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	01/16/2026

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 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. Based on interview and record review the facility failed to treat residents with dignity and respect for 1 of 4 residents (R1) reviewed for resident's rights in the sample of 15.The findings include:On 1/16/26 at 9:25 AM, R1 said this incident had happened a couple of weeks ago but it still bothers R1 up to this time. R1 said, V7 (Certified Nursing Assistant- CNA) came to her room and spoke to her very inappropriately. V7 (CNA) stated, I believe you love me; you know that you love me. R1 said she did not like that statement, that was not a right way to talk to a patient like me, not fair at all. R1 said she called her sister. R1 said she still sees V7 working at the facility.On 1/16/26 at 9:21 AM V13 (R1's POA/sister) said V7 (CNA) making that statement should not be allowed at all at the Nursing Home. V13 said she called the Police on the CNA (V7) On 1/16/26 at 11 AM, V7 (CNA) confirmed he made those statements to R1 you know you love me. But that V7 was just joking. V7 said the Police came and spoke to him. The Police believed that he was joking but was told not to do that again. V7 said the DON (Director of Nursing) spoke to him 1:1, that I should be careful of the things I was saying to the residents. Residents are to be treated with respect.On 1/16/26 at 10;10 AM, V2 (Director of Nursing) said staff were expected to always be respectful and professional. Avoid making jokes so statements will not be misinterpreted. Residents are to be treated with dignity and respect.The facility policy on Dignity (undated) documents, Dignity, as an extension of appropriate interactions between staff and residents: 1, staff will always be polite and respectful. Note: Residents are to have all aspects of their dignity maintained by staff regardless of the resident's cognitive level or ability to realize or not understand what is being said or done by others.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and assess a pressure wound prior to it becoming a Stage III wound for 1 of 5 residents (R2) reviewed for pressure ulcers in the sample of 15. The findings include:On 1/17/26 at 11:10 AM, V16, Wound Care Nurse, was observed as she provided wound treatment to R2's coccyx. R2 had an open area to his coccyx. R2's buttocks were not reddened and did not have any open areas.On 1/17/26 at 1:19 PM, V16, Wound Care Nurse, said R2's coccyx wound was first identified 12/30/25. The wound was a Stage III pressure wound to his coccyx. V16 said R2's coccyx pressure wound was acquired in the facility. V16 said it had yellow slough and was not sure why it was not found sooner. V16 said it (healing) was difficult at first because R2 did not like his low air loss mattress, and he was only moving when staff moved him.On 1/17/26 at 11:40 AM, V8, Certified Nursing Assistant (CNA) said it's important she informs V16 and the (floor) nurse about any changes in the residents' skin right away.R2's Admission/readmission Alteration in Skin Integrity form dated 12/17/25 shows R2 has no open areas or skin breakdown. R2's Weekly Wound Evaluation dated 12/18/25 shows R2 has blanchable redness to his buttocks with no open areas present. No redness or open areas were noted to his coccyx. No open areas or skin breakdown was noted. The document shows a Stage I pressure ulcer that has non-blanchable redness. Non-blanchable redness was not noted to R2's skin. R2's Weekly Wound Evaluation dated 1/2/26 shows R2 was found to have a Stage III pressure injury (In-house acquired) to his coccyx on 12/30/25. The wound had a moderate amount of thin, watery, serous drainage yellow slough and a resident pain rating of an eight (8). R2's Wound Physician's note dated 12/30/25 shows R2 has a Stage III pressure wound of his coccyx which was reported on 12/30/25. R2's Braden Scale(s) for Predicting Pressure Sore Risk dated 12/17/25, 12/25/25, 1/2/26 and 1/9/26 all show R2 is a low risk. R2's Minimum Data Set (MDS) dated [DATE] shows R2 is cognitively intact and has no rejection of care behaviors.The facility's Guidelines for Prevention/Treatment of Pressure Injuries (dated 10/9/23) show that a Risk Assessment is considered the starting point for prevention of pressure injury. The earlier any risk factors can be identified, the more quickly they can be addressed. The at risk resident must be identified because they can develop a pressure injury within hours of the onset of pressure. CNAs should immediately report any new skin concern, or complaint of a painful area of skin to the nurse for assessment.

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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. Based on observation, interview, and record review, the facility failed to implement and/or follow Enhanced Barrier Precautions (EBP) for 2 of 3 residents (R2 and R5) reviewed for infection control in the sample of 15.The findings include:On 1/17/26 at 10:15 AM, V16, Wound Care Nurse, said R2 has a sacral pressure ulcer (Stage III). On 1/17/26 at 11:10 AM, V16 approached R2's room to provide wound treatment. R2's room had no EBP sign nor PPE (Personal Protective Equipment) bin outside his room. V16 did not don a gown prior to entering R2's room. V16 was observed providing wound care to R2's coccyx without a gown.On 1/17/26 at 9:42 AM, V8, Certified Nursing Assistant (CNA), entered R5's room without a gown to change R5's brief. R5's room had an EBP sign on her door and a PPE bin outside her room.On 1/17/26 at 12:50 PM, V2, Director of Nursing (DON), said any resident with wounds or a history of MDROs (multidrug resistant organism) needs to be on EBP. A sign will be placed on their door indicating the type of isolation and the PPE. V2 said the PPE needs to be put on and hand hygiene done before entering the room to do resident care and needs to be removed prior to exiting room. V2 said EBP requires a gown and gloves when providing direct patient care such as incontinence care and wound care.R2's admission Record shows he has a Stage 3 pressure ulcer of his sacral region. R2's Order Summary Report dated 1/16/26 shows R2 has an active order written on 1/2/26 for daily and as needed wound care to his coccyx.R5's Order Summary Report dated 1/16/26 shows R5 has an active order written on 1/2/26 for EBP for ESBL (a MDRO) in her urine.