

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145937	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Forest City Rehab & Nrsng Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Arnold Avenue Rockford, IL 61108	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review the facility failed to manage a resident's indwelling urinary drainage bag in a dignified manner for 1 of 33 residents (R131) reviewed for dignity in the sample of 33. The findings include:R131's Order Summary Report printed on 11/17/25 showed R131 had a suprapubic indwelling urinary catheter. On 11/17/2025 at 11:42 AM, R131 was in the dining room eating lunch with other residents. R131 was in a reclining wheelchair with the indwelling urinary drainage bag hanging on the reclining wheelchair. The urinary drainage bag was not in a privacy bag. Urine was visible in the collection bag. On 11/17/2025 at 1:17 PM, R131 was in bed. The indwelling urinary drainage bag could be seen from the hallway. Urine was visible in the collection bag. On 11/18/2025 at 8:03 AM and at 11:40 AM R131 was in the dining room eating with other residents. R131 was in a reclining wheelchair with the indwelling urinary drainage bag hanging on the reclining wheelchair. The urinary drainage bag was not in a privacy bag. Urine was visible in the collection bag. On 11/18/2025 at 12:35 PM, V2 (Director of Nursing) said indwelling urinary drainage bags should be in a privacy bag and privacy bags are used to provide dignity. The facility's Dignity policy with a revision date 1/25 showed examples of promoting dignity and respect include the use of privacy covering for urinary catheter bags.</p>		

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview and record review the facility failed to provide adaptive utensils to a resident at meals for 1 of 3 residents (R147) reviewed for resident accommodation of needs/preferences in the sample of 33. The findings include: R147's current care plan showed R147 required the use of built up silverware at meals to aid in his ability to feed himself due to his diagnosis of a cerebrovascular accident (CVA) and bilateral carotid stenosis. R147's breakfast meal tickets dated 11/17/25 and 11/18/25 showed R147 was to use built up silverware when eating his meals. On 11/17/25 at 8:36 AM, R147 was seated in his room with his breakfast tray in front of him. R147 was attempting to feed himself, using regular, standard utensils. No weighted utensils or utensils with rubber grips on the handles were noted on R147's meal tray. On 11/18/25 at 8:05 AM, V11 Certified Nursing Assistant (CNA) delivered R147's breakfast tray to R147 in his room. The only utensils on R147's tray were a plastic fork and a plastic spoon. On 11/18/25 at 8:41 AM, R147 was seated in his room, attempting to eat his breakfast with a plastic fork. R147 was able to spear scrambled eggs with the fork but a small amount of egg would fall off the fork as he brought the fork to his mouth. On 11/18/25 at 9:26 AM, V7 Licensed Practical Nurse (LPN) stated R147 required the use of weighted (built up) utensils to eat because he has had a stroke. The weighted silverware helps him eat using his affected hand from the stroke. Those utensils allow him to build up strength in his affected hand when he uses that silverware. He should use weighted silverware at every meal. The facility's Adaptive Eating Devices policy dated 10/11/23 showed, Adaptive eating equipment, such as plate guards, sip cups, and built-up utensils, are provided for residents who need them to promote feeding independence.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review the facility failed to ensure psychotropic and anti-psychotic medications that were ordered as needed had a stop/duration date for 3 of 8 residents (R127, R13, and R10) reviewed for pharmacy services in the sample of 33. The findings include:1. R127's Order Summary Report printed on 11/17/25 showed an order for haloperidol (anti-psychotic medication) as needed every 8 hours. The order had a start date of 11/12/25. There was no stop/duration date for the order.2. R13's Order Summary Report printed on 11/17/25 showed an order for lorazepam (psychotropic antianxiety medication) as needed every 3 hours. The order had a start date of 10/6/25. There was no stop/duration date for the order.3. R10's Order Summary Report printed on 11/17/25 showed an order for lorazepam as needed every 8 hours. The order had a start date of 10/15/25. There was no stop/duration date for the order.On 11/18/2025 at 12:35 PM, V2 (Director of Nursing) said as needed psychotropic and anti-psychotic medications need a stop date.The facility's Psychotropic Medication Policy with a reviewed date of 7/1/25 showed as needed psychotropic and anti-psychotic medication are limited to 14 days.