STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Park Strathmoor	5668 Strathmoor Drive Rockford, IL 61107

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 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 interview and record review, the facility failed to treat a resident in a dignified manner by not ensuring an incontinent resident was changed for 1 of 1 resident (R1) reviewed for dignity in the sample of 3. The findings include: R1's face sheet, printed on 8/1/25, showed diagnoses including but not limited to paraplegia, pressure ulcer of the sacral region stage 4 (lower area of the spine), third degree burns to the left and right lower legs, clostridium difficile (bacterial infection of the colon), neuropathic bladder, and chronic embolism/thrombosis of deep veins of right lower extremity. R1's facility assessment, dated 7/23/25, showed total staff dependence for toileting hygiene, dressing lower body, rolling, and transfers. The same assessment showed R1 is always incontinent of bowel. On 8/1/25 at 9:10 AM, R1 was seated in bed in her room. R1 was alert, oriented, and talkative. R1 stated she is a paraplegic and needs help from staff with brief changes. R1 said she had terrible diarrhea a few nights ago and needed her brief changed multiple times in one evening. R1 said around 9:45 PM, she put on her call light and was told by the CNA (Certified Nursing Assistant) her shift was ending and the next aide on duty would come in to change her. R1 said no staff checked on her or changed her until around 6:15 AM the next morning. R1 said V2 (Wound Care Nurse) was the person who finally came into her room that morning and got her cleaned up. On 8/1/25 at 9:35 AM, V3 (Certified Nurse Aide) stated, (R1's) mental cognition is good. She is totally with it. (R1) is paralyzed from the waist down and needs to be checked for incontinence several times each shift. (R1) cannot feel if she is wet or soiled. On 8/1/25 at 11:05 AM, V2 (Wound Care Nurse) stated R1 is alert and oriented times four. V2 said she did see R1 that morning, and she did have stool in her brief. V2 said R1 was complaining that it had been a long wait to be changed, but did not recall the exact length of time. V2 said R1 had diarrhea overnight and a smell was present in the room. V2 said the sheets had stool on them and looked like they needed to be changed. V2 said, It is important to keep residents clean. Stool can cause infection and is gross to lay in. Staff should be checking residents at least every two hours, especially those that are bed bound and need help turning. On 8/1/25 at 1:26 PM, V1 (Director of Nurses) stated staff do overnight bed checks for safety and incontinence every two hours. V1 said R1 does need bed checks during the night. Residents should be changed immediately to stop wound infections and to stop skin break down. It is a dignity thing too. No one wants to be laying in a dirty brief.The facility's Routine Resident Checks policy, dated 9/2020, states: 1. To ensure the safety and well being of our residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing service personnel.

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 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. Based on observation, interview, and record review, the facility failed to ensure burn wound treatment orders were performed as ordered for 1 of 1 resident (R1) reviewed for non-pressure wounds in the sample of 3. The findings include: R1's face sheet, printed on 8/1/25, showed diagnoses including but not limited to paraplegia, pressure ulcer of the sacral region stage 4 (lower area of the spine), third degree burns to the left and right lower legs, clostridium difficile (bacterial infection of the colon), neuropathic bladder, and chronic embolism/thrombosis of deep veins of right lower extremity. R1's facility assessment, dated 7/23/25, showed total staff dependence for toileting hygiene, dressing lower body, rolling, and transfers. The same assessment showed R1 is always incontinent of bowel. R1's weekly wound assessment, dated 8/1/25, showed a stage 4 sacral pressure ulcer measuring 4.7 x 4 x 0.5 centimeters (length x width x depth). The assessment showed a right, lower extremity burn measuring 6.9 x 1.9 x 1.1 (length x width x depth). The assessment showed the left, lower extremity burn was resolved as of 8/1/25. On 8/1/25 at 9:10 AM, R1 was seated in bed in her room. R1 was alert, oriented, and talkative. R1 stated she has a pressure ulcer on her back side and burns on her lower legs. R1 said the burns on both of her lower legs were from a heating blanket she was using at home (prior to facility admission). R1 said, The staff are not changing the dressings