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	04/08/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review the facility failed to provide sufficient staff to meet the needs of the residents for 20 of 23 residents (R1-R20) reviewed for staffing in the sample of 23. This failure resulted in R1-R20 not receiving their scheduled evening medications on 3/28/26 due to a lack of a licensed nurse to administer the medications.The findings include:1.R1's March 2026 Medication Administration Record (MAR) showed R1 did not receive her prescribed medication doses of Lantus insulin, Melatonin, and Pregabalin on 3/28/26 at 8:00 PM. On 4/8/26 at 8:30 AM, R1 stated, One evening a couple of weeks ago, I didn't get my meds. Our nurse never showed up.2. R2's March 2026 MAR showed R2 did not receive her prescribed doses of Melatonin and Trazadone on 3/28/26 at 8:00 PM.On 4/8/26 at 8:30 AM, R2 stated she did not receive her evening medications on 3/28/26 because her nurse did not show up for her shift.3. R3's March 2026 MAR showed R3 did not receive her prescribed doses of Nabumetone, Entresto, Trazadone, and Atorvastatin on 3/28/26 at 8:00 PM. On 4/8/26 at 8:15 AM, R3 stated on 3/28/26, I never got my evening meds that night. We didn't have a nurse.4. R4's March 2026 MAR showed R4 did not receive her prescribed doses of Vimpat, Metorprolol Tartrate, Mirtazapine, Trazadone, and Latanoprost eye drops on 3/28/26 at 8:00 PM.On 4/8/26 at 8:20 AM, R4 stated, on 3/28/26, I didn't get my evening meds at all that night.A facility list dated 3/28/26 showed R5-R20 also did not receive their 8:00 PM medications on 3/28/26.On 4/8/26 at 11:20 AM, V2 Director of Nursing stated R1-R20 did not receive their 8:00 PM medications on 3/28/26 because the nurse assigned to their wing from 6 PM-10PM never showed up. The nurse was supposed to be here at 6 PM so I called the nursing agency to find out where the nurse was. The agency told me the nurse was running late but would be at the facility in 12 minutes. She never showed up. Someone from the facility should have notified me immediately. V2 stated she was not notified that the agency nurse did not show up for her shift until 3/29/26. V2 stated each resident in the facility must be assigned to a nurse 24 hours a day, 7 days a week to provide skilled nursing to these residents.On 4/8/26 at 1:30 PM, V1 Administrator stated R1-R20 did not receive their medications on 3/28/26 because the nurse assigned their wing did not show up. V1 stated she was not notified of the incident until 3/29/26. On 4/8/26 at 3:05 PM, V12 Certified Nursing Assistant (CNA) stated she was assigned to R1-R20's wing on 3/28/26. V12 stated, Someone told me around 6 PM that evening that the nurse assigned to my wing was running late. I got busy providing cares to residents. Around 7:30 PM, some of the residents started asking where the nurse was. I just assumed the nurse was still running late. By 9:30 PM, no nurse had shown up. When V12 was asked who she notified, on 3/28/26, that no nurse had shown up to provide cares to these residents, V12 stated, No one. I didn't know who to call. On 4/8/26 at 3:15 PM, V13 CNA stated she was assigned to R1-R20's wing on 3/28/26. V13 stated she did not notice until around 8:00 PM on 3/28/26 that her wing did not have a nurse. V13 stated she did not notify any facility staff or administration that her wing did not have a nurse on 3/28/26 because I just figured everyone else knew about it.On 4/8/26 at 10:55 AM, V10 Licensed Practical Nurse stated on 3/28/26 from 6 PM-10 PM, he was assigned to a different wing in the facility. V10 stated, I didn't know the nurse didn't show up to work (R1-R20's wing) until 10 PM that night. No one reported to me that no nurse was covering that unit. I don't know what happened but when I walked over to (R1-R20's (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wing) at 10 PM that night, the med cart for that wing had not been touched and was in the same place I saw it at 6 PM. V10 stated he did not notify any facility staff or administration that R1-R20's wing did not have a nurse on 3/28/26.On 4/8/26 at 10:40 AM, V8 Nurse Practitioner stated the expectation is that each resident is under the care of a nurse 24/7 while residing in the facility and resident medications are administered as ordered.The Facility Assessment Tool dated 4/8/26 showed the facility is to provide skilled nursing care to each resident which includes the provision of care and the administration of medications by a licensed nurse, 24 hours a day, 7 days a week.

