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

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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	01/15/2026

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review the facility failed to ensure a physician or nurse practitioner were notified promptly of radiology results. This applies to 1 of 8 residents (R1) reviewed for mechanical lift transfers in the sample of 8. The findings include: R1's Radiology Results Report shows that R1's x-ray was performed on 1/5/26 at 6:37 PM. This report also shows the results were reported to the facility on 1/6/26 at 1:43 AM and that V11 (Nurse Practitioner) reviewed the results on 1/6/26 at 4:59 PM. Facility nursing schedule for 1/5/26 and 1/6/26 shows that V4 (RN) and V12 (LPN) were the two nurses to work on R1's hall when the x-rays were ordered and the results received by the facility. On 1/15/26 at 9:46 AM, V12 said V12 checked R1's electronic medical records for any updated x-ray results around 3:30 AM on 1/6/26, but all V12 could see was the results were pending. V12 said nurses are instructed to check for any results at the end of each shift or close to the end of each shift. V12 did not check again for updated x-ray results the rest of V12's shift. V12 said if V12 saw the results came in, V12 would reach out to V11 either by phone call or by sending V11 a text message. V12 said when you get the results, V11 should be notified immediately. On 1/15/26 at 1:45 PM, V4 said V4 could not recall when V4 and V11 spoke about R1's x-ray results, but believed it was in the evening on 1/6/26. V4 said it should be in a progress note. R1's Nurses Note dated 1/6/26 at 5:30 PM, written by V4, states the results were relayed to V11. V11 ordered to send R1 to the local hospital for further evaluation and treatment. On 1/15/26 at 9:00 AM, V11 said no facility staff notified V11 that R1's x-ray results were uploaded to R1's electronic medical records prior to V11 reviewing them at 4:59 PM. V11 said if staff told V11 about receiving R1's x-ray results sooner, V11 would have sent R1 to the local hospital earlier in the day.On 1/15/26 at 10:00 AM, V2 (Director of Nursing) said it is the expectation of the facility that nurses should check for x-ray results at the beginning and end of their shifts. If and when staff see the results, it is the expectation that staff notify V11 so V11 can review the x-ray results and to ensure V11 gets the results. V2 said staff can call or text V11 or when V11 is in the facility, staff can tell V11 in person.

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