect all 76 residents residing in the facility. The example includes: On 6/25/2010 at 2:56 PM, a confidential interviewee states, "It's a scary place to work. If	F 165		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 165	Continued From page 1 you have concerns you can't complain because everyone is related." Another confidential interview took place at 2:41PM. The interviewee stated, "I was told to be careful what I say to state. There is too much family working here - a lot of favoritism. I keep my mouth closed because everyone is related. Other staff have warned me that it is a waste of time to complain because nothing will get done about the concerns." During a confidential resident interviews it was said that any concerns brought to the administration do not get acted upon. During another resident interview, she said, "They told me state is here. I don't know what they expect me to do. Look, I'm not paranoid but they keep walking slowly by my room while you are in here." On 6/15/2010 at 1:00 PM Z2 was interviewed and on 6/16/2010 at 1:10 PM Z1 was interviewed. Z2 said that residents have told her that they are afraid to report concerns because many of the supervisory staff have relatives working in the facility. Z1 said that many of the supervisory staff are supervising their own family members. Z1 said that family members of E1(Administrator) , E2 (Director of Nursing), E14(Dietary Supervisor), and E11 (Social Service Director) work in the facility. It was said that the residents are afraid to talk to anyone or complain. The facility's Abuse Prevention Program Procedure states, "All personnel, residents, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear or retaliation from the facility or its staff..."	F 165		
F 223	483.13(b), 483.13(b)(1)(i) FREE FROM	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223 SS=H	Continued From page 2 ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review, the facility failed to ensure that residents were not verbally abused by E7. (R14, R2, R12, R18). This failure resulted in E7 speaking to R14, R2 and R12 in a demeaning manner and E7 encouraging R18 to view R12's exposed breasts while she was calling for help. The examples include: 1. According to Admission and Discharge Logs presented by the facility, R14 was a resident in the facility from 1/19/10 until her discharge to another long term care facility on 4/9/10. A confidential interview was conducted on 6/25/10 at 9:10 AM. The interviewee stated E7 (Licensed Practical Nurse) "curses" at the residents "all the time." He/She said this behavior was witnessed by himself/herself while also in the presence of E1 (Administrator) and E2 (Director of Nursing). The confidential interviewee stated E1 and E2's response to E7's behavior was to laugh. This interviewee stated R14 required leg wrapping while at the facility. The interviewee witnessed E7 yell the following	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 3 to R14, "You wouldn't have to have your legs wrapped so much if you would quit pissing yourself!" On 7/1/2010 at 2:15 PM, E1 denied that he or E2 had ever laughted at E7's behavior. The facility Policy and Procedure defines Verbal Abuse as "use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability." During this interview, he/she said, E7 has even made the comment himself that he couldn't work on the first floor because he would probably get fired. The interviewee explained that the first floor housed more alert residents than the second floor which is where E7 typically works. E7 was observed on 6/24/10 to be on the first floor. When asked, E7 stated he usually works on the second floor but he does come down to "help out." 2. A confidential interview was conducted on 6/25/10 at 2:56 PM. E7 was observed and heard speaking to R2 on 6/24/10. E7 said "Oh, so your going to kick my ass." R2 made the comment to a staff member that E7 owes her a 24 pack of Pepsi for talking nice about him to the Public Health Surveyors. R12 is an female resident who was observed on 6/24/10 at 11:10 AM in the dining room sitting alone. R12 was removing her clothing (shirt and socks). During the interview conducted on	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 4 6/25/10 at 2:56 PM, the interviewee referred to R12 as a resident who is confused, calls out, and removes her clothing. During the interview it was stated that a resident was heard calling for help saying she was "choking." The interviewee stated R18, male resident, was sitting near the nurses station on the second floor with full view of R12. The interviewee stated R12 had her shirt up around her neck and the neck line of the shirt was at her throat, exposing her entire chest. E7 responded to the incident by saying to R18, "look (R18), she's (R12) showing you her tits." This interviewee said E7 "always makes nasty comments." 3. On 6/15/2010 at 1:00 PM, Z2 said E7 is mean to the residents, he is verbally abusive. The facility's Abuse Prevention Program Procedure states that verbal abuse is "the use oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, humiliation, harassment, threats of punishment, or deprivation. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment." The policy states, "Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator policy, under Abuse Reporting, states, "All personnel must promptly report any incident or suspected incident of resident abuse...Our facility will not tolerate resident abuse by anyone,	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 5 including staff members...Any alleged violations involving mistreatment, neglect, or abuse...must be reported to the Administrator...All personnel, residents, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear or retaliation from the facility or its staff...A completed copy of the Resident Abuse Report Form and written statements from witnesses, if any, will be provided to the Administrator within 24 hours of the occurrence of each incident. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within five working days of the occurrence of such incidents...The administrator or designee will review the report. The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Department of Public Health within five working days of the reported incident...".	F 223		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report and thoroughly investigate allegations of resident abuse and failed to report allegations of abuse to the state agency. This is for 2 residents (R19 & R20) with investigations of alleged abuse and 2 residents (R2 & R14) that had allegations of abuse but no investigation. This also has the potential to affect all residents in the facility. The examples include:	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 On 6/24/2010 at 10:30 AM, E1 (administrator)said that he is currently investigating a CNA (E12) regarding verbal abuse. E1 said, "I let someone go for verbal abuse a few weeks ago. There are no other allegations of abuse right now." On 6/25/2010 at 3:00 PM, E1 said that there have only been 2 abuse investigations. Those investigations involved R20 & R21. On 6/25/2010 the facility provided the abuse allegations and investigations for the past year. A Preliminary 24-hour Incident Investigation report shows that on 6/14/2010, R19 reported that E12 (Certified Nursing Assistant) came into the resident's room, pulled the covers off of the resident, saying "get up". R19 reported that E12 slammed the door, leaving the room. In the same folder, was an abuse investigation regarding R20. The 24-hour Incident Investigation Report shows that the facility became aware of an allegation of verbal abuse on 6/15/2010. R20 reported that E12 called him a liar. R20 said that he was telling his wife about the call light being on for over an hour. R20 said that E12 overheard the conversation. He said that E12 said, "That's not true, he is lying." The facility's investigation shows that only R20 was interviewed regarding the verbal abuse by E12. No other residents or staff were interviewed to ensure that this was an isolated event. The facility began the abuse investigation on 6/15/2010. The investigation was not reported to the state agency until 6/29/2010. On 6/29/2010 at 12:35 PM, E1 said that he was not aware of an abuse allegation involving R19. The facility could not provide an investigation	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8 During a confidential interview of 6/25/2010 at 9:10 AM, the interviewee stated that E7 (Licensed Practical Nurse) makes verbally abusive comments to the residents. The interviewee said that she has witnessed the comments being made in the presence of E1 (Administrator) and E2 (Director of Nursing). The interviewee said that E1 & E2 laughed. It was said that E7 works mostly on the 2nd floor. She said that E7 said that if he worked 1st floor he would probably be fired, because many of the residents are alert. The interviewee said that she overheard E7 tell R14, "You wouldn't have to have your legs wrapped so much if you would quit pissing yourself." On 6/25/2010 at 9:30 AM, a confidential interview took place. The interviewee said that on 6/24/2010 E7 was observed sticking his buttocks toward a resident stating, "want to kick my a...now?" The interviewee stated that E2 saw and heard what was said from the hallway. She said that E2 told E7 to be careful because the state agency is in the building and could have overheard him. On 6/25/2010 at 10:45 AM, Z3 said E13 (nurse) said to her, "If I had a gun, I'd shoot that B...(R2). Z3 said that she reported the incident to E1 and E2. Z3 said, "They (R1 & R2) never talked to me regarding the incident." During a confidential interview it was stated that a resident was heard calling for help saying she was "choking." The interviewee stated R18, male resident, was sitting near the nurses station on the second floor with full view of R12. The interviewee stated R12 had her shirt up around	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9 her neck and the neck line of the shirt was at her throat, exposing her entire chest. E7 responded to the incident by saying to R18, "look (R18), she's (R12) showing you her tits." This interviewee said E7 "always makes nasty comments." On 7/2/2010 at 2:30 PM, E1 said, "You call that verbal abuse? I call it (E7) making a statemnt about what happened." 3. On 6/15/2010 at 1:00 PM, Z2 said E7 is mean to the residents, he is verbally abusive. The facility did not have any abuse investigations involving E7 & E12. The employee files were reviewed. There were no disciplinary actions taken. The facility's Handbook for Professional and Administrative Staff, April 2009 states, " (page 18) While it is impossible to name every conceivable offense, the following list is illustrative of the kind of behavior that is unacceptable to the facility: 3. Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on facility property. 4. Engaging in words or actions that violate the residents' legally protected rights. (Note: This includes but is not limited to threatening, intimidating, or abusing residents in any way - physically, mentally, verbally, sexually, etc.)..."	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that the residents were offered and engaged in meaningful activities. The facility failed to plan activities based on residents individual identified needs. This has a potential to affect all 76 residents in the facility. The examples include. On 6/24/10 at 10:45 AM, E6 Activity Aide was observed in the downstairs TV lounge. E6 had a few boxes of board games. E6 said she was setting up to have an activity of board games now. A large screen TV was playing and approximately 10 residents were sporadically seated about the room. E6 said that any residents "who won't get up and wander can come down from upstairs to the activity, they can watch TV while the others play board games." On 6/24/10 at 10: 55 AM, R15 was observed sleeping in a chair in front of the second floor nurses station. R15's Minimum Data Set (MDS) Assessment of 6/23/10 showed that R15 has a short and long term memory problem. R15 has moderately impaired cognition. R15's activity interests included exercise, music, spiritual/religious activities, trips/shopping, walking,wheeling outdoors, and watching TV. On 6/24/10 at 11:00 AM on the second floor, R10 was observed wandering back and forth in	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 the corridor. R10 was observed exiting from a male residents room. (227) R10 was observed to sit down and rest on the chair of the weight scale near the dining room. R10 then continued pacing the hallway. R10's Minimum Data Set (MDS) assessment of 4/5/10 showed that R10 had a short and long term memory problem with severe cognitive impairment. R10's MDS showed that she is not involved in activities. R10's activity interests included crafts, music, spiritual activities, trips/shopping and watching TV. At 11:10 AM, on 6/24/10 R12 was observed in the second floor dining room alone. R12's Minimum Data Set (MDS) Assessment of 4/30/10 documents that R12 had a short and long term memory problem and moderately impaired cognitive skills. The assessment showed that R12 exhibited socially inappropriate behaviors, and had a fall within the last 180 days. The same assessment showed that R12 preferred activities that include crafts/ arts, exercise/sports, music, spiritual/religious activities, walking, watching TV, and talking or conversing. R12 was observed to lean over and remove her sock, then she began taking her arms out of her blouse and pulled her blouse up toward her neck. At 11:15 AM, E6 Activity Aide came into the second floor dining room with R13. R13's MDS of 5/20/10 documented that R13 had a short and long term memory problem. R13 had severe cognitive Impairment. The same assessment showed that R13 likes cards, crafts, exercise, music, spiritual activities, walking/wheeling outdoors, watching TV, gardening, and talking or conversing. According to the facility Activity Calendar for	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 12 6/24/10, the residents upstairs were to be engaged in story time at 11:00 AM. E6 Activity Aide then left the dining room and came back at 11:20 with R11. R11 was observed to be asleep in his wheel chair. E6 pushed R11's wheel chair into the center of the room and left him there, R11 continued to sleep. Then E6 then left again and came back with R10. E6 placed all four residents at a table and took out two plastic peg boards. E6 gave 1 set of pegs and a board to R10. R10 began fitting the pegs into the slots on the board. E6 then took a board and pegs over to R12 .E6 emptied the plastic bag of pegs in front of R12 and placed the board on the table. E6 then took the pegs and placed them back in the bag and said " Oh it's 11:30, I have to get residents into lunch now." E6 then gathered the pegs and boards. E6 was asked why the activity was scheduled at lunch time. E6 said " This wasn't even planned, my supervisor just told me to leave from the downstairs activity and come up here (second floor) and do something with these residents." E6 said she has not had training in working with cognitively impaired residents. E10 Activity Director entered the second floor dining room during this same time (11:15 AM) and said that E6 was directed to do activities upstairs. E10 said the activities for the second floor had been scheduled by a previously employed Activity Aide. E10 was asked about activities for residents with cognitive impairments and said "we just interact with them, like throwing balls, things like that." E10 stated she had not had any training in planning activities for cognitively impaired residents. E10 said she had	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 13 been given some papers of things they could do. E10 said " next month we are going to revise the whole activity calendar because it is not suited for these residents. The calendar