

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 07/08/2026
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review the facility failed to ensure the pureed macaroni and cheese was a smooth consistency, not requiring chewing. This applies to 4 of 4 residents (R30, R17, R38, R44) reviewed for puree diets in the sample of 23. The findings include: Facility provided Thicken Liquids/Fluid Restrictions/Puree form dated 7/1/26 shows R30, R17, R38, and R44 receive Puree Diets. On 7/6/26 at 11:11 AM, V6 (Food Service Director) finished pureeing the macaroni and cheese. V6 tested the consistency of the puree macaroni and cheese and was chewing while V6 said, nobody is going to choke on that. The puree macaroni and cheese appeared chunky as V6 scooped it into a steam table pan. On 7/6/26 at 12:35 PM, the facility provided test tray of pureed macaroni and cheese and pureed green beans was tested by this surveyor. The macaroni and cheese consistency was not smooth, had chunks of macaroni, and required this surveyor to chew. On 7/6/26 at 11:20 AM, V6 said the purees should be a smooth consistency. Chicken broth would be added if the product is too thick and food thickener would be added if the product is too thin. Facility Texture and Consistency-Modified Diets policy, no date, states, . 5. The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered.		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review, the facility failed to implement the recommendations from the criminal history analysis report for a convicted sex offender, and failed to invite residents to their quarterly care plan meetings for 2 of 12 (R7and R39), reviewed for care plans in the sample of 23.The findings include: 1.On 07/06/2026 at 1:35pm, R39 was sitting in his recliner in his room. R39 had a private room and bathroom. R39 stated that he keeps to himself.R39's criminal history analysis security recommendation report dated 10/24/2020, shows R39 is a, convicted and or registered sex offender and must be placed in a single resident room with a private bathroom facility.R39's current care plan shows R39 is an identified sex offender. R39's care plan does not include the resident must be placed in a single resident room with a private bathroom.On 07/08/2026 V1 Administrator, was not aware that the specific recommendations for the private room and bathroom were not care planned. 2.On 07/06/2026 at 1:35pm, R39 was sitting in his recliner in his room. R39 was asked about being invited to participate in his individual care plan meetings to discuss his specific needs, he replied no, they only invite my guardian, not me.R39's Minimum Data Set, dated [DATE], shows R39 has mild cognitive impairment.On 07/07/2026 at 12:49 pm, V4 (Social Worker Director) stated when notifying residents and families of upcoming care plan meetings, she emails or mails the invitation to the family or guardian and verbally tells the residents. She stated that she does not usually document the giving of the invitation or refusals to attend the meeting. She only documents who attends the care plan meeting.3.On 07/06/2026 at 10:06am, R7 was lying in his bed. R7 stated that he is never invited to participate in his care plan meetings. On 07/08/2026 at 9:45am, the facility provided R7's notice of care plan conference invitation dated 03/24/2026 and 6/23/2026. On 07/08/2026 at 9:47am, V4 reviewed R7 care plan conference invitations and stated, this is what I handed R7 for his care plan conference. On 07/08/2026 at 9:54am, R7 was presented with the care plan conference invitations. R7 stated that he had never seen the invitations before.R7's Minimum Data Set, dated [DATE], shows R7 has mild cognitive impairment.R7's Social Service Notes from March 2026 to June 2026 were reviewed. There were no notations of invitations or refusal to attend his care plan conference.The facility's Care Plan Conference Meeting policy, with an implemented date of 01/05/2025, shows, The resident and or family are invited to attend the care conference. An invitation is sent to the families by Social Services or designee.