

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

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No. 0938-0391

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 07/31/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure medications were administered timely as ordered and scheduled for 4 of 5 residents (R58, R111, R184, R73) reviewed for medication administration in the sample of 63. Findings include: On 7/30/25 at 9:11 AM, the surveyor approached V11 (Agency RN (Registered nurse)) to observe medication administration. V11's medication cart was parked in the middle of the hall. R182 was seated in her wheelchair next to the medication cart and R58 was standing behind R182. V11 said she was preparing medications for R182. The surveyor waited while V11 administered the prepared medications to R182. R58 told V11 that he needed something for his stomach. V11 opened her computer to the Medication Administration Screen and numerous residents showed up in red. V11 stated, I know there's a lot of red on the screen. That's because they're considered late. R58 was red on the computer screen. V11 stated, I need to give you your morning medications and I'll see what you have for your stomach. While V11 prepared R58's medications he said he had to go, and walked away. V11 did not have R1's Isosorbide 60 mg (milligrams) (blood pressure medication). V11 said it had been ordered yesterday, so she would need to check with a supervisor to see if it was available in the automated medication dispensing system. V11 prepared Amlodipine 10 mg (for blood pressure), Aripiprazole 20 mg (antipsychotic medication), Aspirin 81 mg, Benztropine (anticholinergic) 1 mg, Losartan 100 mg (for blood pressure), Omeprazole 20 mg (for acid reflux), Venlafaxine 150 mg (antipsychotic), Venlafaxine 37.5 mg, and Colace 100 mg (stool softener). V11 collected R58's two inhalers from the medication cart and the prepared medications and went to R58's room at 9:20 AM. V11 said he's not in here and walked to the other end of the hall to look for R58. At 9:24 AM, V11 returned to R58's room and found him in the bathroom. At 9:27 AM, R58 exited the bathroom and requested applesauce to take his oral medications and said he didn't want to take his inhalers at this time. V11 obtained applesauce and administered R58's oral medications. At 9:30 AM, V11 and the surveyor returned to the medication cart. The surveyor asked V11 if she still had morning medications to pass and she said she still had several residents to finish medication pass on. V11 said she doesn't pick up too many shifts at the facility because the morning medication pass is usually like this (late). 2. R58's Facesheet dated 7/30/25 showed he had diagnoses to include, but not limited to: COPD (Chronic Obstructive Pulmonary Disease), vascular dementia, schizoaffective disorder (bipolar type), hypertension, diabetes, and generalized anxiety disorder. R58's Medication Administration Audit Report dated 7/31/25 showed R58's nine (0800) oral medications were administered late at 9:30 AM. R58's Progress Notes were reviewed for July 2025. There were no notes regarding notification of R58's Provider that medications were administered late or not available for administration. On 7/30/25 during the Resident Council Meeting, residents said the medication pass is late on the hall when agency staff are working. They said the regular staff will usually get their 8 AM medications to them by 8:30 AM, but if it's agency it could be 10:30 AM or later. On the afternoon of 7/30/25, R184 was lying in bed, reading a book. The surveyor asked her if her morning medications are given on time. R184 replied, I consider it (0800 meds) on time if I get them by 10:30 AM. R184 smiled and said R184 said if agency is working that's the way it is. If the regular staff are working, the medications are always on time. R184's Medication Administration Audit Report dated (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/31/25 showed R184's 8 AM scheduled medications were administered from 9:53 AM - 9:57 AM. R184's Progress Notes were reviewed for July 2025. There were no notes regarding notification of R184's Provider that medications were administered late. R73's Medication Administration Audit Report dated 7/31/25 showed 8 AM scheduled medications were administered between 9:05 - 9:14 AM on 7/30/25. R73's Progress Notes were reviewed for July 2025. There were no notes regarding notification of R73's Provider that medications were administered late. R111's Medication Administration Audit Report dated 7/31/25 showed 8 AM scheduled medications were administered between 10:13 - 10:14 AM on 7/30/25. R111's Progress Notes were reviewed for July 2025. There were no notes regarding notification of R111's Provider that medications were administered late. On 7/31/25 at 7:57 AM, V4 (DON) said the nurses should follow the 5 rights of medication administration. V4 said the 5 rights include the right time. V4 said the nurses have one hour before and one hour after the scheduled medication time to administer the medications. V4 said 0800 medications would be considered late if they were given after 9 AM. V4 said if medications are given outside the medication administration window then the Provider should be notified and a progress note should be entered. The facility's Medication Administration Policy dated 09/2020 showed, Medications will be administered in accordance with the established policies and procedures. Procedures: 1. Drugs must be administered in accordance with the written orders of the attending physician.