was done by a previously employed Activity Aide. " E10 said that she is the one who trains the Activity Aides. Z2 was interviewed on 6/15/10 at 1:00 PM. Z2 said that there is one activity staff who is responsible to conduct activities for both floors. Z2 said the group had different abilities, and not all of them can participate due to their low functioning level. Z2 said she was told to just put on the radio or put on the TV for the residents with cognitive impairment. Z2 said often the cognitively impaired residents are just lined up to sit in front of the second floor nursing station. Z2 said she had received no training in working with the cognitively impaired residents and had difficulty engaging residents as a group. (various functioning levels) E1 Administrator was interviewed at 10:30 AM on 6/24/10. E1 said that they are trying to get the second floor activities going. E1 said that the activity staff were told to involve more than just a few residents in the activities. E1 said the second floor activities need to be better and they need a better program.	F 248		
F 249 SS=F	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities	F 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 249	Continued From page 14 professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed ensure that the Activity Director coordinated and directed the resident activity programs. The facility failed to ensure that the Activity Director was trained in the development, implementation, supervision, and evaluation of resident activities. This has potential to affect all 76 residents of the facility. The examples include. On 6/24/10 at 11:15 AM E10 (Activity Director) said that she had not had any training in planning activities for cognitively impaired residents. E10 said she had been given some papers with things they could do. E10 said that she is the one responsible for training the Activity Aides. E10 said that her own training was just day-to day work at the facility. E10 said that she had no evidence of any training she had received. The Activity Director Job Description shows the following:	F 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 249	Continued From page 15 Job Summary: The primary purpose of your job position is to plan, organize, develop, evaluate, supervise, direct and take part in the operations of the facility's Activities Department to assure the quality of activities services is provided on a daily basis. The Qualifications include Must have, or obtain promptly after commencement of employment (i) certification by a recognized accrediting body as a Therapeutic Recreation Specialist, or (ii) a license from the State of Illinois as a Registered Occupational Therapist, or a Certified Occupational Therapy Assistant or (iii) completion of an Activity Director Training program approved by the State of Illinois. Must complete a minimum of ten hours per year of approved continuing education pertaining to activities programming.	F 249		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the building was free of odors. This has the potential to affect all 76 residents	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 16 residing in the facility. The examples include: On 6/24/2010 at 10:50 and 11:45 AM, the 2nd floor shower room, near the elevator had a permeating foul odor. Two used razors were observed on the floor of the shower room. On 6/25/2010 at 1:10 PM a feces odor was observed in the hallway by the stairway exit on the 1st floor. A strong urine odor was observed by the 1st floor nurses station. At 1:30 PM, the hallway by the stairwell on the 2nd floor had a urine odor. On 6/24/2010 at 3:00 PM, R5 stated the resident's bathrooms are very dirty and have foul odors. On 6/25/2010 at 3:29, Z5 said that the bathroom by the dining room on the first floor is often very dirty. She said, "I have requested sanitizing spray be used after each resident." Z5 said that she has gone into a resident room to find feces on the toilet, urine on the floor, and an overall offensive odor. Z5 said that she has seen the staff clean urine up off the floor in the hallway using The Residents' Rights for People in Long Term Care Facilities states, "Your facility must be clean...". The facility Housekeeping Cleaning Schedule shows that daily cleaning shall include toilets, lavatory, and central bathing areas. The Housekeeping Guidelines shows under item number 6) Housekeeping personnel shall adhere to daily cleaning assignments developed to	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 17 maintain the facility in a clean and orderly manner.	