

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 05/14/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was contact isolation was allowed to leave her own room. This applies to 1 of 31 residents (R143) reviewed for resident rights in the sample of 31.</p> <p>The findings include:</p> <p>R143's face sheet shows she is a [AGE] year old female, with diagnoses including type 2 diabetes, fibromyalgia, generalized anxiety, chronic pain, restless leg syndrome, major depression, and urinary tract infection (UTI).</p> <p>R143's Urinalysis Culture Report, dated 4/29/25, shows Klebsiella pneumonia (MDRO).</p> <p>R143's Physician Order Sheets shows orders on 5/1/25 for Isolation: Contact Precautions: E Coli Urine.</p> <p>On 5/12/25 at 9:42 AM, R143 said last week she was placed on isolation for seven days for a urinary tract infection. At first, the staff said she could leave the room as long as she washed her hands. Then they changed their mind and said she had to stay in her room with the door closed, the last four to five days of her isolation. When she asked the staff why she couldn't leave they responded, It's (Facility) policy. She spoke to several staff including V4 (Assistant Administrator) and V8 (previous Director of Nursing-DON). R143 said, They did this so they could exert their power over me. It was rude, barbaric, and controlling. R143 said she is independent with cares, ambulates and toilets herself. She was compliant with hand washing, but they did not let me leave my room. R143 said she carries a small bottle of hand sanitizer with her and they told her no, she could not leave the room.</p> <p>On 5/13/25 at 7:49 AM, V7 (Unit Manager) said R143 was on contact isolation and could not leave her room. If they are on contact or droplet precautions residents remain in their room until the isolation time is discontinued. (R143) was upset she could not leave her room.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 9:03 AM, V6, Registered Nurse (RN), said, (R143) is very independent, and she is alert and oriented. She was moved to a private room and placed on isolation for Klebsiella (MDRO-multi drug resistant organism). (R143) was upset she could not leave her room, she does not like to be alone. Residents who are on contact isolation should remain in their room until isolation is completed, and practice hand hygiene when leaving the room.</p> <p>On 5/13/25 at 11:02 AM, V4 (Assistant Administrator) said R143 was on isolation, and she was told R143 could not leave her room. (R143) was asking why she couldn't leave her room, and the nurse on A wing said she has to stay in room. She notified V8 (previous Director of Nursing-DON) about R143's isolation concern.</p> <p>On 5/13/25 at 12:43 PM, V8 (previous Director of Nursing-DON) said, (R143) was on contact isolation and was not allowed to leave her room. She was educated on hand hygiene and educated to stay in her room. (R143) was independent, she could toilet herself, she could wash her hands and use appropriate infection control measures. We really wanted to make sure the organism was contained, and told (R143) she needed to remain in her room.</p> <p>On 5/13/25 at 10:25 AM, V14 (Corporate RN) said, If a resident is on contact isolation for an UTI, they can leave their room if they perform hand hygiene on their own, and as long as they are not touching other residents or residents food.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>37232</p> <p>Based on observation, interview, and record review, the facility failed to set a resident's tube feeding pump to the Dietitian's recommended infusion setting for 1 of 4 residents (R30) reviewed for tube feedings in the sample of 31.</p> <p>The findings include:</p> <p>R30's Face Sheet, printed on 5/12/25, indicated R1 had a gastrostomy (tube feeding).</p> <p>On 5/12/25 at 11:00 AM, R30 was in bed connected to her tube feeding. The tube feeding pump showed an infusion rate of 55 milliliters (ml) per hour. The pump indicated the total volume to be infused was 1100 ml.</p> <p>On 5/13/25 at 8:28 AM, R30 was in bed, connected to her tube feeding. The tube feeding pump showed an infusion rate of 55 ml per hour. The pump indicated the total volume to be infused was 1100 ml.