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent potential cross-contamination by failing to don the proper personal protective equipment (PPE) while providing high-contact resident care for residents requiring enhanced barrier precautions (EBP) and failing to remove gloves and perform hand hygiene after providing incontinence care. These failures affect 3 of 5 residents (R77, R160, R99) reviewed for infection control in the sample of 63. Findings include: 1. R77's admission Record, provided by the facility on 7/31/2025, showed diagnoses including, Hypertensive stage 5 Chronic Kidney Disease, or end-stage renal disease, dependence on renal dialysis, acute angle-closure glaucoma, type II diabetes mellitus, and heart failure. R77's care plans, provided by the facility on 7/31/2025, show R77 requires assistance from staff for transfers, experiences bladder and bowel incontinence, and requires enhanced barrier precautions (EBP) related to use and care of indwelling dialysis device. R77's care plan initiated on 5/9/2024, showed R1 has an ADL (activities of daily living) functional performance deficit and staff should assist with transfers and toileting needs as necessary. On 7/29/2025 at 10:43 AM, V16 (Certified Nursing Assistant-CNA) entered R77's room, applied hand sanitizer to her hands and donned gloves. V16 told R77 she was going to get him up to take him to the bathroom. The signage by R77's door showed he was on enhanced barrier precautions. V16 put R77's shoes on, placed a gait belt around R77, and transferred him from his recliner to his wheelchair. V16 propelled R77 into the bathroom and transferred him from his wheelchair to the toilet. V16 removed R77's soiled brief, then removed her gloves and washed her hands. V16 verified that there was urine in R77's brief. V16 put on clean gloves then put a clean brief on R77. When R77 was done, V16 pulled his brief up, then his pants and transferred him back to his wheelchair. V16 did not clean R77 after removing the urine soiled brief or prior to placing a new brief on R77. V16 did not wear a gown while providing high-contact direct care for R77. The signage on R77's door showed staff should wear a gown and glove when providing high-contact care to a resident on EBP. On 7/30/2025 at 9:19 AM, R77 said the CNA did not wash him yesterday when this surveyor watched care. R77 stated, Sometimes they do and sometimes they don't. He said his brief was wet due to incontinence. R77 said the CNA should have probably washed him up, so he did not get a rash. On 7/30/2025 at 9:35 AM, V17 (Registered Nurse/agency) said R77 is on EBP due to having dialysis. Staff should be wearing a gown and gloves when providing any direct-care activities listed on the signage by his door. On 7/30/2025 at 9:52 AM, V18 (LPN/Infection Preventionist) said R77 is on EBP because he receives dialysis. If a resident is on enhanced barrier precautions, staff need to wear a gown and gloves if touching the resident, transferring, toileting, emptying a resident's catheter, or doing anything with the catheter. 2. R160's admission Record, provided by the facility on 7/31/2025, showed he had diagnoses including, but not limited to, retention of urine, encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, local infection of the skin and subcutaneous tissue, and need for assistance with personal care. R160's Order Summary Report, printed by the facility on 7/31/2025, showed an order for an indwelling urinary catheter. The report showed an order dated 6/26/2025 for a wound vac to left stump at 125 mmHg (millimeters of mercury) continuous (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	suction. Cut black sponge to fit the size of the wound and cover with draping. Change three times a week. Wash left stump with soap and water during dressing change. The Order Summary Report also shows active orders for EBP for a chronic wound and EBP for use of device care or use of urinary catheter. R160's care plan initiated 7/19/2025 showed he has an increased risk of infection due to chronic care and use of indwelling urinary catheter and management of chronic wound. The care plan showed R160 requires use of enhanced barrier precautions. The care plan showed enhanced barrier precautions will be implemented during