

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: 145259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2025
NAME OF PROVIDER OR SUPPLIER Alden Park Strathmoor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure narcotic medication was safely stored and failed to ensure medications were administered for 2 of 4 (R1, R3) residents reviewed for medication storage and administration in the sample of 4. The findings include: 1. The facility's undated and unsigned incident summary documents on 11/7/25, nursing staff on the behavioral care unit reported narcotic medications assigned to 2 residents were missing. A facility-wide search was immediately initiated. During the interview process, it was determined the medication cart had been left unlocked while the assigned nurse was within visible distance. This lapse in medication security allowed R1 to open the cart, remove several narcotic medications, and take them into his room with the intention of hiding them. On 11/22/25 at 1:00 PM, V8, Registered Nurse (RN), said he was working on the behavioral unit on 11/7/25, when he discovered missing narcotic medications in his medication cart. V8 said towards the end of his shift, he was verifying the count in his cart when he found 2 cards of Xanax (controlled medication) missing. He said the Director of Nursing was immediately notified. He said after searching the unit, the medication cards were found in R1s room. He does not know how R1 would have gotten the medications out of his cart. V8 said he had his keys throughout the shift, and the cart was within view. R1s face sheet documents he was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder, recurrent, severe with psychotic symptoms, and disorganized schizophrenia. The 10/29/25 quarterly resident assessment and care screening documents he is cognitively intact. R1s 8/31/23 care plan notes he displays socially inappropriate behaviors due to his poor impulse control and psychosis such as taking things that do not belong to him or disregarding rules that interfere with his immediate desires. On 11/22/25, R1 said he was compliant with taking his medications from the nurse. He denied taking any medication cards from the medication cart. On 11/22/25 at 10:20 AM, V4, Licensed Practical Nurse (LPN), said R1 wanders the unit and takes medications. The nurse must stay with him to ensure he takes them. She said the nurse is the only person with the keys to the medication cart. It must be locked when stepping away. She was not sure what had happened, but somehow R1 ended up with medication cards in his room. She said there was a meeting about not leaving keys on the medication cart. On 11/22/25 at 12:00 PM, V3, Corporate Nurse, said V8 was assigned to the behavioral unit for 2nd shift. Towards the end of the shift, 2 narcotic medication cards were missing, and it was reported to V9, Director of Nursing. After the cart was re-checked, a search was conducted. V3 said V8 reported to him the medication cart had been locked. V3 said he determined the medication cart was located at the nurse's station and V8 was there with another resident. R1 came around the cart and opened the drawer. V3 could not say if the drawer was locked for sure, but R1 had 2 cards of Xanax. V3 said the medication cards were intact and R1 had not removed any of the pills. On 11/22/25, the behavioral unit medication cart was observed to be locked when unattended, and V4 was the only nurse working on the unit. She unlocked the cart when passing medications and locked the cart when stepping into resident rooms. 2. R3 admission record shows an admit date of 6/3/25, with multiple diagnoses including aphasia (difficulty speaking) following a cerebral infarct (stroke), vascular (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 - Few	dementia, and major depressive disorder. The 9/8/25 quarterly resident assessment and care screening documents her to have moderate cognitive impairment. The undated care plan showed she is resistive to care. She will also refuse/resist medications at times; including spitting medications out after administration despite education/encouragement and incentivized programming from staff. R3s nursing progress notes of 10/8/25 at 10:13 PM, show the counselor found in her room several pills that had been hidden by resident. DON aware and demanded 15-minute checks, and for the nurse to be aware of that behavior and assure the resident is taking her pills properly. On 11/22/25 at 12:00 PM, V3, V1 Administrator, and V7, Assistant Director of Nursing, said they were unaware of the incident. V3 said nurses should be staying with residents while administering medications and make sure they are not cheeking the pills. On 11/22/25 at 12:30 PM, V10, Behavioral Health Director, said, We found the pills in her room where she had spat the pills back into a cup following one of her medication administrations. I do not recall the number of pills, but it appeared to have been from 1 med pass. She was on daily room checks because she tends to hoard things. I gave the pills to the nurse to verify if they were hers. That is one of her behaviors, refusing her medications. On 11/22/25 at 1:00 PM, V8 said the [NAME] did find the medications and it looked like they were wet and had been spit out. He did not know how long she had those and was not able to identify the pills. He said when giving medications, the nurses are supposed to make sure the resident takes the pills and have them open their mouth to make sure they are taken. R3 is pretty compliant with doing the mouth check if you just ask her. V8 said R3 has a history of cheeking and pocketing her medication. On 11/22/25, R3 said she was not going to take her medications. R3 was alert but confused and had difficulty expressing her thoughts. Her room was located on the behavioral unit. On 11/22/25 at 10:20 AM, V4 said the nurse should stay with a resident to make sure they take their medications. On 11/22/2025 at 10:18 AM, R2 said he receives his medications daily when scheduled but did indicate two weeks ago, an African American agency nurse had come into his room on the evening shift and set a med cup that contained pills and a cup of water on my bedside table. R2 then indicated that this nurse said here's your meds then went back to her med cart that was outside of his doorway. R2 added that the nurse was standing in the doorway with her back turned away from him. R2 said he picked up the med cup and self-administered the medications with the water left by the nurse. On 11/22/2025 at 10:42 AM, R4 said a few weeks ago, a nurse on the evening shift left pills in a med cup on her bedside table then left the room and did not return. R4 said she does not recall taking the medications on that day. The facility's 2/2019 policy for Medication pass guidelines documents 11. Administering medications; Watch the resident swallow all medications. Do NOT leave any meds with the resident to take later. Do mouth checks, if necessary, to ensure meds were swallowed. The facility's 4/2019 policy for medication pass guidelines documents 3. Locking carts/keys: Carry your keys with you at all times. Never leave keys unattended in carts or out of the nurse's control, Do not leave cart(s) unlocked when unattended, lock cart when not in direct view. Schedule II controlled substances MUST be kept double locked.		