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview and record review the facility failed to provide incontinence care and to reposition a resident dependent on staff for these cares for 1 of 33 residents (R27) reviewed for activities of daily living (ADLs) in the sample of 33. The findings include: R27's current care plan showed R27 was nonverbal and cognitively impaired due to his diagnoses of intellectual disability and paralytic syndrome. The plan showed R27 is dependent on staff for toileting/incontinence care, transfers and repositioning. R27 was incontinent of bowel and bladder. The plan showed staff will reposition R27 as per facility protocol and keep R27's skin clean and dry. On 11/17/25 at 10:21 AM, R27 was seated in a high-back wheelchair in his room. R97 (R27's roommate) was also in the room. R97 looked at this surveyor and stated, He (R27) doesn't talk. When R97 was asked how long R27 had been up in his wheelchair that morning, R97 stated, He's been up in the wheelchair since around 5 AM. They (staff) don't lay him down much during the day. On 11/17/25 at 11:36 AM, R27 remained seated in his high-back wheelchair in the dining room of the facility. On 11/17/25 at 12:15 PM, V5 and V6 Certified Nursing Assistants (CNA) transferred R27, from his wheelchair to bed, via a mechanical lift. V5 and V6 CNAs removed R27's incontinence brief. A large amount of dried out, hard stool was stuck to the crease between R27's buttocks. R27's brief contained a large amount of dark yellow urine. Redness was noted to the skin of R27's buttocks, groin and scrotum. Skin creases, caused by exposure to R27's wet incontinence brief, were noted to R27's buttocks. V6 CNA stated R27's incontinence brief was last changed sometime between 5 AM-6 AM when staff had gotten him up and out of bed for the day. On 11/18/25 at 9:26 AM, when V7 Licensed Practical Nurse (LPN) stated residents are to be repositioned every 2 hours to help prevent skin breakdown. V7 stated residents should be checked every 2 hours for incontinence and changed if soiled. The facility's Repositioning and Turning policy dated June 2014 showed, It is the policy of the Nursing Department that residents, unable to reposition themselves, will be turned and repositioned every two hours, in accordance with their needs.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have pressure treatments and pressure reducing interventions in place which applies to 4 of 9 residents (R117, R129, R51, R73) reviewed for pressure wounds in a sample of 33. The findings include:1) R117's Medical Record showed R117's is a [AGE] year-old female resident readmitted to the facility on [DATE] with diagnoses which includes Stage 4 pressure ulcer of the sacral (tailbone) region.</p> <p>On 11/17/25 at 12:30 PM, V5 and V6 Certified Nursing Assistants (CNAs) were performing peri-care for R117. R117's incontinence brief had urine in it. R117's sacral pressure wound had no coverage dressing in place. V5 stated V34 Hospice CNA told them R117's dressing came off after their shower. V5 stated they should have let the nurse know the dressing was missing.</p> <p>On 11/17/25 at 12:55 PM, V34 stated when they cleaned up R117 the dressing on R117's wound came off. V34 stated they cleaned up R117 around 11:15 AM to make sure she would be up for lunch. V34 stated they let V5 know.</p> <p>On 11/17/25 at 2:00 PM, V31 Wound Nurse stated no one had come to let them know R117's dressing had come off earlier in the day. V31 stated someone should have come to let them know about the dressing not being in place. R117's wound is being treated for an infection and needs to be covered. Dressing should be in place per order.</p> <p>R117's Physician Orders printed on 11/17/25 showed a wound care order for the sacral area to apply crushed Cipro (antibiotic) and gauze soaked with antibacterial solution to the wound bed and cover with border dressing.</p> <p>On 11/17/25 at 2:30 PM, V2 Director of Nursing stated wounds should have their dressings in place. CNAs need to let a nurse know it is missing so it can be replaced.</p> <p>2. R129's Wound and Skin Alteration Review dated 11/13/25 showed R129 had a Stage 4 pressure injury to her right heel that measured 0.2 cm (centimeters) x 1.2 cm x 0.5 cm.