high-contact resident care activities. On 7/29/2025 at 10:09 AM, the sign by R160's door showed he was on enhanced barrier precautions. R160 said the nurses do dressing changes to the surgical site for his left above the knee amputation. At 10:33 AM, V14 (CNA unit manager) and V15 (CNA) went to empty R160's catheter urinary drainage bag. V14 held the urinal. V15 emptied the urine from the drainage bag into the urinal. Neither V14, nor V15 put a gown on to empty R160's urinary drainage bag. On 7/31/2025 at 11:50 AM, V4 (Director of Nursing) said enhanced barrier precautions are put in place if a resident has an infection or has anything inserted into the body that is a route to inside the body, such as a port for dialysis. V4 said when a resident is on EBP precautions, staff should wear a gown and gloves whenever providing direct patient care, such as bathing, toileting, emptying a catheter, etc., V4 said when toileting a resident, staff should ask the resident first if they (the CNA) can clean them up, to maintain the resident's dignity. If the resident allows, the CNA should clean the resident up. If the resident does not allow, and is able to do it, the CNA should give the resident the supplies to clean themselves and make sure the resident does not need assistance. V4 said she would expect staff to wear the appropriate PPE that is listed on the signage outside the resident's door. The facility's Enhanced Barrier Precaution signage outside R77 and R160's rooms showed Stop. Enhanced Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care: Any skin opening requiring a dressing. The facility's 12/2024 policy and procedure titled Enhanced Barrier Precautions showed Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. As well as to prevent multidrug resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. EBP involves gown and glove use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. The policy lists high-contact resident care activities include the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care. 3. R99's electronic face sheet printed on 7/31/25 showed R99 has diagnoses including but not limited to heart failure, chronic kidney disease, dementia without behaviors, and history of falls. R99's facility assessment dated [DATE] showed R99 has moderate cognitive impairment and is incontinent of bowel and bladder. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R99's undated care plan showed, (R99) experiences bladder incontinence. On 7/29/25 at 10:08AM, V25 (Certified Nursing Assistant) provided incontinence care for R99. V25 applied clean gloves, removed R99's soiled incontinence brief, provided incontinence care, applied a clean incontinence brief, and dressed R99 in clean clothes without changing her gloves. V25 then removed her gloves, picked up all R99's soiled linens with no gloves on, and carried the linens out into the hallway. V25 came back into the room and applied clean gloves without performing hand hygiene. V25 stated she knew she didn't do what she was supposed to do but it was too late to fix it. On 7/31/25 at 12:45PM, V4 (Director of Nursing) stated, When staff are performing incontinence care, they should be changing their gloves when going from a dirty to clean task to prevent cross contamination. It is our policy that staff wear gloves when handling soiled linen for the same reason. Our policy specifically shows all of this as well as performing hand hygiene in between glove changes. This is nothing new, especially for an aide. She should have known that. The facility's policy titled, Glove Use dated 04/2024 showed, Gloves will be used to prevent the spread of infection and disease to other residents, personnel, and visitors. Gloves will be used when anticipating touching blood, body fluids, secretions, excretions, contaminated items.1. Disposable single-use examination gloves are worn when.c. handling or touching contaminated items or surfaces.5. Procedure guidelines.e. non-sterile gloves are used primarily to prevent contamination of the employee's hands when providing care/services to the resident.h. provide hand hygiene when gloves are removed. The facility's policy titled, Perineal Care dated 09/2020 showed.b. put on gloves.j. remove gloves and wash hands and/or use hand hygiene. K. apply gloves before putting on clean brief.