

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Belvidere Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 5th Avenue Belvidere, IL 61008	
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 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. Based on observation, interview, and record review, the facility failed to assess and implement prevention interventions for 1 of 3 residents (R2) reviewed for pressure wounds in the sample of 3. The findings include: R2's Skin Impairment/Wound Evaluation dated 7/19/25 shows R2 has a Stage 2 Pressure Injury of his right buttock. R2's admission Record dated 9/30/25 shows R2's diagnoses include, but are not limited to, Type 2 diabetes mellitus, hypertension, and anemia. R2's current care plan provided by the facility does not show any skin alterations or wounds and no interventions to treat or prevent further wounds or worsening of existing wounds. R2's current Order Summary Report dated 9/30/25 shows an active order for dressings to the open area on R2's right buttock every other day and as needed. R2's Treatment Administration Records beginning 7/1/25 through 9/30/25 all show R2 has been receiving wound treatments beginning on 7/20/25 through 9/30/25 to his right buttock wound. On 9/30/25 at 10:09 AM, V6, Registered Nurse (RN), said R2 is back from his shower, and she is going to do his wound care. V6 used gloved hands to clean R2's right buttock wound with normal saline and gauze. V6 changed her gloves then applied xeroform and a foam dressing. V6 said R2's dressing change is every other day and as needed. On 9/30/25 at 10:21 AM, V3, Wound Care Nurse, said all skin abnormalities are reported to the primary care provider (PCP) and to herself. V3 said she goes in and assesses the wound and takes measurements, communicates with the wound care doctor, V4, and gets treatment orders. V3 said she does a weekly wound assessment. V3 said she has never assessed R2's wound. V3 said she would have to look at R2's wound to know what type of wound it is. V3 said R2's wound was not brought to her attention, and the wound care doctor has not seen it either. V3 said V4 sees all pressure wounds in the facility. On 9/30/25 at 11:17 AM, V2, Director of Nursing (DON)/Infection Prevention Nurse, said when nursing identifies a skin alteration, they should notify V3. V2 said pressure wounds should be assessed weekly or more often by V3 and V4. The assessment includes measurements, tissue appearance, any undermining or tunneling, odor, and drainage type and amount. V2 said V3 sees all pressure wounds and V4 gets involved with wound treatment at V3's request. On 9/30/25 at 12:20 PM, V4 said he has not seen R2. V4 said it would be new to him if R2 had a pressure wound. On 9/30/25 at 9:03 AM, V7, RN, said V3 does weekly wound measurements and wound treatments. The facility was unable to provide weekly assessments of R2's Stage 2 pressure injury of his right buttock identified on 7/19/25. The facility's Pressure Injury Prevention and Management Policy (reviewed 6/17/25) shows licensed nurses will conduct a full body skin assessment after any newly identified pressure injury. Assessments of pressure injuries will be performed by a licensed nurse and documented. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 implement Enhanced Barrier Precautions (EBP) for 2 of 3 residents (R2 and R3) reviewed for infection control in the sample of 3. The findings include: R2's Skin Impairment/Wound Evaluation dated 7/19/25 shows R2 has a Stage 2 Pressure Injury of his right buttock. R2's admission Record dated 9/30/25 shows R2's diagnoses include, but are not limited to, Type 2 diabetes mellitus, hypertension, and anemia. R2's current Order Summary Report dated 9/30/25 shows an active order for dressings to the open area on R2's right buttock every other day and as needed. R2's Treatment Administration Records beginning 7/1/25 through 9/30/25 all show R2 has been receiving wound treatments beginning on 7/20/25 through 9/30/25 to his right buttock wound. R3's admission Record dated 9/30/25 shows she was admitted to the facility on [DATE]. The facility's Pressure Ulcer Tracking log dated 9/30/25 shows R3 was identified as having a Stage 2 left buttock pressure injury on 9/3/25. On 9/30/25 at 10:09 AM, V6, Registered Nurse (RN), said R2 is back from his shower, and she is going to do his wound care. V6 used gloved hands, without donning a gown, to clean and dress R2's right buttock wound. There were no EBP or other transmission-based precaution signs on his door or near the entrance to his room and no PPE (personal protective equipment) was outside his room. On 9/30/25 at 09:13 AM, R3's room had no EBP or other transmission-based precaution signs on her door or near the entrance to her room and no PPE (personal protective equipment) was outside her room. On 9/30/25 at 10:21 AM, V3, Wound Care Nurse, said R3 has a stage 2 pressure ulcer on her left buttock, present on admission. V3 said R3 was admitted on [DATE] and is having daily wound treatment. On 9/30/25 at 2:43 PM, V8, RN, said if a resident has some type of wound, staff are supposed to wear a gown, glove and masks when doing wound treatment to protect themselves. V8 said she knows when someone is on EBP they put the order in the computer, place gowns and PPE outside the resident room, and signs outside their door. On 9/30/25 at 2:48 PM, V2, Director of Nursing (DON)/Infection Prevention Nurse, said residents who have pressure wounds require EBP. V2 said EBP are essentially contact precautions directed at potential exposure to the patient. Gloves and gowns are required to be worn with close contact care activities, there are signs on the patient's door that says EBP, and it's in the resident chart. V2 said they do not require a doctor's order to initiate the precautions; nursing can initiate EBP. V2 said wound care is a close contact care activity. The facility's Enhanced Barrier Precautions Policy (implemented 2/25/25) shows it is the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms. EBP applies to all residents with wounds. Staff need PPE during high contact resident care such as wound care: any skin opening requiring a dressing. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound.		