STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighbors Health Center	811 West 2nd Byron, IL 61010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident dignity was maintained during personal care for 1 of 2 residents (R53) reviewed for dignity in the sample of 43. The findings include:R53's face sheet printed on 5/7/26 showed diagnoses including but not limited to rheumatoid arthritis, dementia, generalized anxiety disorder, and senile degeneration of brain. R53's facility assessment dated [DATE] showed severe cognitive impairment and total staff assistance required for toilet hygiene, dressing, and transfers. The same assessment showed that R53 is always incontinent of urine and bowel. On 5/5/26 at 9:26 AM, V10 and V11 (Certified Nursing Assistants/CNA) transferred R53 from the wheelchair onto the bed using a mechanical lift. R53's bed was next to the room window. The window looked out to the front parking lot and sidewalk. V10 and V11 removed R53's pants and incontinence brief. Peri care was performed and a fresh brief was put on the resident. R53 was naked from the waist down and exposed to the outside during the entire process. On 5/7/26 at 8:51 AM, V2 (Assistant Director of Nurses) stated resident doors and curtains should be closed during care. Window curtains need to be down during all care for privacy. It is undignified for people outside to be able to see inside. Landscapers, visitors, or anyone walking around outside could see the care being done. V2 said even if a resident is confused and unaware of what is happening, staff still need to put those things in place. The facility's Resident Rights and Dignity policy revision dated 10/24 states: 1. All residents should: a) be treated with dignity in the way in which staff deal with dressings, bathing, feeding, incontinence and all other needs.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a urinary drainage bag was off the floor, failed to use a dignity cover, and failed to use personal protective equipment (PPE) during direct catheter care for 1 of 3 residents (R22) reviewed for catheters in the sample of 43. The findings include:R22's face sheet printed on 5/7/26 showed diagnoses including but not limited to right side paralysis following cerebral infarction, heart disease, diabetes mellitus, benign prostatic hyperplasia with urinary tract symptoms, retention of urine, and obstructive/reflux uropathy. R22's facility assessment dated [DATE] showed moderate cognitive impairment and staff assistance required for transfers and personal hygiene. The same assessment showed R22 is always incontinent of bowel. R22's May 2026 order summary report showed an order start dated 11/21/24 for a urinary catheter for urinary retention/obstructive and reflux uropathy. The same report showed an order start dated 4/30/25 for enhanced barrier precautions due to medical device-foley catheter. On 5/5/26 at 11:27 AM, R22 was seated in a wheelchair in the hallway, next to his room door. R22 had a urinary drainage bag under the wheelchair that was touching the floor. A blue dignity sleeve was partially covering the bag and dark urine was visible. R22 stated he had soiled himself and wanted his pants changed. A sign was posted on the door of his room showing enhanced barrier precautions. The sign showed staff must wear gowns and gloves for high contact resident care activities, which included the use of a urinary catheter, changing briefs, and transferring. On 5/5/26 at 11:53 AM, R22 was still sitting outside of his room. The urinary drainage bag was in the same position, uncovered and lying on the floor. At 11:58 AM, V12 (Registered Nurse) hooked the drainage bag up under the chair without wearing gloves. V13 and V14 (Certified Nursing Assistants) assisted V12 to propel R22 down the hall, across the building, and to a neighboring unit. The drainage bag was uncovered during the process. R22 was transferred by V12 and V13 from the wheelchair to the bed using a mechanical lift. V14 exited the room prior to care. V12 and V13 cleansed R22 of the bowel movement, including cleansing of the groin area and catheter tubing. V12 and V13 transferred R22 back to the wheelchair and wheeled R22 down the hall. Staff used gloves but did not wear gowns during the transfer and incontinence care. On 5/7/26 at 8:57 AM, V2 (Assistant Director of Nurses) stated a catheter bag lying on the floor is an infection control issue. It puts a resident at a