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to maintain a residents dignity, by failing to dispose of and clean emesis from a basin from the resident's bedside. This applies to 1 of 1 residents (R2) reviewed for dignity in the sample of 63. Findings include: R2's admission Record (Face Sheet) showed an admission date of 4/24/23 with diagnoses to include heart bypass, morbid obesity, and diabetes type 2. R2's 6/6/25 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R2's 7/25/2025 Nurses' Note from 12:40 showed, Resident had another emesis occurrence. NP (Nurse Practitioner) came to assess. Ordered [nausea medication] 4mg (milligram) PO (by mouth) q4PRN (every four hours as need for pain). On 7/29/25 at 10:26 AM, R2 was asleep in bed. R2 was pale and she did not arouse to a door knock. R2 had a pink basin in front of her on the over-bed table. The basin had a approximately one cup of emesis in the basin. The emesis was chunky, dark brown, with round off-white pieces. At 7/29/25 at 10:26 AM, R114 R2's roommate stated, R2 had been sick that morning and she was not feeling well. On 7/29/25 at 2:10 PM, R2 was as before, asleep with the emesis bin in front of her. The emesis was the same amount of the chunky dark brown emesis with off-white pieces. On 7/29/25 at 2:10 PM, R114 stated staff had entered the room and tried to get R2 to eat lunch but she would not eat. (Staff did not clean the emesis from the basin at lunch.) On 7/29/25 at 2:16 PM, V23 Licensed Practical Nurse (LPN) stated she was aware R2 had been sick at lunch time, however, when she saw R2 at that time she was asleep. On 7/30/2025 at 9:00 AM, R2 stated, I got sick and threw up yesterday. I got too hot. I get overheated and then I throw up. This happens every year when it gets hot, it's not a new thing. They should have taken the vomit instead of leaving it in front of me; it took the nice male nurse in the afternoon to clean it up. It was there since breakfast. I threw up the oatmeal and the eggs that I had for breakfast. On 7/30/2025 at 1:36 PM, R4 Director of Nursing stated staff should be rounding hourly and addressing resident concerns and meeting resident needs when rounding to include emptying urinals and emesis basins. The facility's Residents' Rights policy (11/2017) showed, The facility will respect and uphold residents' rights. The Residents' Rights for People in Long-term Care Facilities (4/2024) showed, Your facility must provide services to keep your physical and mental health, and sense of satisfaction.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide clearly defined target behaviors and failed to provide an appropriate indication for the use of an antipsychotic medication for two (R34, R55) residents with a diagnosis of Dementia of five residents in the sample of 63. Findings include: R55's Physician Order Summary Report indicates R55 was admitted to the facility on [DATE], with diagnoses including Vascular Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Unspecified Bipolar Disorder. This Order Summary Report indicates R55 has current orders for Seroquel (antipsychotic) 50mg (milligrams) in the morning related to Bipolar Disorder and Seroquel 25mg at bedtime for Bipolar Disorder. (Order date initiated 6/5/25) R55's Medical Diagnosis List indicates R55's diagnosis of Bipolar Disorder was initiated on 10/14/24 and Dementia diagnosis on 7/21/25. On 7/28/25 at 11:10am R55 was seen in bed. R55 stated he was too sick to talk. On 7/29/25 at 9:50am R55 was sitting in a wheelchair in the doorway of his room. R55 was asking everyone who passed by in a loud demanding manner Why are you still here? Your shift was over four hours ago! Don't expect to get a paycheck for staying over. R55 insisted he was the Owner of the building. R55 was argumentative but was able to be engaged if response was not contradictory to his statements. R55 stayed within the area of his room, and was primarily focused on interacting with staff. Progress Notes dated 7/30/25 at 10:17am indicate R55 was referred to a Psychiatric Hospital for evaluation and was later transferred on that date at 2:08pm. Progress Notes do not indicate the behavior R55 was displaying to require hospital evaluation. On 7/31/25 at 11:45pm R55 was seen sitting in a wheelchair in his room. At that time V29, RN (Registered Nurse) stated R55 was sent out for his usual behavior and was sent right back. V29 described R55's usual behavior as believing he is the owner (of the facility) and treating staff like they are his employees. Progress Notes dated 7/23/25 at 5:50am, 7/20/25 at 6:12am, 7/9/25 at 6:04am and 7/5/25 at 5:34am all indicate R55 has behaviors and refuses care at times. R55's Progress Notes do not include a description of behaviors. Current Care Plan indicates R55 receives Quetiapine (Seroquel) for mood issues of insomnia, self isolation and lack of motivation. Behavior Tracking Report dated May 2025, June 2025, and July 2025 indicates R55 is monitored for mood disturbances, lack of motivation and lack of self-initiation; Delusions - confusion about life events and believing he is back in the war. Tracking Report indicates R55 displays the behaviors listed almost daily during the evening hours from 2pm, to 10pm and the interventions of Not arguing are effective and the interventions of Conducting reality testing are not effective in reducing behaviors. On 7/31/25 at 12:30pm V13, Behavioral Health Director acknowledged R55 displays typical behaviors of Dementia including cycling and needs a medical diagnosis review by psychiatry services. V13 stated R55 did have a previous diagnosis of Bipolar however it is unclear if his current delusions are a continuation of Bipolar or related to Dementia. V13 confirmed there was a need for more specific documentation describing R55's delusions and therapeutic goal of antipsychotic use in a resident with a dual diagnosis. 