

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Alden Debes Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  550 South Mulford 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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175</b></p> <p>Based on observation, interview and record review, the facility to ensure a resident's right to be free from neglect for 1 of 3 residents (R1) reviewed for neglect in the sample of 5. This failure resulted in R1 lying in urine for hours causing embarrassment and emotional distress.</p> <p>The findings include:</p> <p>R1's face sheet showed an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of acute cystitis with hematuria, syncope and collapse, acute kidney failure, obstructive sleep apnea, hypertension, history of falling, adult failure to thrive, and urinary tract infection.</p> <p>On 4/18/24 at 10:41 AM, R1 was in her room. R1 became tearful and her crying increased as she spoke about the incident night of 4/9/24. R1 said I done forgot about that girl. She didn't want to help me go to the bathroom. I put the call light on waited hours and started calling out nurse, nurse. She had a nasty remark. She didn't want to be bothered with me. I wet myself. I feel like she was abusive to me. You got to have a decent attitude. I don't think she is qualified to take care of people. Some people got jobs they ain't cut out for, but they think they are. I prayed and hoped I made it through the night. I felt afraid to ask for help. She was the one waiting on me. You don't want to call that person to come back in. I hate to say it but that's the way I feel. I was embarrassed that I had to wet myself.</p> <p>On 4/18/24 at 9:41 AM, V7 (Registered Nurse/RN) said R1 alert and oriented x 3. If I was told a resident had not been changed all night and was upset, I would report it to management. If it's true, then someone did not perform their duties. I would call it neglectful if it's true.</p> <p>On 4/18/24 at 9:48 AM, V8 (Certified Nursing Assistant/CNA) said the morning of 4/10/24, R1 told her nobody changed her all night. I got her up and cleaned up, washed her good. R1's bed was wet all the way to the mattress. I reported it to V1 (Administrator) as soon as I cleaned her up. It felt like that was neglect on the patient. We give report that she gets up to the bathroom. Normally she gets up to the bathroom and doesn't wet herself. She is very aware of her surroundings. She was very upset and embarrassed. Honestly, as wet as she was, I don't think she was changed or toileted at all. I know she is continent, and she lets you know when she needs to use the bathroom. She'll put her call light on. If you leave them in their urine too long their skin can start breaking down and leave bedsores.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 2:24 PM, V11 (R1's daughter) said she arrived at the facility around 10:00 AM on 4/10/24. R1 told her that during the night she put her call light on to tell staff she needed to go to the bathroom. R1 said a staff person answered the call light and told her to go (urinate) in her undergarment and moved the call light away from her. She (R1) was angry and embarrassed. V1 (Administrator) was in a meeting, and I had to get back to work so I left a note on V4 (Admissions Director's) desk at 11:10 that morning that I wanted to speak to him about the situation. I also told the nurse on duty about it. This incident has changed her mood. I would not say it was abuse. I would say it was neglect. They neglected to attend to her care needs.</p> <p>On 4/18/24 at 3:08 PM, V8 said when she went in R1's room on 4/10/24, the call light was out of R1's reach.</p> <p>R1's 4/5/24 transfer evaluation showed she required 2 persons to transfer. R1's 4/5/24 care plan showed she was admitted to the facility for a skilled stay requiring physician ordered, medically necessary services including skilled nursing care, management and evaluation of the care plan, observation, and assessment of the patient's condition and/or teaching and training activities related to the reason for the stay or in preparation to transition to a lesser care environment. R1's care plan showed the intended discharge location was home and R1 was unable to turn side to side independently.</p> <p>R1's 4/12/24 facility assessment showed cognitively intact, required partial/moderate assistance to toilet and was occasionally incontinent of bladder and bowel.</p> <p>R1's 4/9/24 antibiotic therapy note showed she was on an antibiotic for a urinary tract infection.</p> <p>The facility's 2/2017 Abuse Policy showed the facility affirms the right of our residents to be free from abuse, neglect. Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or in the deterioration of a resident's physical or mental condition.</p> <p>The facility's reported incident showed V6 (an unnamed Certified Nursing Assistant/CNA) was investigated for resident neglect as R1 was dissatisfied with care. An interview with a CNA Supervisor showed V6 was not always the most pleasant. An interview with V10 (R1's daughter) was actually done with V11 (R1's other daughter and power of attorney). The investigation showed V11 said R1 was changed during the night (contrary to surveyor interview). An interview with V8 (CNA) showed R1 told her she had been soiled a long time when she was found soiled the morning of 4/10/24. This interview showed R1 was saturated in urine and all linens had to be changed. An interview with R1 showed V6 told R1 to go (urinate) in her brief and she was left in her urine for hours. R1 also said the call light was not within reach. This report showed V6 was let go due to poor performance.</p>		