F 252		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that staff play their personal music at a volume that is not disrupting to the residents. This has the potential to affect all 44 residents residing on the 2nd floor. The example includes: On 6/24/2010 at 1:50 PM, loud, obtrusive, music was observed playing at the 2nd floor nurses station. The song playing was, "All right now baby it's all right now". There were 6 residents near the nurse's station (R10, 11,12, 13, 15, & 16). On 6/25/2010 at 1:20 PM, music from a personal music device was playing the song, "Right time of the Night". E7 (Licensed Practical Nurse - LPN) said that the device playing the music was his. E7 said, "I play the top 100 songs and music from 1952-1978." On 6/25/2010 at 9:10 AM, a confidential interviewee said, "(E7) plays his music all of the time. He plays rap music so loud you can't hear the residents." At 10:10 AM, Z4 states that E7 plays Rap and heavy metal music very loudly at	F 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 18 the 2nd floor nurses station. On 6/25/2010 at 2:56 PM, a confidential interviewee stated, " He (E7) plays loud music at the nurses station. I have asked him to play music that is age appropriate. One song he was playing had the "N" word in it." The facility's Handbook for Professional and Administrative Staff, April 2009. states, " (page 18) While it is impossible to name every conceivable offense, the following list is illustrative of the kind of behavior that is unacceptable to the facility: 3. Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on facility property...".	F 258		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that residents requiring assistance to bathe were provided showers as scheduled. The facility failed to ensure that residents were provided assistance with dressing as needed. This applies to (R1, R17, R22) The examples include:	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 19 1. R1's Minimum Data Assessment of 6/23/10 documents that R1 had a short-term memory problem and modified independence in cognitive skills. (some difficulty in new situations only) The same assessment showed that R1 requires extensive assistance of one person for bathing. R1 was observed on 6/24/10 at 2:15 PM sitting in a wheel chair in her room. R1 said that "They keep switching my showers, they don't do them as scheduled. I have to ask for the showers, if they think I forget about it they won't do it." R1 said sometimes the Certified Nursing Assistant (CNA) will ask me to switch my shower day with someone else, and then will not give me mine. I went for 2 weeks one time with no shower. I want to have a shower at least twice a week. Review of the Activities of Daily Living sheet for R1 showed the following: R1 received a shower on 5/30/10 then 10 days later on 6/10/10. The same report shows R1 received a shower on 6/17/10 (7 days) then on 6/19/10 (2 days later). Review of the facility shower schedules showed that residents are scheduled for two showers a week. Z5 was interviewed on 6/24/10 at 2:30 PM. Z5 said that some residents have received showers at 4:00 AM and have been brought to the breakfast table with wet hair. R9 was interviewed on 6/25/10 at 2:10 PM. R9 said that she had problems one or two times with CNA (Certified Nursing Assistants) who refused to help her pull up her pants after she used the bathroom. R9 said that it upset her. Z3 was interviewed on 6/25/10 at 10:45 AM. Z3 said that R9 was refused care by E13 Licensed	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 20 Practical Nurse. R22 was interviewed on 6/24/10 at 10:10 AM and said that she was left alone in the bath. R22 said " it was not my usual aide, can't recall her name, I have seizures and didn't feel safe." On 6/24/10 at 11:00 AM R17 was observed seated in a wheelchair outside the second floor dining room. R17 was talking to herself. R17 said " I didn't do it, I think it's terrible." R17 was wearing a pair of black pants. The lap area of R17's pants were observed to have several white stains on them.	F 312		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure nursing staff assess and monitor residents' PICC (peripherally inserted central catheter) lines during use for intravenous antibiotic therapy. This applies to 2 residents with PICC catheters.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 21 (R14, R23) The example includes: 1. The hospital discharge/transfer form dated 1/19/10 documents R14 had a PICC line catheter and was ordered to receive IV antibiotics every 8 hours for 10 days upon return to the facility. R14 was hospitalized with an Infected Sacral Wound and a Urinary Tract Infection. The physician progress notes (during hospitalization) on 1/10/10 at 10:00 AM documents, "A #5 French solo power PICC placed to right arm, (dual lumen). Insertion site: Basilic Vein, Catheter length: 45 cm, Tip location: Superior vena cava and placement was confirmed by x-ray." The nursing notes dated 1/20/10 at 1:13 AM states R14 returned to the facility from the hospital. "PICC to right arm with dual lumen intact no s/s of infection or redness noted at this time." Review of the medical record between 1/20/10 and 2/4/10 showed there were no additional assessments performed of the PICC line site for R14. The facility policy for PICC line dressing changes (6.4) dated March 19, 2007 states: 5. Assessment of venous access site is performed: 5.1 During dressing changes 5.3 Before and after administration of intermittent infusions 5.4 At least once every shift when not in use. 6. Assessment is to include but is not limited to the absence or presence of: 6.1 Erythema 6.2 Drainage 6.3 Swelling or induration 6.4 Change is skin temperature 6.5 Tenderness at the site or along vein tract 6.6 Integrity of transparent dressing. 