2. R34's current Physician Order Summary Report indicates R34 was admitted to the facility 8/4/19 with diagnoses that include Dementia with Other Behavioral Disturbance (9/4/24), Alzheimer's Disease (8/27/19) and Delusional Disorder. R34's Order Summary report indicates R34 receives Quetiapine (antipsychotic) 25mg at bedtime (date initiated 1/7/25) related to Delusional Disorder. On 7/29/25 and 7/30/25 R34 was seen in a wheelchair in the hallway. R34 was pleasant and appropriate during interaction. R34's current Care Plan indicates R34 receives an anti-depressant (Paroxetine) and Quetiapine (antipsychotic) related to the diagnosis of Recurrent Depressive Disorders, Schizoaffective and symptoms of sadness. This Care Plan indicates R34 receives psychotropic anti-psychotic Quetiapine for diagnosis of Delusional Disorders for symptoms of delusions. Date initiated: 6/5/19 R34's Care Plan does not include details/descriptions of R34's delusions, the specific (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms of delusions or targeted behaviors that require monitoring. This Care Plan does not include any non-pharmacological interventions. Behavior Tracking Report dated July 2025 indicates R34 is being monitored for Delusions - fixed false beliefs (example: believing someone is there to take her home; waiting for the bus with her purse to go shopping; believing she is being discharged . This report indicates R34 displayed these behaviors 9 times during the report month (across all three shifts).R34's Psychiatry/Psychologist Note dated 7/31/25 at 2:02pm indicates 'R34 was originally started on Seroquel in 2019 for agitation and delusions and was often found yelling with outbursts related to delusions. Note further indicates On 4/12/23 (R34's) change of condition required involuntary psychiatric admission. Per the petition, (R34) had become physically aggressive with staff evidenced by hitting and kicking staff during ADL's (Activities of Daily Living). Based on this she continues to benefit from this medication (Seroquel/Quetiapine). (R34) needs it for stability and it treats her underlying delusions. Our goal is to have (R34) on the lowest dose possible, but her symptoms make this difficult. R34's Psychiatry Note dated 7/31/25 does not specify any symptoms or description of delusions that require antipsychotic medication use, other than R34 becoming aggressive with staff during ADL's and was yelling out. On 7/31/25 at 2:55pm V31, Nurse Consultant confirmed R34 remains on Seroquel as she is still aggressive with care.The facility Policy/Use of Psychotropic Medications dated 9/2020 documents:A resident will not receive psychotropic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's target behavioral disturbance. A resident will not receive psychotropic medications unless a medication is needed to treat a specific condition and each medication will be given to treat clearly defined target behaviors.A psychotropic medication will be defined as any medication that is prescribed for the purpose of modifying mood and/or behavior.Prior to the administration of an antipsychotic medication, the following must be documented:An appropriate supporting diagnosis and/or targeted behavioral symptom to be treated.Target behaviors will be identified with supporting documentation in the clinical record.Plan of Care including treatment goals, evaluation of any precipitating factors in the residents environment, and any non-drug approaches to providing care.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide bed rails for assistance with bed mobility for 1 of 2 residents (R99) reviewed for activities of daily living (ADL's) in the sample of 63. Findings include: R99's electronic face sheet printed on 7/31/25 showed R99 has diagnoses including but not limited to heart failure, chronic kidney disease, dementia without behaviors, and history of falls. R99's facility assessment dated [DATE] showed R99 has moderate cognitive impairment and does not utilize side rails. R99's undated care plan showed, (R99) has an ADL functional performance deficit. cue resident to grasp side rail and pull self-up to a sitting position or to the side of the bed. R99's document titled, Side Rail Assessment dated 4/25/25 showed, Is the resident able to use a side rail to assist in bed mobility? Yes. the use of side rails is indicated and serves as an enabler to promote independence. R99's document titled, Side Rail Assessment dated 7/22/25 showed, Decision regarding side rail use: One side rail. resident has requested the use of side rails while in bed. The use of