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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 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 20 of 23 residents (R1-R20) reviewed for medication errors in the sample of 23. This failure resulted in R1 and R2 experiencing insomnia. This failure resulted in R1 experiencing increased pain and discomfort.The findings include:1.R1's current care plan showed R1 received medications for treatment of insomnia, Type 2 Diabetes, neuropathy (nerve pain), and restless leg syndrome. The plan showed facility nursing staff were to administer medications as ordered for treatment of these conditions. The care plan showed R1 was cognitively intact.R1's March 2026 Medication Administration Record (MAR) showed the following physician orders for R1:Lantus Insulin 100 units/milliliters (ml), inject 25 units subcutaneously (SQ) daily at 8:00 PM for treatment of Type 2 Diabetes.Melatonin 3 mg (milligrams), give one tablet daily at 8:00 PM for insomnia.Pregabalin 100 mg, give one tablet daily at 8:00 PM for pain management.R1's MAR showed R1 did not receive these medications on 3/28/26.On 4/8/26 at 8:30 AM, R1 stated, One evening a couple of weeks ago, I didn't get my meds. Our nurse never showed up. I didn't get my insulin. My blood sugar was a little higher the next morning but not awful. It was hard to sleep because I get meds for pain and sleep. In fact, that was one of the nights I didn't sleep at all. I couldn't get comfortable. I had pain in my legs from my neuropathy. 2.R2's current care plan showed R2 received medications for treatment of depression and insomnia. The plan showed facility nursing staff were to administer medications as ordered for treatment of these conditions. R2's March 2026 MAR showed the following physician orders for R2:Trazadone 50 mg, give one tablet daily at 8:00 PM for depression.Melatonin 3 mg, give two tablets daily at 8:00 PM for depression and insomnia.R2's MAR showed R2 did not receive these medications on 3/28/26.On 4/8/26 at 8:30 AM, R2 stated she did not receive her evening medications on 3/28/26 because her nurse did not show up for her shift. R2 stated, I didn't sleep well that night. I kept waking up. I was tired the next day.3.R3's current care plan showed R3 received medications for treatment of hyperlipidemia, insomnia, and pain. The plan showed facility nursing staff were to administer medications as ordered for treatment of these conditions. R3 was cognitively intact.R3's March 2026 MAR showed the following physician orders for R3:Nabumetone 750 mg, give one tablet twice a day, at 8 AM and 8 PM, for joint pain.Entresto 24-26 mg, give one tablet twice a day, at 8 AM and 8 PM, for hyperlipidemia.Trazadone 50 mg, give one tablet daily at 8:00 PM for sleep disturbances.Atorvastatin 20 mg, give one tablet daily at 8:00 PM for hyperlipidemia.R3's MAR showed R3 did not receive her 8:00 PM medications on 3/28/26.On 4/8/26 at 8:15 AM, R3 stated on 3/28/26, I never got my evening meds that night. We didn't have a nurse. My pain wasn't too awful that night.4.R4's current care plan showed R4 had diagnoses including epilepsy, hypertension, depression, and glaucoma. R4's March 2026 MAR showed the following physician orders for R4:Vimpat 100 mg, give one table twice a day, at 8 AM and 8 PM, for treatment of epilepsy.Metoprolol Tartrate 25 mg, give one table twice a day, at 8 AM and 8 PM, for hypertension.Mirtazapine 7.5 mg, give one tablet daily at 8:00 PM for depression.Trazadone 50 mg, give 1/2 tablet daily at 8:00 PM for depression.Latanoprost eye drops 0.0005%, install one drop to both eyes daily at 8:00 PM for glaucoma.R4's MAR showed R4 did not receive her 8:00 PM medications on 3/28/26.On 4/8/26 at 8:20 AM, R4 stated, on 3/28/26, I didn't get my evening meds at all that night.A facility list dated 3/28/26 showed R5-R20 also did not receive their 8:00 PM medications on 3/28/26.On 4/8/26 at 11:20 AM, V2 Director of Nursing stated R1-R20 did not receive their 8:00 PM medications on 3/28/26 because the nurse assigned to their wing from 6 PM-10PM never showed up. V2 stated she was not notified that the nurse did not show up for her shift until 3/29/26. V2 stated each resident in the facility must be assigned to a nurse 24 hours a day, 7 days a week to provide skilled nursing to these residents.On 4/8/26 at 1:30 PM, V1 Administrator stated R1-R20 did not receive their medications on 3/28/26 because the nurse assigned their wing did not show up. V1 stated she was not notified of the incident until 3/29/26. On 4/8/26 at 10:40 AM, V8 Nurse Practitioner stated the expectation is that each resident is under the care of a nurse 24/7 while (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	residing in the facility and resident medications are administered as ordered. V8 stated if residents do not receive pain medications and medications for sleep as ordered, it could potentially cause increased pain and insomnia for residents. V8 stated, (R4) takes Vimpat for seizures so missing a dose could potentially put her at increased risk for seizures.The facility's Medication Pass Guidelines policy dated January 2025 showed resident medications are to be administered at the correct time, as prescribed by physician order, by a licensed nurse. The Facility Assessment Tool dated 4/8/26 showed the facility is to provide skilled nursing care to each resident which includes the provision of care and the administration of medications by a licensed nurse, 24 hours a day, 7 days a week.