7. Length of the external catheter and upper arm	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 22 circumference is obtained: 7.1 Upon admission 7.2 During dressing changes 7.3 If signs or symptoms of complications are present. The treatment record for R14 for January 2010 documents "Remove PICC line after completion of IV antibiotics. Change PICC dressing as needed." There are staff initials on the day shift on 1/29/10 identifying this was done. There are no medical record entries dated 1/29/10 for R14 regarding the dressing change or removal of the catheter. The facility policy for PICC line dressing changes (6.4) dated March 19, 2007 states: 1. Dressing changes using transparent dressings are performed: 1.1 Upon admission 1.2 At least weekly 1.3 If the integrity of the dressing has been compromised. 3. Gauze dressing are changed: 3.1 Upon admission 3.2 Every 48 hours 3.3 If the integrity has been compromised. The nursing notes dated 2/2/10 at 11:14 AM, the nursing notes for R14 states the PICC line removed. The facility policy for PICC line removal (6.7) dated March 19, 2007 states: 30. Monitor site for bleeding through dressing every 15 minutes x 2, every hour x 2. 31. Leave dressing in place for 24-48 hours. Inspect and redress site every 24 hours until site has epithelialized. 32. Documentation in the medical record includes, but is not limited to: Date and time, Reason for removal, Length and condition of catheter, Site assessment, Resident response to procedure.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 23 On 7/6/10 at 2:45 PM, E2 (Director of Nurses) stated, "If the resident has a PICC line, it should be documented in the nursing notes. If there was a problem with the site they would notify me." R14's initial care plan dated 1/14/10 identifies a potential for infection related to the PICC line. The plan states to administer antibiotics as ordered, obtain cultures, monitor lab results, monitor temperature, vital signs, institute isolation. The plan did not contain specific information regarding the location, length of catheter or individualized interventions for use of the catheter. 2. The Physician Order Sheet (POS) documents R23 has the following diagnoses: Kidney Transplant (1/09), and History of Endocarditis. R23 was 62 years old and resided at the facility from 1/23/10 through 2/11/10. The hospital transfer sheet dated 1/23/10 stated R23 was prescribed to receive Intravenous (IV) antibiotics due to Endocarditis. R23's physician prescribed Gentamycin 40 mg IV every 12 hours for 6 weeks, and Ampicillin 2 gm IV every 4 hours for 6 weeks. R23's nursing admission notes dated 1/23/10 at 11:05 PM documents, "IV site changed, Left forearm patency check infusing well dressing intact." The type of catheter, site assessment or catheter length documentation was not completed. Further medical record review between 1/23/10 and 2/11/10 showed the PICC line and site assessments were incomplete and inconsistently documented during this time frame. On 2/11/10 at 3:31 PM, the notes document that	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 24 R23 left the facility to return to the hospital. There was no information in the medical record regarding R23's PICC line and site. A Venous Access Care plan was initiated on 2/2/10 at 8:26 AM for R23. The care plan does not identify specific information or individualized interventions regarding R23's PICC line and site. On 7/6/10 at 3:05 PM, E2 stated, "I'm pretty sure R23's catheter was a double lumen PICC and was placed in his left upper arm. If he had a PICC line, it should be documented in the nurses' notes." E2 stated the staff should follow the facility policy for dressing changes, site care and documentation. E2 reviewed R23's notes and care plan and confirmed the medical record did not contain location or specific location of the PICC line. E2 stated that when no registered nurse was on duty to administer the medication, "The salaried management staff just came in. We would not be on the schedule. I liked to take the night shift."	F 328		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to be administered in a way to ensure that: The facility ' s Abuse Prevention Policy and	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 25 Procedures were followed to include prevention of abuse by staff, prompt reporting of allegations of abuse and thoroughly investigating allegations of abuse; Residents and staff are free from reprisal when voicing concerns; The facility Activity program was run by a qualified activity director; These failures apply to all 76 residents in the facility. The examples include: 1. Information from confidential interviews state that E1 Administrator and E2 Director of Nursing have witnessed E7 (Licensed Practical Nurse-LPN) curse and yell at residents. An abuse allegation of R19 was not reported to the state agency nor was it completed. An allegation of abuse involving R20 was not thorough and was not reported to the state agency according to the procedures in the facility ' s abuse policy. The facility did not follow their abuse policy and investigate or remove E7 or E12 from resident contact. There were no investigations involving these two employees. According to the facility ' s abuse reporting policy (page 1 of 3) states: 2. Any alleged violations involving mistreatment , neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported to the administrator. 