STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366234	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing Center of Rockford	201 Buckeye Street Rockford, OH 45882

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff and resident interviews, review of facility documentation and review of facility policy, the facility failed to implement enhance barrier precautions as required. This affected one (#1) of five residents reviewed for infection control. The facility also failed to document Legionella prevention control measures were documented. This had the ability to affect all 33 residents residing in the facility. The facility failed to ensure a resident's urinary collection bag was stored in a manner to reduce the chance of infection. This affected one (#35) of two residents reviewed for urinary catheters. The census was 33. Findings include: 1.Review of Resident #1's medical revealed an admission date of 04/29/21. Diagnoses listed included hemiplegia, diabetes mellitus, irritable bowel syndrome, pathological fracture, depressive disorder, hypertension, and schizophrenia. Review of an annual Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had moderately impaired cognition and received nutrition through a feeding tube. Review of physician orders revealed and order dated 06/06/25 for EBP related to percutaneous endoscopic gastrostomy (PEG) tube. Observation of Resident #1's medication administration on 12/30/25 at 4:12 P.M. revealed EBP were not implemented. Licensed Practical Nurse (LPN) #52 administered medications per Resident #1's PEG tube and rectally. LPN #52 was assisted by Certified Nurse Aide (CNA) #27. Incontinence care was also provided to Resident #1 after administration of a rectal medication. Neither LPN #52 nor CNA #27 downed gowns while performing any of the care. Interview with LPN #52 on 12/30/25 at 4:24 P.M. confirmed neither herself or CNA #27 had downed gowns during Resident #1's medication administration and incontinence. LPN #52 confirmed Resident #1 should have been on EBP because of her PEG tube. LPN #52 also confirmed there was not any signage at the entrance of Resident #1's door to inform staff that Resident #1 was on EBP. Interview with the DON on 12/31/25 at 8:00 A.M. confirmed Resident #1 was on EBP due to her PEG tube. The DON confirmed there was not any signage at the entrance of Resident #1 rooms to inform staff of EBP. Review of the facility's policy titled Enhance Barrier Precautions dated 03/01/25 revealed EBP refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employees targeted gown and gloves use during high contact resident activities. High-contact (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident care activities include: dressing; bathing; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use: central lines, urinary catheters; feeding tubes; tracheostomy/ventilator tubes; hemodialysis catheters; peripherally inserted central catheters (PICC); midline catheters; and wound care: any skin opening requiring a dressing. 2. Review of the facility's Legionella Prevention documentation binder revealed control measures listed to be completed were hot water heaters would be flushed and cleaned monthly, faucets would be cleaned monthly and aerators replaced as needed, shower heads would be cleaned monthly and replaced as needed, drinking fountains would be cleaned to remove scale monthly, and ice machines would be cleaned and sanitized quarterly. Further review of the facility's Legionella Prevention documentation binder revealed no documentation of any of the above listed control measures being completed. Interview with Maintenance Director (MD) #57 on 12/29/25 at 10:34 A.M. confirmed he had not been documenting any control measure checks. Review of the facility's policy titled Water Management Program dated 10/01/25 revealed based on the risk assessment control points will be identified. The list of identified points shall be kept in the water management program binder. Control measures will be applied to address potential hazards at each control point. Testing protocols and control limits will be established for each control measure. Individuals responsible for testing or visual inspections will document findings. 3.Review of medical record for Resident #35 revealed admission date of 04/06/23. The resident was admitted with diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease, and congestive heart failure and depression, obstructive and reflux uropathy. The resident remained at the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. He required set up with meals, bed mobility, transfers and moderate assistance with toileting hygiene. Observation on 12/30/25 at 8:23 A.M. revealed Resident #35 was sitting on the side of his bed. Resident #35's urinary catheter bag was observed laying uncovered on the floor towards the foot of the bed. Interview with Resident #35 at the time of the observation revealed a staff member came in to get his walker to clean it. Resident #35 stated the staff removed the urinary catheter bag off of his walker and placed it on the floor. Interview and observation on 12/30/25 at 8:28 A.M. with the Director of Nursing (DON) verified the urinary catheter was uncovered and laying on the floor. The DON stated the urinary catheter bag should be secured to an area below the bladder and should not be laid on the floor for infection prevention.