side rails is indicated and serves as an enable to promote independence. On 7/29/25 at 10:08AM, V25 (Certified Nursing Assistant) provided incontinence care for R99. R99 attempted multiple times to reach out for something to grab onto during her bed mobility. At one point, R99 grabbed onto her bedside table as she stated, I need something to grab onto so I can turn over. I feel like I'm going to fall if I don't hold something. V25 stated R99 does not have bed rails and as far as she knows, she has never had them. V25 stated R99 does help move herself in bed when she has something to grab onto. On 7/31/25 at 11:21AM, V27 (Restorative Nurse) stated, Side rail assessments are done by the floor nurse. If the resident does seem to need side rails, then it will come to the restorative department and then the interdisciplinary team (IDT) will discuss it. If they need siderails for positioning, then they will bring the rail up during cares and then lower it back down. (R99's) side rail assessment was done 7/22 and shows that she would benefit from 1 side rail. I believe she has one if I'm not mistaken but I can't be positive. On 7/31/25 at 12:45PM, V4 (Director of Nursing) stated, Floor nurse's do the initial side rail assessment and as needed. If a resident is deemed to need side rails and benefit from them then we would discuss it as an IDT. I'm not sure if we have discussed (R99) but I feel like we have. If the assessment shows she could use one, then it would probably be a benefit for her. The facility's undated policy titled, Side Rise Assessment showed, It is the policy of this facility to properly assess a resident's need for side rail use .		

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NAME OF PROVIDER OR SUPPLIER Alden Debes Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Mulford Avenue Rockford, IL 61108	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure signs and symptoms of nausea and vomiting were treated as ordered and failed to provide wound/skin care as ordered for 2 of 7 residents (R2, R99) reviewed for quality of care in the sample of 63. Findings include: 1. R2's admission Record (Face Sheet) showed an admission date of 4/24/23 with diagnoses to include heart bypass, morbid obesity, and diabetes type 2. R2's 6/6/25 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R2's 7/25/2025 Nurses' Note from 12:40 showed, Resident had another emesis occurrence. NP (Nurse Practitioner) came to assess. Ordered [nausea medication] 4mg (milligram) PO (by mouth) q4PRN (every four hours as need for pain). On 7/29/25 at 10:26 AM, R2 was asleep in bed. R2 was pale and she did not arouse to a door knock. R2 had a pink wash basin in front of her on the over-bed table. The wash basin had a approximately a cup of emesis in the bin. The emesis was chunky, dark brown, with round off-white pieces. At 7/29/25 at 10:26 AM, R114 R2's roommate stated, R2 had been sick that morning and she was not feeling well. R2's July 2025 Medication Administration Record (MAR, provided on 7/30/25) showed R2's nausea medication was not documented as being administered on 7/29/25. On 7/29/25 at 2:16 PM, V23 stated Licensed Practical Nurse (LPN) stated she wasn't aware R2 was sick then stated she had heard R2 was not feeling well at lunch. V23 stated when she saw R2 she was asleep, and she did not bother her. V23 stated she did not offer R2 nausea medication. On 7/30/2025 at 9:00 AM, R2 stated, I got sick and threw up yesterday. R2 stated she threw up after breakfast. R2 stated she gets overheated in the summertime, which makes her sick and vomit. R2 stated she was not offered nausea medication in the morning and the nausea medication does work well for her. R2 stated that had she been offered the medication she may have been able to eat lunch. On 7/30/2025 at 1:36 PM, V4 Director of Nursing stated residents should be educated what medications they have available so they are aware what they can request; however, R2 should have been offered her nausea medication the morning of 7/29/25. 2. R2's admission Record (Face Sheet) showed an admission date of 4/24/23 with diagnoses to include heart bypass, morbid obesity, and diabetes type 2. R2's 6/6/25 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 7/30/25 at 9:16 AM, R2 stated there are many days when her abdominal dressing is not changed. R2's July 2025 Treatment Administration Record (TAR, as of 7/30/25 at 9:24 AM) showed a (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment order for her abdominal wound. The order showed the wound should be cleansed with normal saline then a wet-to-dry dressing should be applied every night shift. The TAR showed this was not documented as being done on 7/9/25, 7/25/25, and 7/26/25. On 7/30/2025 at 9:34 AM, V6 Wound Care nurse stated dressing changes are important for wound healing and to prevent infection. On 7/30/25 at 1:50 PM, V4 Director of Nursing stated all staff including agency staff are trained on wound care documentation and treatments should be documented when they are done. On 7/30/25 at 1:52 PM, V6 stated the only place wound care would be documented would be the TAR or a progress note. The facility's wound care policy was requested on 7/29/25 at 1:55 PM and again on 7/30/25 at 11:00 AM. The policy provided, Prevention and Treatment of Pressure Injury and Other Skin Alterations (dated 3/2/21), does not show and guidance on following physician orders or documentation of wound care treatments. 