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review the facility failed to ensure the prescribed treatment was provided for a resident with a venous ulcer and failed to assess an open wound and obtain treatment orders. This applies to 2 of 12 residents (R2, R7) reviewed for quality of care in the sample of 23. The findings include: 1.R2's face sheet shows he has diagnosis including type 2 diabetes, non-pressure chronic ulcer of left lower leg, peripheral vascular disease and acquired absence of right leg above the knee. On 7/7/26 at 8:51 AM, V8 (Registered Nurse-RN) donned PPE (Personal Protection Equipment) to provide wound care. V8 removed R2's left lower leg dressings. R2's left lower leg was reddened. His skin was dry and scaly, with multiple white patches of cream scattered on his leg with open areas noted. V8 cleansed R2's distal portion of the leg with a wound cleanser but did not cleanse or wash off the white cream. V8 applied the A & D ointment over the white cream, the medicated cream with the moist gauze and wrapped his leg with the elastic bandage. On 7/7/26 at 9:10 AM, V8 (RN) said the white cream is zinc oxide, from a previous treatment order. We try to remove the cream, but his skin is so fragile, and we can't wash the cream off. On 7/7/26 at 12:12 PM, V5 (Wound Nurse) said R2 has a chronic venous ulcer to his left lower leg. The current treatment is to cleanse with the wound cleanser, apply A & D ointment, wet gauze, absorbent pad, and elastic bandage. V5 said R2's treatment orders recently changed, and she updated the orders on 7/6/26. R2 was previously receiving zinc cream. We have been discussing the residual of the cream being on the leg and that's why the treatment was discontinued. The wound physician said staff should be using soap and water to remove the cream and then cleanse the leg with the wound cleanser. V5 stated, I don't see an order for the zinc cream to be applied to his leg, but I know he did. On 7/7/26 at 12:35 PM, R2 was observed in his room sitting in his wheelchair. R2 stated, some of the nurses use white cream and some don't. R2 said a nurse applied the white cream a couple of days ago. They are supposed to wash my leg with soap and water first; not all the nurses change the dressing the same. R2 said for a while it was not healing. R2's Wound Progress note dated 6/25/26 shows left lower venous ulcer measuring 10.5 cm x 11 cm with treatment orders including cleanse with Hibiclens (skin cleanser), apply Dakin 1/2 strength wet to dry, calcium alginate, A & D ointment to peri wound and left lower extremity, secure with absorbent pad (ABD), elastic bandage change twice a day. R2's Treatment Administration Record dated July 2026 shows two concurrent treatment orders to the left lower leg. The first treatment order (Initiated 4/26/26 and discontinued 7/6/26): Dakins (1/4 strength) apply to venous ulcerations topically, Apply A & D ointment to peri wound skin and LLE (left lower extremity). Apply Dakin's half strength moistened gauze to open areas. Cover with calcium alginate then absorbent pad, wrap kerlix, elastic bandage from foot to lower leg, twice a day. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second treatment order (Initiated 6/29/26) Hibiclens (skin cleanser) apply to left lower leg, apply A&D to peri wound skin and LLE. Apply Dakin's half strength solution moistened gauze to open areas. Cover with calcium alginate then absorbent pad, wrap with kerlix and elastic bandage twice a day. The T.AR. shows both treatments were signed off by staff as being administered from 7/1/26 to 7/6/26. R7's face sheet dated 07/07/2026, shows R7 has diagnoses to include diabetes, muscle wasting and atrophy, and schizoaffective disorder. On 07/07/2026 at 8:18am, R7 was in his wheelchair, self-propelling down the hallway. R7's had 2 bandages on his right knee. One of the undated bandages was peeling back exposing pink exudate on the bandage. On 07/06/2026 at 10:33 am, R7 was lying in bed wearing a T-shirt and shorts. R7 had multiple scabs on the lower right leg R7 had two square bordered dressings near their right knee, neither were dated. On 07/07/2026 at 9:23 AM, R7 was sitting in his wheelchair in his room. R7 stated a couple days ago the nurse put these dressings on. These are the same ones from that day. R7 stated they apply ointment (lower scabbed areas) every few days. R7 then proceeded to remove his shoes and socks. The top of R7's left foot second and third toe, top of foot and outer ankle had multiple scabbed areas. The top of R7's right foot and second toe also had several scabs. Resident stated that he scratches