STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145142	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Debes Rehab & Hcc	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure the facility was free from abuse to 2 of 3 residents (R2, R1) reviewed for sexual abuse in the sample of 3.Findings include:R2's electronic Face sheet show R2 has diagnoses that include Dementia Alzheimer's disease, metabolic encephalopathy.R1's electronic Face sheet show R1 is a hospice resident with diagnoses that include dementia, atrial fibrillation and atherosclerotic heart disease. The facility Reported Incident dated 11/30/25 with final report dated 12/5/25 documents, R2 and R1 were in the activity, we confirm R2 made physical contact with R1. R2 was observed touching R1 around her diaper area. R2 and R1 were separated. R2 and R1 both have dementia. R2's BIMS score-4 (severely impaired). R1's BIMS score-0 (severely impaired) The residents were interviewed about the interaction with neither being able to provide any details about the occurrence. R2 is placed on one-on-one until further notice, placement to memory care unit has been discussed, option for more appropriate placement. R1 with no signs of injury, R1 remains in stable condition. R1's POA does not want to file a police report.On 12/11/25 at 8:15 AM, R2 was in bed alert, R2 said he was fine and had not bothered anyone. V4 (Certified Nursing Assistant-CNA) said V4 was the CNA assigned to provide 1:1 to R2. V4 said R2 touched another resident.On 12/11/25 at 8:30 AM, R1 was sitting in her wheelchair in activity room, asked how she was doing R1 was not able to respond verbally, R1 was just looking around.On 12/11/25 at 9:30 AM, R3 BIMS of 15 (no cognitive impairment) said she witnessed R2 touching R1. R3 said she was sitting in her wheelchair in the activity room with R1. R3 said she noticed R2 was messing with R1, R2 had his hand inside R1 pants. R3 said hey stop to R2, then I called for the staff who came and kept R2 away from R1.On 12/11/25 at 9:47 AM, V7 said she was the Activity Aide working when the incident happened with R2 and R1. V7 said she was bringing residents to the Activity room when R3 asked me to come over. R3 pointed to R2 who was sitting by R1. R2 had his right hand inside R1 pants in the waist area/ abdominal area. V7 stated It appeared that he (R2) was working his way towards (R1's) private areas when I intervened. V7 said he told R2 to stop you know better than that! R2 looked up to me then R2 immediately pulled his hands out from R1's pants. R2 and R1 were separated. V7 said she informed the Nurse.On 12/11/25 at 12;04 PM, V8 (License Practical Nurse) said she was R1's nurse on 11/30/25. V8 said she was handed a blank body assessment form by V9 (admission Staff) who said, I need you to do a thorough assessment on R1, focus on the private area because another resident had his hand in her pants. On 12/11/25 at 12:11 PM, V9 (admission Director) said she was the MOD (manager on duty) last 11/30/25. V9 said she was informed there was an abuse allegation-one male resident touched a female resident. V9 said this was immediately reported to the Administrator (V1) who was the Abuse Coordinator) V9 said V1 gave instructions to do an assessment to R1. R2 was put on 1:1. On 12/11/25 at 10:43 AM, V3 (Nurse Practitioner) said on 12/1/25 the day after the incident, V1 (Administrator) asked for her to do a follow up assessment on R1. R1 had an incident with another resident whose hand was in (R1's) diaper area. Body Assessment was done, within normal limits. R1 has Alzheimer's dementia and cannot recall what happened. R1's latest care plan (undated) documents R1 is at risk for abuse related to dementia with intervention of R1 will remain safe, calm and free from abuse. On 12/11/25 at 1:50 PM, V1 (Administrator) said the incident between R2 touching R1 was reported to the state agency which was the right thing to do. R1 continues be monitored. R2 was still on 1:1.The facility policy entitled Abuse dated 3/25 documents, the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of residence property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of a crime, this facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and residence secure environment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Sexual abuse is a nonconsensual sexual contact of any type with a resident this includes but not limited to sexual harassment sexual coercion or sexual assault.