3. When an alleged or suspected case of mistreatment, neglect, or abuse is reported the facility administrator or his/her designee, will notify the following persona or agencies of such intent (includes the state licensing and certification agency). The facility handbook for Professional and Administrative staff dated April 2009, page 18, under employee Conduct and Work Rules documents unacceptable behavior as: (3)	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	**1920 NORTH MAIN STREET ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 26 Engaging in abusive discourteous, profane, indecent or unprofessional language or conduct while on duty or on facility property. 4. Engaging in works or actions that violate the residents legally protected rights. (Note: this includes, but is not limited to threatening, intimidating or abusing residents in any way- physically, mentally, verbally, sexually, etc.). 2. Confidential interviews were conducted and found that residents and staff are afraid to express or report concerns to administrative personnel. The abuse reporting policy under procedure number 4 states, " All personnel, residents , visitors, etc., are encouraged to report incidents of resident abuse or suspected abuse. Such reports may be made without fear or retaliation from the facility or its staff. " On 6/25/2010 at 9:10AM through confidential interview it was learned, " I ' m afraid to tell you everything because I will get fired. " On 7/2/2010 at 9:30AM E8 said that staff are afraid to speak with state agency surveyors because they are afraid they will lose their jobs. E8 said, " I told E1, on Friday (6/25/2010) that I spoke to the state agency surveyor. On Monday (6/28/2010), I was terminated. " Other confidential interviewees stated that E1, E2, E14 (dietary supervisor), E15 (human resources) and E11 (social service director) supervise family members. E1 was interviewed and asked who the department heads were. E1 gave their names and titles. When asked who they supervise, he said that E2, E14 (dietary supervisor), E11 and E15 supervise family members. The facility handbook for Professional and Administrative staff dated April 2009, page 28 states, family members may not be employed under either direct supervision or within the chain of supervision of one another. For purposes of this policy, the term family	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	1920 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 27 members include employee ' s parents, parent-in-law, step-parents, children, step-children, spouse, former spouse, sibling, nephews and nieces. " On 6/29/2010 at 12:15PM, E1 said that E2 (DON) and E3(ADON) are sisters. E14 and E15 are mother and daughter. E11 (Social Services Director) and E19 (Registered Nurse) are sisters. E20 is the maintenance supervisor (E2 ' s brother-in-law). R15 is the social services director and the office manager. E18 supervises E15 (part time receptionist and is E15 ' s father). On 6/16/2010 at 1:10PM, Z1 said many of the supervisory staff are supervision their own family members. Residents are afraid to talk to anyone or complain. On 6/15/2010 at 1PM Z2 said that residents have told her that they are afraid to report concerns because many of the supervisory staff have relatives working in the facility. The administrator ' s job description received on 6/29/2010, under Main Duties, letter D states: Write definitive policies regarding duties and activities of the staff, which will assure health care and safety of the residents and others and explain these policies so that the aim and purpose of the facility may be achieved by cooperative effort; letter E states: Recruit, employ and release all department heads. 3. Resident interviews, observations and record reviews of planned show activities do not meet the needs and interests of the residents. The facility did not follow their posted activity calendar. The facility does not have a qualified activity director to develop, implement, supervise and evaluate resident activities. E1 (Administrator) and E10 (Activity director) verified that E10 has not completed the required course work to qualify her to be an activity director. E10 stated that she trains the activity aides. On	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	**1920 NORTH MAIN STREET ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 28 6/24/2010 at 11:20 E6 activity aide began a peg board activity with 4 residents. At 11:30 the aide said it was time for lunch and took back the board and pegs because it was lunch time. E6 was asked about the timing of the activity and stated that the event wasn ' t planned but her supervisor just told her to leave the downstairs activity and come up to the second floor and do something with these residents. E6 said she has had no training in working with cognitively impaired residents. The Job Description for the facility Administrator shows the following: Job Summary includes to safeguard the health, safety and welfare of all residents of the facility in accordance with the facility's established policies and procedures and applicable laws and regulations. Page two of the same document shows under item G) Interpret the lines of authority to each employee so that each will have a clear understanding of the person to whom he is responsible and exercise disciplinary action or termination when necessary and provide appropriate documentation int he employee's personnel files.	F 490		