his foot on the bed, and he continues to pick his scabs. V11 Registered Nurse walked into R7's room. V11 removed R7's bandages to right knee. There were two open wounds approximately half a centimeter each. V11 was not aware he had wounds to right knee but was aware R7 is to have ointment applied to his legs every night to prevent him from picking at his legs. On 07/08/2026 at 10:30am, V2 Director of Nursing, stated that she was R7's nurse on Saturday 07/04/2026, the 2-10pm shift and there were no bandages on R7's knees or wounds, but he had scabs and pointed to the lower shin area. On 07/08/2026 at 12:18 PM V9 (Registered Nurse) stated she worked Sunday 7/5/2026, the 2-10pm shift with R7. V9 stated she applied the ordered ointment to both lower legs, on his scratches, and she denies seeing any new wounds on R7's right knee. She denied putting bandages on. V9 stated that when there are new wounds, they assess the wounds and notify the wound nurse who assesses the new wounds; and notify the physician for treatment orders. On 07/07/2026 at 3:17pm, V5 Wound Nurse/MDS Coordinator stated, today was first time she was aware R7 had wounds (V5 assessed seven new wounds). V5 stated that facility staff usually alerts her when a resident has a new wound or skin issue. V5 stated that the nurse on duty, if she is not available, can assess the wound and she will follow up on the next shift she works. V5 also stated dressings should not be applied without an order. R7 Physician Order Summary does not show an order for his right knee until 07/07/2026. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Initial Skin Impairment/Wound evaluation form dated 07/07/2026 completed by V5, shows the following wounds. Wound #1 Location: right knee Measurement of wound: 0.3x0.2x0.1 Partial thickness Scant sanguineous drainage Wound #2 Location: Right outer leg below knee Measurements: 0.4x0.4x0.1 Partial thickness Scant sanguineous drainage Wound #3 Right inner ankle Measurement: 0.8x0.5x0.1 Partial Thickness Scant sanguineous drainage Wound #4 Left outer ankle Measurement: 0.7x0.5x0.1 Partial Thickness No drainage Wound #5 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Location; top of left foot Description: scab Measurements: 7.5x0.3x0 Thickness not documented No drainage Wound #6 Location: R second toe Measurement: 0.5 x 0.5 x 0.1 Partial thickness Scant serous drainage Wound #7 Location: left third toe Measurement: 1 x 0.5 x 0.1 Partial thickness Scant serous drainage R7's Skin Impairment/Wound Evaluation dated 07/07/2026, completed by V5 shows R7's physician was notified and treatment orders were obtained. The facilities wound treatment management policy dated 01/5/2025, shows wound treatments will be provided in accordance with physician orders. In the absence of treatment orders the licensed nurse will notify the physician to obtain treatment orders.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview and record review the facility failed to provide the prescribed therapeutic diet for 1 resident (R14) of 12 residents reviewed for therapeutic diets in the sample of 23. The findings include: R14's face sheet shows she has diagnoses including end stage renal disease, type 2 diabetes, dependence of renal dialysis, and cerebral infarct. R14's Physician Order Sheets dated July 2026 shows orders including liberalized diet, double protein all meals, low potassium, and 2000 cc fluid restriction, high protein snack at night. On 7/6/26 at 12:28 PM, the lunch service was observed by a surveyor. At the end of service V6 (Food Service Director) utilized all the regular macaroni and cheese and even the gluten free macaroni and cheese. There were no leftovers after everyone was served their regular portion/meal. V6 scooped every last bit of macaroni and cheese from both the gluten free and normal meals to serve all residents with one portion served to all residents. On 7/6/26 at 12:46 PM, R14's noon plate was served with one bowl of macaroni and cheese and was not served double protein. On 7/6/26 at 3:01 PM, R14 said she received one serving of the macaroni and cheese. I got one bowl of the mac & cheese. On 7/7/26 at 2:14 PM, V6 (Food Service Director) said R14 is on a liberalized renal diet and gets double proteins with each meal. She received one bowl of mac and cheese and the staff came back and got another one.		