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	02/05/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received assistance with showers. This applies to 1 of 3 (R2) residents reviewed for activities of daily living in the sample of 4. The findings include: On 2/4/26 at 12:05 PM, R2 was in her room sitting in a chair. There was no contact isolation sign posted outside of her room. R2's hair covering was in place, and she did not have a shower stall in her bathroom. R2 said when she was admitted on [DATE], she was on isolation for a blood infection. She was asking staff if she could shower, staff told her she could not leave the room because she was in isolation. R2 said yesterday 2/3/26, she got off isolation and finally got a shower (11 days later). R2 said she smelled bad and that was the worst not being able to shower that long.On 2/5/26 at 9:08 AM, V11 (Certified Nursing Assistant-CNA) said residents should receive showers twice a week. If a resident is in contact isolation, they can leave their room to shower. On 2/5/26 at 11:24 AM, V9 (CNA) said R2 was in isolation for a while she did not assist R2 with showering and certain residents could leave their room to shower. On 2/5/26 at 11:48 AM, V7 (RN) confirmed R2's contact isolation was discontinued on 2/3/26 and she received a shower. R2 mentioned she had not received a shower prior. R2's current care plan shows she has a deficit (ADL) performance deficit with interventions including assisting with setting up supplies for bathing, assist with personal hygiene, assist with ADL tasks. R2's care plan shows she was on contact isolation precautions. R2's Bath/Shower Report provided on 2/5/26 shows she did not receive showers twice a week. The facilities Bath/Tub or Shower policy dated 7/25 states, To provide cleanliness and comfort to the resident, to assist in bathing . to prevent body odors.

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

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	02/05/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure safety interventions were in place for a resident at risk for falls. This applies to 1 of 3 (R2) reviewed for safety in the sample of 4. The findings include: R1's face sheet shows she has diagnoses including osteomyelitis, palliative care, type 2 diabetes, heart disease, chronic kidney disease stage 3, hypertension, mild cognitive impairment, and lymphedema. R1's Fall Incident Report dated 2/1/26 documents (R1) observed on the floor on the right side of her bed lying on he left side. CNA at bedside stated she got weak and let go. Right side of forehead lump with swelling, right eye bruising, chin abrasion, right elbow small cut, right ring finger bruise and small cut and left knee bruising. R1's current care plan shows she is at risk for falls, self care deficit performance, requires assistance from staff with bed mobility, interventions include use side rail support, cue resident to grasp side rail for positioning.On 2/4/26 at 12:58 PM, R1 was lying in large bariatric bed, her eyes closed and did not respond to her name after several attempts. A large dark purple/greenish bruise was to the right side of her eye/forehead area and a small laceration to her chin. R1's bedside table was located to the right side of her bed and thick bilateral floor mats on the floor. On 2/4/26 at 1:02 PM, V14 (Certified Nursing Assistant-CNA) said R1 fell from her bed during care. R1 was a one person assist with bed mobility now she is a two person assist. She did not have side rails in place prior to the fall, she can hold on to the side rails for bed mobility and should have both floor mats on the floor. On 2/4/26 at 1:12 PM, V5 (Licensed Practical Nurse-LPN) said she was R1's nurse when she fell on 2/1/26. V10 (CNA) reported R1 fell when she was changing her in the bed. R1 fell towards the right side of her bed where the bedside table was located. I'm guessing she hit her head on the bedside table. The floor mats were not on the floor when she entered the room. R1 sustained a right black eye, scrap to her chin, and bruising to her left knee. V5 said she notified, the physician, hospice and left a message for R1's guardian. R1 did not have side rails in place prior to the fall, they just put them up after the fall. R1 can hold on to the side rails with bed mobility. On 2/5/26 at 8:53 AM, V10 (CNA) said on 2/1/26, she was providing incontinence care to R1. She rolled R1 to her side and she was holding on the bedside table because she did not have side rails in place. V5 said one hand was on R1's body and with the other hand she leaned back trying to get the towel and she left go of the bedside table and rolled off the bed. R1 usually is able to hold on the bedside table but she said she got weak and let go. V10 said she put the floor mats up during cares and R1 needs something to hold for bed mobility.R1's Restorative Nursing assessment dated [DATE] shows R1 is on a bed mobility program. R1 will role side to side during care and repositioning, using side rails as needed . the use of side rails is indicated and serves as an enabler to promote independence. On 2/5/26 at 9:58 AM, V6 (Restorative Nurse) said confirmed R1 is on a bed mobility program and should have side rails for bed mobility. V6 said if side rails are indicated for bed mobility he would in the request order for the side rails. I don't know why side R1 did not have the side rails on. He is not sure who is responsible for making sure side rails are in place. R1's strength levels vary day to day, if she is weak she should have something to hold onto. V6 said it's okay for residents to hold on to the equipment including bed side table, windowsill for extra piece of mind. The facility's Management of Falls Policy states, The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate interventions and revise the resident's plan in order to minimize the risks for fall incidents and/or injuries to the resident.