</p> <p>R129's Order Summary Report dated 10/30/25 showed R129's right heel pressure injury was to be covered with a gauze dressing at all times.</p> <p>On 11/17/25 at 10:30 AM, R129 was observed propelling her wheelchair around the facility. R129 wore only socks, no shoes. It appeared there was no dressing to R129's right heel. R129 was asked if she had a dressing to the wound on her right foot. R129 shook her head no.</p> <p>On 11/17/25 at 2:35 PM, R129 was seated in her wheelchair on the second floor of the facility. R129 again stated she had a wound to her heel. When R129 was asked if she had a dressing covering the wound on her right heel, R129 shook her head no and pulled down the sock on her right foot. No dressing was noted to R129's right heel pressure wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/18/25 at 9:26 AM, V7 Licensed Practical Nurse (LPN) stated R129 had a boggy pressure wound to her right heel. V7 LPN stated staff provide treatment and a dressing change to R129's pressure injury every Monday, Wednesday, and Friday. V7 stated, She is supposed to have a dressing covering her wound at all times to protect it.</p> <p>3. R51's Care Plan with a completed date of 10/15/25 showed R51 was at risk for breakdown in skin integrity as evidenced by pressure over bony prominences. Listed under interventions was for a low air loss mattress.</p> <p>On 11/17/2025 at 8:41 AM, R51 was in bed. Hanging on the foot of the bed was an air mattress pump. There was a black tube coming from the pump that was disconnected from the mattress resting on the floor. The green power switch was in the off position.</p> <p>On 11/17/2025 at 11:22 AM and on 11/18/25 at 8:01 AM, R51 was in bed and there was no change in R51's air mattress pump.</p> <p>4. R73's Care Plan with a completed date of 10/1/25 showed R73 was at risk for breakdown in skin integrity as evidenced by pressure over bony prominences.</p> <p>On 11/17/2025 at 10:23 AM, R73 was in bed. Hanging on the foot of the bed was an air mattress pump. The green power switch was in the off position and not lit up.</p> <p>On 11/18/2025 at 8:00 AM, R73 was in bed and the air mattress pump remained off.</p> <p>On 11/18/2025 at 11:36 AM, V7 (Licensed Practical Nurse) said an air mattress is a preventative intervention for residents at risk for pressure injuries and if a resident has an air mattress it should be working/on.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure electrical wiring was appropriately insulated and stowed out of reach in one resident's room (R149) and failed to ensure a resident was transferred in a safe manner for 2 of 6 residents (R149, R147) reviewed for safety in the sample of 33. The findings include: 1. On 11/18/25 at 12:53PM, R149 showed the surveyor two wires sticking out of the wall in the resident's room. R149's room has a black and a white electrical wire hanging out of a conduit tube under the window. The electrical wires were wrapped with black electrical tape.</p> <p>On 11/18/25 at 1:25PM, V12 Maintenance used a voltage tester to check the electrical wires. The voltage tester started flashing and emitted a tone signifying electrical current was present in the wires. V12 Maintenance said, there is 120 volts of electrical power coming through the wires. The wires should be enclosed with wire caps (rather than electrical tape). The facility's Preventative Maintenance Program dated 02/19 shows all electrical equipment is checked for safety.</p> <p>2. R147's Restorative assessment dated [DATE] showed he required partial to moderate assistance of staff for transfers and toileting due to his diagnoses of frequent falls, cerebrovascular accident (CVA) and bilateral carotid stenosis.</p> <p>On 11/17/25 at 9:01 AM, V8 and V9 Certified Nursing Assistants (CNA) entered R147's room to provide cares. V9 CNA wheeled R147 into the bathroom via his wheelchair. V9 then transferred R147, from his wheelchair to the toilet, by placing her arm under R147's left arm and guiding R147's buttocks onto the toilet. V9 did not use a gait belt when transferring R147. V8 CNA stood in the doorway of the bathroom and watched as V9 CNA transferred R147.</p> <p>On 11/18/25 at 1:03 PM, V10 Restorative Nurse stated R147 required partial to moderate assistance of one staff for all transfers which included the use of a gait belt to ensure R147's safety. V10 stated R147 was at risk for falls due to his previous falls in the facility.