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on review of infection control documents, staff interview, and review of facility policy, the facility failed to have a qualified infection preventionist. This had the potential to affect all 33 residents residing in the facility. The census was 33. Findings include: Review of the facility's infection control program documentation revealed no evidence of any current staff member being certified infection control and prevention. Interview with the Director of Nursing (DON) on 12/20/25 at 9:50 A.M. revealed she had not received specialized training in infection prevention and had not obtained any infection control and prevention certification. The DON had been responsible for the facility's infection control program since 10/20/25. Interview with Administrator on 12/30/25 at 11:09 A.M. confirmed the DON had not received specialized training in infection prevention and had not obtained any infection control and prevention certification. The Administrator stated Contracted Registered Nurse (CRN) #36 had been certified in infection prevention. During a follow-up interview on 12/30/25 at 1:40 P.M. the DON stated the CRN #36 was not actively overseeing her infection control program. The DON stated CRN #36 had not been in the facility to review or infection control logs or to audit any findings. Review of the facility's policy titled Infection Prevention and Control Program dated revised 05/01/25 revealed the designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, policy review, and review of the Centers of Disease Control (CDC) website, the facility failed to ensure a resident who tested positive for coronavirus (COVID-19) was monitored for changes in health status as per Center for Disease Control (CDC) guidelines. This affected one (#34) out of one residents reviewed for COVID-19. The facility census was 33. Findings include: Review of the medical record for Resident #34 revealed an admission date of 04/30/24 with medical diagnoses of gastroparesis, diabetes mellitus, hypertension, and depression. Review of the medical record for Resident #34 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #34 was cognitively intact and required partial/moderate staff assistance with toilet hygiene, bathing, bed mobility, and transfers. Review of the medical record for Resident #34 revealed a nurses' note, dated 12/25/25 at 2:15 P.M., which stated Resident #34 had returned from the hospital and tested positive for COVID-19 and was put into isolation. Review of the medical record for Resident #34 revealed a physician order dated 12/25/25 for airborne isolation for three days for COVID-19. The order was discontinued on 12/28/25. Review of the physician orders revealed an order dated 12/28/25 to recheck resident for COVID-19 one time only. Review of the medical record for Resident #34 revealed no documentation to support the facility staff had obtained Resident #34's temperature or oxygen saturation levels since 06/01/25. Further review of the medical record for Resident #34 revealed no documentation to support the facility staff had monitored Resident #34's clinical status since COVID-19 positive test or had documentation to support results of further COVID-19 tests. Interview on 12/30/25 at 1:29 P.M. with Resident #34 confirmed she tested positive for COVID-19 on 12/25/25 and the facility staff had completed a few more tests which came back negative. Resident #34 confirmed the facility staff have not completed any respiratory evaluations or obtained her vital signs since she tested COVID-19 positive on 12/25/25. Interview on 12/30/25 at 3:30 P.M. with Administrator confirmed the medical record for Resident #34 did not contain documentation to support the facility staff who had monitored Resident #34's respiratory status or obtained vital signs since Resident #34 tested COVID-19 positive on 12/25/25. Administrator also confirmed that the medical record for Resident #34 had no documentation to support further COVID-19 test results and Resident #34 did not have a current order for isolation in place. Review of the CDC website, https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html, stated staff should monitor the vital signs (temperature, respiratory rate, heart rate, blood pressure, oxygen saturations) for residents in a nursing home who are COVID-19 positive. Review of the facility policy, Covid-19 prevention, response, and reporting, revised 10/01/25, stated the facility would ensure appropriate interventions were implemented to prevent the spread of COVID-19 and to promptly respond to any suspected or confirmed COVID-19 infections. The policy stated staff would be alert to signs of COVID-19 and notify the resident's physician of any fever/chills, cough, shortness of breath or difficulty breathing, fatigue, muscle weakness, headache, new loss of taste or smell, sore throat, congestion, nausea or vomiting, and diarrhea.