on any of the wounds like they should be doing. They should be changed on a daily basis and that is not happening. R1's sacral area was observed with a Certified Nurse Aide (V3) assisting her to turn. R1's sacral area had a dressing on it, which was not dated or initialed. R1's left and right calves were observed and had dressings on them. Again, neither area was dated or initialed.R1's July 2025 physician orders showed an order, start dated 7/26/25, for wound care to the right and left lower extremities to be done on a daily basis. R1's July 2025 treatment administration record showed wound care was not performed on either extremity for 7/28 or 7/30/25. On 8/1/25 at 9:35 AM, V3 (Certified Nurse Aide) stated, (R1's) mental cognition is good. She is totally with it.On 8/1/25 at 11:05 AM, V2 (Wound Care Nurse) stated, (R1) is alert and oriented times four. She has to keep her wounds clean to avoid infection. She has orders for wound care on a daily basis. It is important to treat wounds as ordered. It is a basic nursing thing. Not treating wounds as ordered can cause them to worsen and slow healing.On 8/1/25 at 1:26 PM, V1 (Director of Nurses) stated, Wound care should be documented as soon as it is performed. No documentation means either the nurse forgot to document, or it was not done. There is the potential for wounds to heal slower or get infected when care is not given as ordered. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations policy, dated 3/2/21, states: 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. 24. Document the dressing change on the TAR or EHR (treatment administration record or electronic health record).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure pressure ulcer treatments were performed as ordered for 1 of 1 resident (R1) reviewed for pressure ulcers in the sample of 3. The findings include: R1's face sheet, printed on 8/1/25, showed diagnoses including but not limited to paraplegia, pressure ulcer of the sacral region stage 4 (lower area of the spine), third degree burns to the left and right lower legs, clostridium difficile (bacterial infection of the colon), neuropathic bladder, and chronic embolism/thrombosis of deep veins of right lower extremity. R1's facility assessment, dated 7/23/25, showed total staff dependence for toileting hygiene, dressing lower body, rolling, and transfers. The same assessment showed R1 is always incontinent of bowel. R1's weekly wound assessment, dated 8/1/25, showed a stage 4 sacral pressure ulcer measuring 4.7 x 4 x 0.5 centimeters (length x width x depth). The assessment showed a right, lower extremity burn measuring 6.9 x 1.9 x 1.1 (length x width x depth). The assessment showed the left, lower extremity burn was resolved as of 8/1/25. On 8/1/25 at 9:10 AM, R1 was seated in bed in her room. R1 was alert, oriented, and talkative. R1 stated she has a pressure ulcer on her back side and burns on her lower legs. R1 said the burns on both of her lower legs were from a heating blanket she was using at home (prior to facility admission). R1 said, The staff are not changing the dressings on any of the wounds like they should be doing. They should be changed on a daily basis and that is not happening. R1's sacral area was observed with a Certified Nurse Aide (V3) assisting her to turn. R1's sacral area had a dressing on it which was not dated or initialed. R1's left and right calves were observed and had dressings on them. Again, neither area was dated or initialed.R1's July 2025 physician orders showed an order, start dated 7/26/25, for wound care to the sacrum to be done on a daily basis. R1's July 2025 medication admission record showed wound care was not performed on 7/28 and 7/30. On 8/1/25 at 9:35 AM, V3 (Certified Nurse Aide) stated, (R1's) mental cognition is good. She is totally with it.On 8/1/25 at 11:05 AM, V2 (Wound Care Nurse) stated, (R1) is alert and oriented times four. She has to keep her wounds clean to avoid infection. She has orders for wound care on a daily basis. It is important to treat wounds as ordered. It is a basic nursing thing. Not treating wounds as ordered can cause them to worsen and slow healing.On 8/1/25 at 1:26 PM, V1 (Director of Nurses) stated wound care should be documented as soon as it is performed. No documentation means either the nurse forgot to document, or it was not done. There is the potential for wounds to heal slower or get infected when care is not given as ordered. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations policy, dated 3/2/21, states: 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. 24. Document the dressing change on the TAR or EHR (treatment administration record or electronic health record).