higher risk of UTIs (urinary tract infections). Germs can get on the bag and into the bladder. Staff should be wearing gloves anytime the bag is handled. It is for the same reason; it lowers the risk of UTIs. The blue dignity sleeves are to be clipped over the drainage bags to cover the urine. It is a dignity thing for a resident. Enhanced barrier precautions (EBPs) are needed to protect the residents from us. Staff should be wearing gowns and gloves during high contact activities if they have a catheter. Incontinence care is a high contact activity, and they should have been wearing gowns. The facility's Urinary Catheter Insertion and Maintenance policy revision dated 07/26 states: 2. Attach drainage bag to frame, below level of resident's bladder-not touching the floor. The facility's Resident Rights and Dignity policy revision dated 10/24 states: 1. All residents should: a) be treated with dignity in the way in which staff deal with dressings, bathing, feeding, incontinence and all other needs. The facility's Enhanced Barrier Precaution policy last revision dated April 2025 states: 2. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities.ii. Indwelling medical device examples include.urinary catheters.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow their policy for food brought in by family or visitors for 1 of 1 resident (R80) reviewed for food safety in the sample of 43. The findings include: On 5/5/26 at 10:05 AM, R80 was seated in a wheelchair in her room. A counter size mini refrigerator was on a stand, next to her bed. The door had a handwritten sign on the front dated 4/1 and it stated do not take anything out of it or throw anything away. The family makes the food for the resident to eat. R80 gave permission for this surveyor to look inside the refrigerator. The small, freezer section was thawed and dripping water over all the items. A plastic storage container with an unidentified liquid was wet and a small baggie of meat was wet. R80 identified the items as soup and lunch meat. There was a baggie of cinnamon bread and a baggie of croissants which were both wet. None of the foods had any dates or labels on them. There was a baggie of grapes and a bottle of syrup on the inside door. Neither item had dates or labels on them. There was a small packet of French dressing on the door which showed an expiration date of 10/9/25. There was a May 2026 temperature log on the side of the refrigerator. The log stated: Temperature parameters: 36-46 degrees. Circle temp and initial daily. The log was blank for 5/2, 5/3 and 5/5.On 5/6/26 at 8:31 AM, the temperature log and food items remained the same. On 5/7/26 at 8:15 AM, the temperature log and food items remained the same. The baggie of grapes had a white, creamy substance on the outside of it. At 9:37 AM, R80 said her sister brings food to her now and again. R80 could not recall how often or how long the food had been in her refrigerator. R80 said she is losing her eyesight and has trouble reading or seeing things clearly. R80 could not identify the white substance on the grapes and said they came from her grandfather. (R80 is [AGE] years old.) On 5/7/26 at 9:45 AM, V10 and V11 (Certified Nursing Assistants) said nursing staff does not monitor resident room refrigerators. The housekeeping staff was responsible for that. V10 and V11 stated R80 is somewhat confused at times and her vision is declining. On 5/7/26 at 9:49 AM, V15 (Housekeeping Supervisor) stated she was not sure who monitors resident room refrigerators, but it should be done daily. They need to stay within the temperature parameters for food quality. On 5/7/26 at 9:53 AM, V1 (Administrator) and V2 (Assistant Director of Nurses) said the housekeepers should be checking the room refrigerator temperatures daily and document them on the log. It ensures the refrigerator is holding temperature appropriately. Food could spoil if the temperature falls out of range. V1 and V2 stated nursing staff should be reviewing the food brought from R80's family and dating it the same day. It should be dated to ensure it is still good and gets disposed of if it is not fresh or unsafe to eat. The facility's Foods Brought by Family/Visitors policy dated 01/16 states: 5.Perishable foods must be destroyed after 3 days. The facility's undated Resident Refrigerator policy states: All refrigerator temperatures will be checked at least once daily and a log maintained. Staff will assist