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility optometrist visit log, and staff and resident interviews, the facility failed to ensure a resident was provided with the opportunity to see an optometrist. This affected one (05) out of four residents reviewed for ancillary services. The facility census was 33. Findings include: Review of the medical record for Resident #05 revealed an admission date of 04/02/24 with medical diagnoses of schizoaffective disorder, suicidal ideations, hypertension, diabetes mellitus, depression, post traumatic stress disorder, and anxiety. Review of the medical record for Resident #05 revealed a quarterly Minimum Data Set (MDS) assessment, dated 10/01/25, which indicated Resident #05 was cognitively intact, required supervision with bathing and was independent with bed mobility and transfers, and required set-up with eating and toileting. The MDS indicated Resident #05 had no vision issues with the use of glasses. Review of the medical record for Resident #05 revealed no documentation to support the resident was seen by an eye doctor since admission. Review of the facility's optometrist log revealed the last visit by an optometrist to the facility was on 03/14/24. Interview on 12/29/25 at 9:24 A.M. with Resident #05 stated she had not been provided with the opportunity to see an eye doctor since she was admitted to the facility. Resident #05 confirmed she wore glasses and that she thought her vision had worsened a little since admission, but it had not affected her ability to perform her activities of daily living. Interview on 12/30/25 at 12:18 P.M. with Social Service (SS) #74 confirmed Resident #05 had not been seen by an optometrist since prior to admission on [DATE]. SS #74 stated the facility had been working to get another optometrist to the facility but had not been successful in arranging the service at the facility. SS #74 stated some residents had gone out to their private optometrist and the facility had assisted with arranging the appointments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, observations, staff interviews, and policy review, the facility failed to provide cares/services to prevent falls. The facility also failed to investigate and initiate interventions to prevent further falls. This affected one (#20) out of three residents reviewed for falls. The facility census was 33. Findings include: Review of the medical record for Resident #20 revealed an admission date of 04/19/25 with medical diagnoses of Parkinsonism, chronic obstructive pulmonary disease, schizophrenia, dementia, and depression. Review of the medical record for Resident #20 revealed a quarterly Minimum Data Set (MDS) assessment, dated 10/24/25, which indicated Resident #20 was cognitively intact and required supervision with eating, toilet hygiene, and transfers, and was independent with bed mobility and ambulation. Review of the MDS indicated Resident #20 did not have any recent falls. Review of the medical record for Resident #20 revealed an at risk for falls care plan indicated an intervention for staff to walk with resident when feeling weak, resident needs one staff assistance for transfers when feeling weak, and resident was encouraged to lower self to floor on knees to prevent falls. Review of the activities of daily living deficit care plan, stated Resident #20 had lack of coordination and unsteady on feet. Interventions included staff to assist resident with wheeled walker for mobility. Review of the medical record for Resident #20 revealed a nurse's note, dated 12/21/25 at 5:44 P.M. which stated resident was very weak today, dropping to his knees several times throughout the AM, this nurse gave resident wheelchair to use and found him several times without his wheelchair trying to use his walker again and going to his knees. The note stated the physician was notified. Review of the nurse's note dated 12/22/25 at 12:11 P.M, stated neurology group was notified that since Resident #20's Sinemet was decreased the resident had increased tremors, shakes and weakness and stated Resident #20 went down on his knees several times over the weekend. Lastly, review of the nurse's note, dated 12/30/25 at 8:43 A.M., stated visualized Resident #20 ambulating with his walker and went down onto one knee to prevent falls. The note stated the nurse encouraged Resident #20 to request assistance with ambulation due to increased weakness noted this morning. Observations on 12/30/25 at 8:25 A.M. revealed Resident #20 ambulating independently down the hall with his walker and was noted to have uncoordinated and unsteady gait. Continued observation revealed resident went down to his knees while his hands remained on the walker. Approximately 30 seconds later, Resident #20 was observed to stand back up and continued his uncoordinated gait down the hall. The observation revealed Resident #20 dropping to his knees and getting back up a total of five times. The observation revealed the Director of Nursing (DON) had observed Resident #20 ambulating and lowering self to the floor. Interview on 12/30/25 at 1:33 P.M. with Registered Nurse (RN) #71 stated Resident #20 had increased weakness since the neurologist discontinued his Sinemet but stated the medication was recently restarted. RN #71 confirmed Resident #20 would lower to his knees with ambulation at times and that it was not considered a fall. RN #71 stated Resident #20 was independent with ambulation and was care planned to lower self to floor. Interview on 12/31/25 at 1:00 P.M. with Administrator confirmed Resident #20's nursing notes on 12/21/25, 12/22/25, and 12/30/25 indicated Resident #20 had fallen to his knees several times due to weakness and the staff did not complete fall investigations or initiate interventions to prevent further falls. Administrator also confirmed Resident #20's care plan did not stated Resident #20 lowered himself to his knees as a behavior. Administrator also stated the incidents when Resident #20 dropped to his knees due to weakness, this should have been considered falls. Review of the facility policy titled, Fall Prevention Program, revised 10/01/25, stated each resident would be assessed for fall risk and would receive care/services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy stated a definition of a fall was an unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g. bed, chair, or bedside mat) or the result of an overwhelming external force (e.g. a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident pushes another resident). An intercepted fall occurs when the resident would have fallen if they had not caught themselves or had not been intercepted by another person, this is still considered a fall. The policy stated if there is a loss of balance during supervised therapeutic interventions and the resident comes to resident on the ground, floor, or next level surface despite the clinician's effort to intercept the loss of balance, it is considered a fall. The policy stated to provide interventions to address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent changes in functional status. Lastly, the policy stated any resident who experiences a fall, the facility would: 1) assess the resident, 2) complete a post- fall assessment, 3) complete an incident report, 4) notify physician and family, 5) review the resident's care plan and update as indicated, 5) document all assessments and actions, 6) obtain witness statements in the case of injury. This deficiency represents non-compliance investigated under Complaint Number 1334906 (OH00166383).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, staff interview, and policy review, the facility failed to ensure a medication as administered as ordered. This affected one (#05) resident out of five residents reviewed for medication administration. The facility census was 33.Findings include: Review of the medical record for Resident #05 revealed an admission date of 04/02/24 with medical diagnoses of schizoaffective disorder, suicidal ideations, hypertension, diabetes mellitus, depression, post-traumatic stress disorder, and anxiety. Review of the medical record for Resident #05 revealed a quarterly Minimum Data Set (MDS) assessment, dated 10/01/25, which indicated Resident #05 was cognitively intact, required supervision with bathing and was independent with bed mobility and transfers, and required set-up with eating and toileting. Review of the medical record for Resident #05 revealed a physician order dated 09/20/25 for losartan potassium 50 milligram one tablet by mouth daily, hold if systolic blood pressure <100. Review of the medical record for Resident #05 revealed the December 2025 Mediation Administration Record (MAR) indicated Resident #05 received losartan potassium on 12/07/25 with blood pressure of 98/62, on 12/20/25 with a blood pressure of 94/54 and on 12/21/25 with blood pressure of 99/66. Interview on 12/31/25 at 10:21 A.M. with Administrator confirmed Resident #05 was administered losartan potassium on 12/07/25, 12/20/25, and 12/21/25 and that the medication should have been held due to Resident #05's blood pressure was outside of the parameters ordered. Review of the facility policy titled, Medication Administration, revised 10/01/25, stated medications are to be administered by licensed nurses, or other staff who are legally authorized to so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination of infection. The policy stated to obtain and record vital signs, when applicable per physician orders, when applicable, hold medication for those vital signs outside the physician's prescribed parameters.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure laboratory work was completed as per physician orders. This affected one (#04) resident out of the five residents reviewed for unnecessary medications. The facility census was 33. Findings include:Review of the medical record for Resident #04 revealed an admission date of 06/29/22 with medical diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, Ogilvie syndrome, diabetes mellitus, depression, hyperlipidemia, and atrial fibrillation. Review of the medical record for Resident #04 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #04 was cognitively intact and was dependent upon staff for toilet hygiene, showering, transfers, and required substantial/maximum assistance with bed mobility. Review of the medical record for Resident #04 revealed a physician order dated 08/24/22 for the following laboratory values to be completed every June: thyroid-stimulating hormone (TSH), thyroxine (T4), triiodothyronine (T3), free T4 (FT4), lipid panel, complete blood count (CBC), comprehensive metabolic panel (CMP), hemoglobin blood (A1C) test, magnesium levels, B12 level, and Vitamin D level. Review of the medical record revealed no documentation to support the laboratory values had been completed in 2025. Interview on 12/30/25 at 3:37 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #04 did not contain any documentation to support the laboratory values ordered to be completed every June had been completed in 2025.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interviews, the facility failed to complete performance reviews for Certified Nurse Aides (CNA) as required. This affected two (#13, and #18) of three CNA reviewed and had the potential to affect all 33 residents residing in the facility. The census was 33. Findings Include: Review of CNA #13's personnel file revealed a hire date of 04/25/23. Further review revealed no documentation of an annual performance review being completed in 2025. Review of CNA #18's personnel file revealed a hire date of 04/25/23. Further review revealed no documentation of an annual performance review being completed in 2025. Interview with Business Office Manager (BOM) #11 on 12/31/25 at 12:11 P.M. confirmed there were no annual evaluations for CNA #13 and CNA #18.