</p> <p>The facility's Gait Belt policy dated January 2025 showed, Purpose: To provide support and safety during ambulation, lifting, or transferring residents. Place the gait belt around the resident's waist. Make certain that the belt fits snugly. Grasp belt webbing securely at resident's back and resident's right or left side to support resident balance during transfers.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a residents urinary catheter bag below the level of the bladder and off the floor for 2 of 7 residents (R82, R3) reviewed for urinary catheters in the sample of 33. The findings include: 1. R82's current care plan showed R82 had a urinary catheter in place due to his diagnoses of prostate cancer and obstructive and reflux uropathy. The plan showed R82 is at risk for infection or complications related to catheter use. Observe position of drainage bag and keep below waist to ensure proper drainage.</p> <p>R82's progress note dated 11/5/25 showed R82 developed blood in his urine. R82's physician/nurse practitioner was notified. A urinalysis of R82's urine was ordered.</p> <p>R82's urinalysis result dated 11/11/25 showed R82 was diagnosed with a urinary tract infection (UTI) and started on antibiotics for treatment of the UTI.</p> <p>On 11/17/25 at 8:53 AM, R82 was in bed, lying on his right side. The catheter bag, connected to R82's urinary catheter, rested on the seat of a wheelchair that was located directly next to the left side of R82's bed. Because R82's bed was positioned lower than the seat of the wheelchair, R82's catheter bag rested below the level of R82's bladder. R82's urine was unable to drain into the urinary catheter bag.</p> <p>On 11/17/25 at 1:27 PM, R82 remained asleep in bed. R82's urinary catheter bag remained on the seat of the wheelchair next to R82's bed. Because R82's bed was positioned lower than the seat of the wheelchair, R82's catheter bag rested below the level of R82's bladder. R82's urine was unable to drain into the urinary catheter bag.</p> <p>On 11/18/25 at 7:28 AM, R82 was asleep in bed, R82's urinary catheter bag rested on the seat of the wheelchair next to R82's bed. Because R82's bed was positioned lower than the seat of the wheelchair, R82's catheter bag rested below the level of R82's bladder. R82's urine was unable to drain into the urinary catheter bag.</p> <p>On 11/18/25 at 9:26 AM, V7 Licensed Practical Nurse (LPN) stated a resident's urinary catheter bag should be positioned below the level of a resident's bladder so urine can drain out of the resident into the bag. V7 stated if a resident's urine can't drain into the catheter bag, it can cause an infection and/or discomfort to a resident.</p> <p>The facility's Catheter Care policy dated January 2025 showed, Catheters shall be positioned to maintain a downhill flow of urine to prevent a back flow of urine into the bladder or tubing, during transfer, ambulation, and body positioning.</p> <p>2. R3's medical records showed R3 is a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses which include type 2 diabetes mellitus, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>On 11/17/25 at 10:40 AM, 11/17/25 at 12:45 PM, and 11/18/25 at 9:30 AM R3's urinary catheter bag was not in a dignity bag. The lower half of the urinary collection bag was laying on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/18/25 at 8:00 AM, V26 Certified Nursing Assistant (CNA) stated catheter bags should not be touching the floor.</p> <p>On 11/18/25 at 2:45 PM, V4 Infection Control Preventionist (ICP) stated urinary catheter bag should not be hung low enough to touch the floor or be placed directly on the floor which can increase the chance of an infection.</p> <p>The facility's Catheter Care Policy dated 10/13/18 showed urinary drainage bags and tubing shall be positioned to prevent them from touching the floor.