residents in maintaining log if necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have enhanced barrier precautions in place for residents with pressure wounds. This applies to three of three residents (R2, R47, R105) reviewed for infection control in the sample of 43.The findings include: 1 On 5/6/26 at 10:50 AM R47 was receiving wound care for her stage 3 pressure injury from V8 (Wound Nurse), V9 (Wound Physician) and V16 (Wound Physician's Assistant). No sign was displayed on R47's door showing she was on enhanced barrier precautions and there was no PPE (personal protective equipment) available near her room. V8, V9 and V16 were not wearing a gown during the treatment. On 5/7/26 at 9:08 AM, V8 said R47 did not need to be on enhanced barrier precautions because her dressing was a band-aid like dressing. V8 said when a new wound is found in the facility, the infection preventionist is notified and she determines if they need isolation or not. On 5/7/26 at 9:33 AM, V2 (Infection Preventionist and Assistant Director of Nursing) said if a resident's wound treatment is using a band-aid like dressing or is not a daily dressing, they do not need to be on enhanced barrier precautions. V2 said R47 does not need to be on enhanced barrier precautions because her wound care is only three times a week and her dressing is a foam island dressing. The facility face sheet for R47 shows she was admitted to the facility with diagnoses to include Type 2 Diabetes Mellitus, dementia and congestive heart failure. The facility assessment dated [DATE] shows R47 to have severe cognitive impairment and requires assistance with her activities of daily living. A nursing note dated 2/11/26 shows R47 has a new stage 3 pressure injury to her left heel. The Physician orders for R47 dated May 2026 does not show any orders for enhanced barrier precautions. An order for R47's left heel shows to apply a calcium alginate sheet cut to fit the wound and cover with a gauze island dressing three times per week. The facility policy with a revision date of 4/2025 for enhanced barrier precautions (EBP) shows EBP refers to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are applied to residents with any of the following.b. wounds.chronic wounds which include pressure ulcers. An order for EBP will be entered into the clinical record for residents with any of the following: wounds. Door signage: a sign will be placed to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. The EBP signage shows wear gloves and a gown during high contact resident care activities which includes wound care: any skin opening requiring a dressing. 2. On 5/5/26 at 10:58 AM, R105's door did not have an Enhanced Barrier Precautions (EBP) sign posted and there was no isolation bin outside the room. R105 said he had a pressure ulcer on his left heel. R105 pointed to the back of his heel. R105 said they change the dressings daily. On 5/6/26 at 12:26 PM, R105's door did not have an EBP sign posted and there was no isolation bin. V8 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Nurse), V9 (Wound Care Physician) and V16 (Wound Physician's Assistant) removed R105's previous dressings, performed an assessment of R105's wounds, and provided treatments to R105's wounds. They were not wearing gowns during R105's wound care. V8 (Wound Care Nurse) said R105 developed a pressure ulcer to his heel from his shoes. R105's Face sheet dated 5/7/26 showed diagnoses to include but not limited to routine healing for fractures of the pubis and right hip; anorexia; insomnia; squamous cell carcinoma; hypothyroidism; muscle wasting and atrophy; dysphagia; and heart failure. R105's Physician Order Sheet dated 5/7/26 showed Right heel wound care with iodosorb gel and cover with gauze island dressing three times a week. This document did not contain an order for EBP related to R105's pressure ulcer. R105's facility assessment dated [DATE] showed he was cognitively intact. R105's Skin Note dated 5/6/26 showed he had a Stage 3 pressure ulcer to his right heel. R105's Care Plan revised 5/3/26 showed he had a Stage 3 pressure ulcer to his right heel. R105's Care Plan did not include EBP as a focus area. On 5/7/26 at 11:09 AM, V20 (Registered Nurse/RN) said R105 does have a pressure ulcer, but he was not on EBP. V20 said if R105 was on EBP he would have an EBP sign on the door, isolation bin outside the room with PPE (personal protective equipment), and it would