3. R99's electronic face sheet printed on 7/31/25 showed R99 has diagnoses including but not limited to heart failure, chronic kidney disease, dementia without behaviors, and history of falls. R99's facility assessment dated [DATE] showed R99 has moderate cognitive impairment and is at risk for pressure ulcers. R99's undated care plan showed, (R99) has actual alteration in skin integrity sacral/perineal/buttock MASD (moister associated skin damage), history of pressure to sacrum, history of left heel skin alteration, declines skin interventions, refusing heel lift boots.treatment as ordered. R99's physician's orders dated 6/6/25 showed, (Foam dressing) adhesive 4x4. Apply to left buttock topically ever night shift and as needed for skin condition. On 7/29/25 at 10:08AM, V25 (Certified Nursing Assistant) provided incontinence care for R99. V25 removed R99's soiled incontinence brief and no dressing was applied to R99's buttocks. V25 stated she is unsure if R99 is supposed to have a dressing on her buttocks. On 7/31/25 at 11:08AM, V28 (Licensed Practical Nurse) provided skin care to R99's buttocks. V28 cleaned the area with soap and water and applied a barrier cream. V28 did not clean the area with normal saline or apply a foam pad per physician's orders. V28 stated R99 does not use any dressings to her buttocks. On 7/31/25 at 12:45PM, V4 (Director of Nursing) stated, Treatments should be done as ordered because the specific treatment is ordered for a reason and that reason is to work towards healing a wound or for prevention of a wound. No staff should be doing anything other than what's ordered by the physician. If a resident's dressing comes off, then each resident should have a PRN (as needed) order where they can reapply the dressing. The facility's policy titled, Prevention and treatment of pressure injury and other skin alterations dated 03/02/21 showed, Policy.3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure weights were completed as ordered for residents with weight loss for 2 residents (R95, R3) reviewed for nutrition and weight loss in the sample of 63. Findings include: 1. R95s admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including dysphagia (difficulty swallowing) diabetes mellitus, malignant neoplasm of the prostate (cancer) and gastric reflux. The 5/2/25 quarterly resident assessment and care screening shows R95 has moderately impaired cognitive skills for daily decision making. He requires supervision for eating and oral hygiene. The swallowing/nutritional status assessment documents him to be 64 inches in height and weigh 147 pounds. He has a mechanically altered diet. R95's July 2025 order summary report shows a diet order for no concentrated sweets, mechanical soft texture with nectar consistency fluids. The same report shows an order dated 7/23/25 to weigh three times a week and chart weight loss. On R95's comprehensive monthly note dated 7/23/25, V21 (Nurse Practitioner) notes an assessment of a 20-pound weight loss since the previous month. R95 was seen by the dietitian on 7/18/25 and fortified pudding and mighty shakes ordered, and to be weighed 3 times per week. R95s weights were reviewed and show his last weight was 7/3/25. The 7/23/25 order for weights was not on the medication administration record (MAR) or the treatment administration record (TAR). On 7/30/25 at 1:47 PM, V20 Registered Nurse (RN) said when a resident has an order for weights to be done it will be documented on the MAR and alert the nurse it needs to be completed. When the weight is put into the MAR, it will auto-populate into the weight report in the resident profile. V20 reviewed R95s profile and said order for weights was not scheduled and therefore had not been completed. He reviewed the weight history and said R95 had not been weighed since 7/3/25. He said it is important to have weights measured to catch any further weight loss. On 7/31/2025 at 12:30 PM, V4 Director of Nursing (DON) said when a resident has weight loss, interventions are put in place such as fortified potatoes, mighty shakes and med pass. Nursing interventions include monitoring weights and intakes. It would be important to monitor weights to see if they had a weight gain or any loss. Any order for weights comes up on MAR or TAR, and the nurses enter the weight. The order should be initiated as soon as possible. If a resident refuses to be weighed, that would also be documented. V4 said all of the residents are weighed every month by the 5th and are reviewed. She said the error would have been identified during an audit of the weights. R95's progress notes were reviewed and show no refusals for weights from 7/23/25 to 7/30/25. The order summary report shows the weight order was revised on 7/30/25 to include specific days for the weight to be completed, and to start on 8/1/25. The 7/30/25 progress notes show R95 had a weight gain of 4.3 pounds during the month of July. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 9/2020 policy for weights documents residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain. 2. R3's Current Physician Order Summary Report indicates Weight three times for one week - date ordered 7/3/25. Weights and Vitals documentation indicates R3's weight on 5/12/25 was 129.4 pounds and on 7/2/25 was 117.6 pounds. There were no weights after 7/2/25 found in R3's medical records. On 7/31/25 at 12:10pm V29, RN (Registered Nurse) stated the weights ordered for three times on 7/2/25 are not documented in R3's medical record. On 7/31/25 at 12:30pm V22, NP (Nurse Practitioner) stated a different NP ordered the three/week weights for R3. V22 stated she gets a list of all residents who have weight loss and she did not receive those weights for R3. V22 stated there seemed to be a disconnect of ordering the weights, documenting the weights and notifying of the weights so the RD (Registered Dietician) has the most current information.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications per physicians orders as scheduled. There were 9 medication errors out of 28 opportunities, resulting in a 32.1% medication error rate. This applies to 1 of 2 residents (R58) observed for medication administration. Findings include: On 7/30/25 at 9:11 AM, the surveyor approached V11 (Agency RN (Registered nurse)) to observe medication administration. V11's medication cart was parked in the middle of the hall. R182 was seated in her wheelchair next to the medication cart and R58 was standing behind R182. V11 said she was preparing medications for R182. The surveyor waited while V11 administered the prepared medications to R182. R58 told V11 that he needed something for his stomach. V11 opened her computer to the Medication Administration Screen and numerous residents showed up in red. V11 stated, I know there's a lot of red on the screen. That's because they're considered late. R58 was red on the computer screen. V11 stated, I need to give you your morning medications and I'll see what you have for your stomach. While V11 prepared R58's medications he said he had to go, and walked away. V11 did not have R58's Isosorbide 60 mg (blood pressure medication). V11 said it had been ordered yesterday, so she would need to check with a supervisor to see if it was available in the automated medication dispensing system. V11 prepared Amlodipine 10 mg (for blood pressure), Aripiprazole 20 mg (antipsychotic medication), Aspirin 81 mg, Benztropine 1 mg, Losartan 100 mg (for blood pressure), Omeprazole 20 mg (for acid reflux), Venlafaxine 150 mg (antipsychotic), Venlafaxine 37.5 mg, and Colace 100 mg (stool softener). V11 collected R58's two inhalers from the medication cart and the prepared medications and went to R58's room at 9:20 AM. V11 said he's not in here and walked to the other end of the hall to look for R58. At 9:24 AM, V11 returned to R58's room and found him in the bathroom. At 9:27 AM, R58 exited the bathroom and requested applesauce to take his oral medications and said he didn't want to take his inhalers at this time. V11 obtained applesauce and administered R58's oral medications. At 9:30 AM, V11 and the surveyor returned to the medication cart. The surveyor asked V11 if she still had morning medications to pass and she said she still had several residents to finish medication pass on. V11 said she doesn't pick up too many shifts at the facility because the morning medication pass is usually like this (late). R58's Medication Administration Audit Report dated 7/31/25 showed R58's nine (0800) oral medications were administered late at 9:30 AM. On 7/31/25 at 7:57 AM, V4 (DON) said the nurses should follow the 5 rights of medication administration. V4 said the 5 rights include the right time. V4 said the nurses have one hour before and one hour after the scheduled medication time to administer the medications. V4 said 0800 medications would be considered late if they were given after 9 AM. V4 said if medications are given outside the medication administration window then the Provider should be notified and a progress note should be entered. The facility's Medication Administration Policy dated 09/2020 showed, Medications will be administered in accordance with the established policies and procedures. Procedures: 1. Drugs must be administered in accordance with the written orders of the attending physician.		