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on interview and record review the facility failed to consistently document meal intakes and monthly weights and failed to ensure a resident (R40) was assessed by the dietician following a significant weight loss. This failure resulted in additional interventions not being implemented and R40 experiencing on going weight loss. The facility failed to ensure nutritional interventions were implemented for 4 residents (R9, R14, R153, R160) and failed to ensure weekly weights were obtained for a resident (R153). The findings include: 1. On 11/19/2025 at 10:26AM, V14 Dietary Manager said, I perform admission and quarterly nutritional assessment on the residents. The dietitian uses my assessments and performs their own assessment. The dietitian only assesses residents if the computerized medical record triggers the resident for weight loss. The problem with R40's weight loss is the computer did not trigger the weight loss because no weights were documented. I was not made aware R40's weights were not being documented. From January 2025 through July 2025 R40's Medication Administration Record shows, R40 refused being weighed. If I would have known R40 was refusing to be weighed I would have requested an assessment by a Registered Dietitian. Then we would have been aware of R40's weight loss. Now we have a process. If a resident refuses to be weighed twice we have the resident assessed by the Registered Dietitian. Weight loss can be identified through observation. I monitor the resident's weight in the computerized medical record.</p> <p>On 11/19/2025 at 1:17PM, V15 Dietitian said, November 17, 2025, is the first time I assessed R40. I do not see any progress notes addressing R40's weight loss by the previous dietitian. R40 is high risk for weight loss. R40 has a history of anorexia and a new diagnosis of dementia. These diagnoses increase the effects of the weight loss on R40. On 08/07/2025 the prior dietitian recommended a supplement; this recommendation should have been paired with a progress note by the Registered Dietitian. I assess residents in multiple facilities. I am not in R40's facility daily. I only assess the residents that trigger in the electronic medical record for significant weight loss or when the facility requests me to assess a resident. The most effective way to identify significant weight changes is by weighing the resident. R40 refused to be weighed for eight months. It is more difficult, but weight loss can be identified by reviewing Meal Intake Records and through daily observation of the resident during the meal. When R40's weight loss was identified in August (08/06/2025), a Registered Dietitian should have assessed R40 immediately. Significant weight loss is defined as a 5% gain/loss in one month, 7.5% gain/loss in three months, or 10% gain/loss in six months.</p> <p>R40's Weight Record shows, the resident weighed 114.3 pounds on 12/30/2024. On 08/06/2025 R40's weight was 98.6 pounds, which is 13.7 percent weight loss. R40's Weight Record shows on 11/07/2025, the resident's weight was 90.8 pounds, which was a further is a 7.9% loss in three months.</p> <p>R40's Dietary Progress Note dated 11/17/2025 by V15 Dietitian shows, Registered Dietitian Weight Assessment. Weight Changes: Significant weight loss in three months. 7.8-pound loss with 7.9% weight loss.</p> <p>R40's Meal Intake Record shows, nine categories to document R40's intake. The categories include 0-25%, 26-50%, 51-75%, 78-100%, Nothing by Mouth, Tube Feeding, Resident Not available, Resident Refused, Not Applicable. The Meal Intake Record from 10/21/2025 through 11/17/2025, shows there were 45 meals with no entries of the intake percentages.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R40's care plan included a Focus initiated on 03/22/2016 and revised on 07/10/2025, that shows, (R40) . is known to deny meals and only eat her supplements. Will work on encouraging oral intake. The goal, initiated on 06/22/2022 and revised on 10/25/2025 shows, (R40) will not lose any weight through next review. The interventions included, Chart % consumed at each meal and offer substitutes for refused item and Nurse alert MD (Medical Doctor) and guardian of significant weight loss and assure that dietician is made aware so a consult can take place. Both had an initiation date of: 09/01/2024.</p> <p>A second Focus initiated and revised on 10/25/2025, shows, (R40) is at risk for elevated blood pressure related to hypertension. The interventions included, Assess (R40's) weight monthly or as ordered. Date initiated and revised: 10/25/2025.</p> <p>The facility undated Food Service Supervisor-Job Description shows, Main Duties: Make recommendations for changes in diet based on observations. Implement any plan of correction as required by State and Federal surveys in the dietary department.</p> <p>2. On 11/17/2025 the noon meal food serving line on first floor was observed continuously by this surveyor from 11:35 AM-12:15 PM. Staff were heard asking V22 (Cook) for magic cups and ice cream for the resident who have those items on their meal tickets. V22 would inform them that they do not have any. At 12:09 PM, V22 said that the facility ran out of magic cups and ice cream on Friday 11/14/2025, and V8 (Certified Nursing Assistant) added that the facility runs out of things a lot.