be documented in his EMR (Electronic Medical Record). V20 said she thought residents with pressure ulcers were usually on EBP. V20 said she worked as an agency before and other facilities had placed residents with pressure ulcers on EBP. V20 stated, I'm not sure here. I think it's up to V2 (Assistant Director of Nursing /Infection Preventionist). V20 said EBP means the staff would wear gown and gloves during high contact activities, including wound care and transfers. On 5/7/26 at 11:45 AM, V8 (Wound Care Nurse) said R105 was not on EBP for pressure ulcers. V8 said she discusses each resident's wounds with V2 and V2 makes the determination if EBP is needed. V8 said she would refer to her. On 5/7/26 at 11:55 AM, V2 (ADON/Infection Preventionist) said R105 did have a pressure ulcer, and he was not on EBP. V2 said she thought EBP wasn't required for resident's that didn't have daily dressing changes or used a bandaid-like dressing. The surveyor showed V2 the regulation text in the State Operations Manual. V2 replied that all residents with pressure and chronic wounds will need to be put on EBP. V2 said the purpose of EBP was to protect the residents from potential infection from the facility staff. V2 said she was sure that she had learned in order to place a resident on EBP the wound care had to be daily. The surveyor asked V2 to provide documentation showing that residents with pressure ulcers did not require EBP. V2 was unable to provide documentation. V2 said residents on EBP should have a physician's order, EBP sign on the door, isolation bin outside the room, and a care plan for EBP. 3. On 05/05/2026 11:27 AM, R2 was sitting up in his wheelchair, adjusting the stockings to his left stump. R2 had a roommate and there was an EBP sign posted on the door and isolation bin outside the room. On 5/6/26 at 12:52 PM, V8 (Wound Care Nurse) said R2 had developed a pressure ulcer to his left (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stump from his prosthetic. V8 (Wound Care Nurse), V9 (Wound Care Physician) and V16 (Wound Physician's Assistant) removed R2's previous dressings, performed an assessment of R2's wounds, and provided treatments to R2's wounds. They did not wear gowns during R2's wound care. R2's Face sheet dated 5/7/26 showed diagnoses to include but not limited to muscle wasting and atrophy; syncope and collapse; diabetes; COPD (chronic obstructive pulmonary disease); seizures; peripheral vascular disease; and chronic kidney disease. R2's Physician Order Sheet dated 5/7/26 showed he had left shin (stump) wound orders for Mupirocin (antibiotic) ointment after cleansing wound and cover with optifoam dressing daily and as needed. This document did not contain an order for EBP related to R2's pressure ulcer. R2's facility assessment dated [DATE] showed he was cognitively intact. R2's Skin note dated 5/6/26 showed R2 had a Stage 4 pressure injury to his left shin (stump). R2's Care Plan showed he had Stage 3 pressure ulcer to his left shin and a diabetic ulcer to the right dorsal foot. This care plan did not include a focus area for EBP. On 5/7/26 at 11:09 AM, V20 (RN) said the EBP sign on R2's door was for his roommate. V20 said R2 was not on EBP. On 5/7/26 at 11:45 AM, V8 (Wound Care Nurse) said R2 had a diabetic wound to his foot and pressure ulcer to the stump. V8 said R2 wasn't on EBP. V8 said she discusses each resident's wounds with V2 (ADON/Infection Preventionist) and V2 makes the determination if EBP is needed. V8 said she would refer to her. On 5/7/26 at 11:55 AM, V2 (ADON/Infection Preventionist) said R2 did have a pressure ulcer and diabetic wound, but he was not on EBP. V2 said she thought EBP wasn't required for resident's that didn't have daily dressing changes or used a bandaid-like dressing. The surveyor showed V2 the regulation text in the State Operations Manual. V2 replied that all residents with pressure and chronic wounds will need to be put on EBP. V2 said the purpose of EBP was to protect the residents from potential infection from the facility staff. V2 said she was sure that she had learned in order to place a resident on EBP the wound care had to be daily. The surveyor asked V2 to provide documentation showing that residents with pressure ulcers did not require EBP. V2 was unable to provide documentation. V2 said residents on EBP should have a physician's order, EBP sign on the door, isolation bin outside the room, and a care plan for EBP.