STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. Building B. Wing	12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest View Rehab & Nursing Center	535 South Elm Itasca, IL 60143

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. Building B. Wing	12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest View Rehab & Nursing Center	535 South Elm Itasca, IL 60143

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who are dependent on the facility for ADLs (Activities of Daily Living) such as feeding, dressing, and incontinence care are provided the necessary assistance in a timely manner.This applies to 5 of 5 residents (R8, R9, R10, R11, and R12) reviewed for ADLs in the sample of 12.The Findings include:On December 6, 2025, 9:53 AM to 12:48 PM, R8, R9, R10, and R11 were continuously observed sitting in dining room. They were not checked for incontinence during this time.1. R9's admission record showed R9 to be [AGE] years old with diagnoses that include chronic obstructive pulmonary disease, type 2 diabetes mellitus, dementia, anemia, major depressive disorder with severe psychotic disturbance, anxiety disorder, and fall. R9's MDS (Minimum Data Set) dated September 25, 2025 showed R9 to be dependent on staff for all ADL care. On December 6, 2025 at 11:26 AM, V25 (R9's family member) stated she is at the facility visiting R9 once a week and the facility staff do not check R9 for incontinence for more than 2 - 3 hour. V25 stated, They don't have enough help. V25 stated sometimes she comes, and it is 10 or 11AM and R9 is still in bed and her hands are dirty. On December 6, 2025 at 1:37 PM, V24 (Certified Nursing assistant, CNA) took R9 to her room to be changed. R9's incontinence brief was soaking wet from front to back, and R9 had a bowel movement. 2. R8's admission record showed R8 to be [AGE] years old with diagnoses that included displaced fracture of second cervical vertebra, osteoarthritis, left shoulder, dementia, Rheumatoid arthritis, anxiety disorder, psychosis, major depression weakness, difficulty in walking, and need for assistance with personal care. R8's MDS dated [DATE] showed R8 required substantial maximal assistance for toilet transfers.On December 6, 2025 at 1:54 PM, V22 (CNA) and V23 (CNA) took R8 to the restroom. 3. R10's admission record showed R10 to be [AGE] years old with diagnoses that include senile degeneration of brain, atrioventricular block, second degree, dementia, type 2 diabetes mellitus, difficulty in walking, need for assistance with personal care, weakness, and abnormalities of gait and mobility. R10's MDS dated [DATE] showed he was dependent on staff for eating. R10's care plan showed R10 had a self-care deficit and requires assistance with transfers and toileting. On December 6, 2025 at 12:10 PM, R10 was sitting in the dining room at a table alone with a bowl of chili, corn bread, and fruit on his tray in front of him. R10 was eating the chili with his bare hands by sticking his fingers in the chili grabbing some and then putting it in his mouth. V5 (Licensed Practical Nurse, LPN) was feeding R8 at another table to the left and in front of R10. There was no other staff in the room. There was silverware on R10's tray. At 12:16 PM, R10 picked up the bowl of chili and started drinking it rapidly and started coughing vigorously. V5 then turned around and walked over to R10 and put a spoon in his food and said, It's not for drinking, use your spoon. V5 then went back to feeding R8. At 12:21 PM, V24 (CNA) came and sat with R10 and began feeding him. On December 6, 2025 at 12:48 PM, V23 and V24 took R10 to the bathroom to be checked for incontinence.4. R11 admission record showed R11 to be [AGE] years old with diagnoses that include dementia with severe psychotic disturbance, type 2 diabetes, osteoarthritis, epilepsy, difficulty walking, unsteadiness on feet, weakness, and need for assistance with personal care. R11's MDS dated [DATE] showed she required substantial/maximum assistance with toileting hygiene and transfer. On December 6, 2025 at 2:00 PM, V24 took R11 to her room to be changed. 5. R12 face sheet showed R12 to be [AGE] years old with diagnoses that include dementia, sarcopenia, hypertensive heart disease, violent behavior, major depressive disorder, aphasia, unspecified psychosis, weakness, and need for assistance with personal care. R12 had an active care plan that showed he had a self-care deficit with impaired grooming abilities. R12's MDS dated [DATE] showed R12 is dependent on staff for lower body dressing and toileting. On December 6, 2025 at 11:35 AM, R12 was near the nurse's station and had a brown substance on his left fingers and under his fingernails and on the left side of his gray jogger pants. The brown substance ran laterally down the left leg of R12's gray jogger pants and was about a half inch wide and about 5-6 inches long.On December 6, 2025 at 11:39 AM, V23 and V24 took R12 into bathroom.On December 6, 2025 at 11:44 AM, V23 came out of the restroom and stated her and V24 were helping R12 use the restroom. V24 then exited the restroom with R12. V24 stated R12's incontinence brief was changed and R12 now has a clean one on. V24 stated R12 had a bowel movement. V24 stated R12 dug in his incontinence brief with his hand and wiped stool on his pants. V24 was cleaning R12 fingers with wet disposable clothes. A brown substance could still be seen on R12' s fingers/nails. V22 and V23 took R12 to his room and emerged about 1 minute later along with R12. R12 sat at the nursing station and now the