</p> <p>On 11/17/2025 at 12:25 PM, R14 did not have a magic cup on his lunch meal tray.</p> <p>R14's Physician Orders dated 3/12/2025 Magic cup in the afternoon for Magic cup with lunch. Magic Cup in the evening for Magic cup with dinner.</p> <p>On 11/18/2025 at 9:55 AM, V14 (Dietary Manager) said she was not aware the facility had run out of magic cups and ice cream last Friday. V14 said they should have let her know so she could go get some. V14 also said other nutritional supplements should have been given to the residents.</p> <p>On 11/18/2025 at 10:10 AM, R160 said she did not get her magic cup or ice cream at lunch yesterday and she likes that.</p> <p>R160's Dietary Progress Note dated 10/31/2025 shows her current weight as 95.8 pounds (lbs.) and she has had a history of significant weight loss of 10.2# (lbs) or 13.7% in 3 months from July to October 2025. R160's Dietary note shows she should receive nutritional supplements including magic cup and ice cream with lunch and dinner. R160 has a physician order for both Magic Cup ordered on 7/17/2023 and ice cream ordered on 6/23/2025 both to be given with lunch and dinner.</p> <p>On 11/18/2025 at 12:25 PM, R153 said she did not get her magic cup for the past few days, and they often do not give it to her.</p> <p>R153's weight summary shows she had a prior significant weight loss of 10.3% 12.4 lbs. in August of 2025. R153's order summary shows she has a physician order dated 3/16/2025 for magic cup with breakfast and dinner.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Forest City Rehab & Nrsng Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Arnold Avenue Rockford, IL 61108	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/18/2025 at 1:05 PM, R9 said he got the magic cup today, but didn't get it this weekend or yesterday. R9 said he eats it when he gets it.</p> <p>R9's Physician Orders dated 8/5/2025 Serve magic cup with lunch for weight management.</p> <p>On 11/18/2025 at 1:39 PM, V15 (Dietician) said all the residents who have orders to receive magic cup are either at risk for weight loss or have had weight loss and the magic cup is an intervention to prevent weight loss. V15 said she was not aware the facility had run out of the magic cup and ice cream, but they should have given a substitute.</p> <p>The facility provided Supplementation policy dated 8/5/2023 shows supplements are given to meet resident nutritional needs and to maintain weight.</p> <p>3. R153's Order Summary Report printed on 11/17/2025 showed an order for weekly weights to be done every Tuesday. The order had a start date of 4/1/2025.</p> <p>On 11/17/2025 at 10:10 AM, R153 said she was not being weighed every week and she was not sure why.</p> <p>R153's October Medication Administration Record (MAR) and Weight and Vital Summary document for October showed a weekly weight recorded for two out of four weeks in October. The October MAR had not applicable documented for 10/7/2025, 10/21/2025, and 10/28/2025.</p> <p>R153's November MAR printed on 11/19/2025 and Weight and Vital Summary document for November showed weekly weights were done for one of two weeks. The November MAR had not applicable documented for 11/4/2025, 11/11/2025, and 11/18/2025.</p> <p>On 11/18/2025 1:37 PM, V15 (Dietitian) stated weekly weights are done to closely monitor a resident's weight to see if interventions are working or if interventions need to be added.</p> <p>The facility's Weight Assessment and Interventions policy with reviewed date of 1/24 showed ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer medications as ordered by the physician. There were 28 opportunities with 2 errors resulting in a 7.14% error rate. This applies to 2 of 4 residents (R17, R70) observed in the medication pass. The findings include:1.R17's Order Summary Report shows he was admitted to the facility on [DATE], with a diagnosis of type two diabetes mellitus with diabetic neuropathic arthropathy. R17 has an order for humalog tempo pen inject 15 units subcutaneously three times a day for diabetes.On November 17, 2025, at 11:00 AM, V19 Licensed Practical Nurse (LPN) prepared R17's insulin pen by placing a needle on the end. V19 turned the dial on R17's pen to 15 units. V19 then administered the insulin to R17's abdomen. V19 did not prime the insulin pen and needle by wasting two units of insulin prior to administering the insulin to R17. V19 said she only primes the insulin pen when she opens a new pen, not with each administration.On November 18, 2025, at 12:30 PM, V2 Director of Nursing (DON) said insulin pens should be primed with two units of insulin each time the pen is used in order to ensure the residents get the full amount of insulin. The facility's Insulin Pen Injection Administration Policy not dated shows, Always use a new needle for each injection. Remove protective tab from needle and screw it into the pen device. To prime: turn the dose selector to two units. Hold pen with the needle pointing up and tap the cartridge gently to move air bubbles to the top. Press the button all the way in. A drop of insulin should appear at the tip of the needle. Selecting the dose: turn the dose selector to the number of units needed to inject. The device will not allow you to select a dose greater than the number of units left in the pen. 2. R70's Order Summary Report shows she was admitted to the facility on [DATE]. There is an order for zyrtec allergy (cetirizine) oral tablet 10 mg (milligrams), give 10 mg by mouth daily for allergies. On November 17, 2025, at 9:20 AM, V7 Licensed Practical Nurse (LPN) administered loratadine 10 mg instead of cetirizine 10 mg. On November 18, 2025, at 12:30 PM, V2 DON said cetirizine and loratadine are different allergy medications. The facility's Policy and Procedure on Administering Medications dated January 1, 2020, shows, Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview and record review the facility failed to follow the menus for residents on regular, mechanical and pureed diets. This failure has the potential to affect all 166 residents residing in the facility. The findings include: The CMS-671, Long- Term Care Facility Application for Medicare and Medicaid form that was completed by the facility on 11/17/25 shows there were 166 residents residing in the facility. A list of resident diet orders shows all 166 residents receive food prepared by the facility. Facility provided menus show on 11/17/25 during the noon meal a biscuit should be served to residents receiving a regular diet, a soft biscuit served to residents receiving mechanical soft diets and pureed bread should be given to residents on pureed diets. On 11/17/25 the noon meal food service line on the first floor was continuously observed from 11:35 AM until 12:15 PM. Resident meals trays were prepared by V22 (Cook/Dietary Aide) which included BBQ chicken, mashed potatoes, vegetable, oven roasted potatoes, and dessert. There were no biscuits, or bread on the serving line and residents were not served any during the meal service. On 11/17/25 at 12:09 AM, V22 said that she did not make biscuits for the residents because it is too much for their oven space. V22 also said she did not make or give bread to any residents on a pureed diet. On 11/18/25 at 9:55 AM, V14 (Dietary Manager) said the facility menus should be followed and she was not aware that biscuits/bread was not served to the residents on 11/17/25. On 11/18/25 at 1:37 PM, V15 (Dietician) said the menus should be followed and if they do not give what is on the menu or give a replacement item the caloric intake would be less than planned. The facility provided Cycle Menu policy dated 9/26/23 shows that the menus are planned out ahead using national guidelines and will meet the nutritional needs of the residents.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on interview and record review the facility failed to provide R125 a snack outside of the scheduled meal service times for 1 of 5 residents (R125) reviewed nutrition in the sample of 33. The Findings Include: On 11/18/25 at 9:08AM, R125 said, I do not get snacks. I would like a bedtime snack. When I request a bedtime snack, V14 Dietary Manager tells me, only the diabetics get snacks. On 11/18/25 at 9:35AM, V13 LPN-Licensed Practical Nurse said, the facility only provides diabetic residents and residents with weight loss a snack at night. On 11/18/25 at 10:20AM, V14 Dietary Manager, we do not offer snacks to anyone. Diabetic residents are the only residents the snacks are set up for in the evening. On 11/18/25 at 1:38PM, V15 Dietitian said, we only provide snacks to diabetics. R125's Diet Order dated 10/02/2017 shows, regular texture, thin liquids, consistency for general diet. On 11/18/25 R125's Care Plan show, no intervention forbidding R125 from having a snack outside of scheduled meal service times. On 11/18/25 R125's Physician's Orders show, no Physician Order forbidding R125 from having a snack outside of scheduled meal service times.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review the facility failed to ensure beard coverings were worn when preparing resident meals. This failure has the potential to affect all 166 residents residing in the facility. The findings include: On 11/18/2025 at 9:35 AM, V24 [NAME] was observed in the kitchen making pureed bread and vegetables. V24 has a beard and was not wearing a beard covering. V14 Dietary Manager was present in the kitchen while V24 was observed making the pureed food for the noon meal. At 9:54 AM, V24 said he needed about 20 minutes for the turkey to finish cooking so this surveyor and V14 left the kitchen together. On 11/18/25 at 10:08 AM, V14 said that V24 should have a beard covering on while he was preparing food. At 10:16 AM, the surveyor and V14 finished the interview V14 left and did not go into the kitchen. At 10:16 AM, this surveyor returned to watch V24 make the remaining pureed entrees. At no time did he put a beard cover on and continued to puree turkey to serve with the noon meal. On 11/18/25 at 10:22 AM, V24 said the facility policy is beard covers should be worn when preparing food in the kitchen and he should have had one on. The facility provided Food Safety and Sanitation policy dated 9/17/23 shows that beard restraints should be worn at all times.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff wear personal protective equipment (PPE) and have signs posted for residents on enhanced barrier precautions (EBP) isolation which applies to 2 of 33 residents (R117, R82) reviewed for infection control in a sample of 33. The findings include:</p> <p>1) R117's Medical Record showed R117's is a [AGE] year-old female resident readmitted to the facility on [DATE] with diagnoses which includes Stage 4 pressure ulcer of the sacral (tailbone) region.</p> <p>On 11/17/25 at 12:30 PM V5 and V6 Certified Nursing Assistants (CNAs) entered R117's room, performed a mechanical lift transfer, and peri-care without placing a blue gown on prior to entering the room. R117 has a sign on the door for EBP isolation precautions to be used.</p> <p>R1's Physician Orders printed on 11/17/25 showed R117 has dressing change orders which include using a crushed antibiotic and antibacterial solution to be applied to R117's wound.</p> <p>On 11/18/25 at 2:45 PM V4 Infection Control Preventionist (ICP) stated R117 is on EBP for a chronic wound which is currently being treated for an infection. Gowns and gloves should be worn during high contact care.</p> <p>On 11/19/25 at 9:35 AM, V5 stated if someone is on EBP then a gown and gloves need to be used during cares. V5 stated they should have worn a gown during R117's care.</p> <p>The facility's EBP policy dated 11/28/22 showed EBP require the use of gown and gloves during high contact care activities which includes changing briefs or assisting with toileting. EBP applies to resident with a chronic wound.</p> <p>2. R82's current care plan showed R82 had a urinary catheter in place due to his diagnoses of prostate cancer and obstructive and reflux uropathy.</p> <p>R82's Order Summary Report dated 7/16/25 showed a physician order for R82 to have Enhanced Barrier Precautions (EBP) in place due to having a urinary catheter.</p> <p>On 11/17/25 at 8:53 AM and 1:27 PM, R82 was in bed with a urinary catheter in place. No Enhanced Barrier Precautions (EBP) signage was noted on or by the door to R82's room.</p> <p>On 11/18/25 at 9:26 AM, R82 was in bed with a urinary catheter in place. No Enhanced Barrier Precautions (EBP) signage was noted on or by the door to R82's room.</p> <p>On 11/18/25 at 9:26 AM, when V7 Licensed Practical Nurse (LPN) was asked how staff identify if a resident is on EBP or any type of isolation precautions, V7 stated, There is a sign posted on the resident's door which identifies what type of isolation the resident is on and what PPE (personal protective equipment) staff are required to wear when providing cares.</p> <p>The facility's Enhanced Barrier Precautions policy dated 4/28/25 showed, Enhanced Barrier Precautions apply to residents with a wound (chronic wounds, not shorter-lasting wounds, such as skin breaks or tears covered with an adhesive dressing) or similar dressing and indwelling medical device (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) .</p>		