</p> <p>R30's Order Summary Report, dated 5/12/25, showed two orders for R30's tube feeding. One order was for a rate of 55 ml per hour, with a total volume of 1100 ml. The second order was for a rate of 60 ml per hour, with a total volume of 1200 ml. Both orders had a start date of 5/6/25.</p> <p>R30's Medication Administration Record for May 2025 showed, on 5/6/25 - 5/11/25, R30's tube feeding pump was infusing at 55 ml per hour, with a total infused volume of 1100 ml, and at 60 ml per hour with a total infused volume of 1200 ml.</p> <p>R30's Progress Notes, dated 5/12/25, 5/11/25, 5/10/25, 5/9/25, and 5/8/25, showed the tube feeding was infusing at a rate of 55 ml per hour, with a total volume of 1100 ml.</p> <p>On 5/13/25 at 8:28 AM, V12 (Registered Nurse) looked at R30's tube feeding orders and said, That's not right. V12 confirmed there were two tube feeding orders, and she would need to contact the Dietitian for clarification. V12 added there should only be one order.</p> <p>R30's Nutrition note, dated 5/1/25 entered by V13 (Dietitian), showed R30's previous weight loss was related to fluid and current weight loss was undesirable. The recommendation was to increase the tube feeding rate to 60 ml per hour, with a total infusion rate of 1200 ml, to increase caloric intake and promote weight stability.</p> <p>On 5/13/25 at 10:17 AM, V13 said R30 had weight loss that was fluid related, and on 5/1/25 she recommended to increasing R30's tube feeding rate to 60 ml per hour, with a total volume of 1200 ml to maintain R30's weight. V13 confirmed R30's tube feeding rate should be at 60 ml per hour, with a total volume 1200 ml.</p> <p>R30's Care Plan, with an initiated date of 2/6/25, showed R30 required tube feeding. Listed under interventions was to administer tube feeding as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Enteral Nutritional Feeding, dated 9/2020, showed to verify orders for feeding.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35541</p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary aides handled dishware in a manner to prevent cross-contamination.</p> <p>This failure has the potential to affect all 156 residents in the facility,</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form, dated 5/12/25, showed a resident census of 156.</p> <p>On 5/12/25 at 9:05 AM, V16, Dietary Aide, placed a rack of dirty cups into the facility's dishwasher. After placing the cups into the dishwasher, V16 immediately walked over to a rack of clean pots, and began placing the pots on a kitchen shelf. V16 did not wash her hands after loading the dirty cups into the dishwasher. V16 wore no gloves.</p> <p>On 5/12/25 at 9:15 AM, V15, Dietary Aide, placed dirty breakfast dishes on a shelf by a kitchen sink. At 9:16 AM, V15 walked over to a rack of clean food trays, and placed the trays on a kitchen cart. V15 did not wash his hands after handling the dirty breakfast dishes. V15 wore no gloves.</p> <p>On 5/13/25 at 12:07 PM, V17, Certified Dietary Manager (CDM), stated, Staff should not be touching clean dishes after touching anything dirty to avoid cross-contamination. Staff should wash their hands when they are dirty and prior to touching clean dishes.</p> <p>The facility's Cross Contamination policy, dated 8/2018, showed, The Food & Nutrition Services staff will employ measures to prevent cross contamination . to reduce the risk of food borne illness . Practice good hand hygiene, hand washing, and glove use .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to perform hand hygiene and change gloves in a manner to prevent cross contamination for one of 31 residents (R94) reviewed for infection control in the sample of 31.</p> <p>The findings include:</p> <p>R94's Admission Record, dated 5/13/25, shows he was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, narcolepsy, anemia, adult failure to thrive, dementia, and history of falling.</p> <p>R94's Care Plan, initiated 10/1/21, shows R94 experiences bladder incontinence and is incontinent of bowel.</p> <p>On 5/12/25 at 10:42 AM, V22, Certified Nursing Assistant (CNA), transferred R94 onto the toilet. R94 urinated and had a large bowel movement in the toilet. R94 used toilet paper to wipe the stool from R94's buttocks multiple times. V22 then pulled up R94's clean incontinence brief and R94's clean pants. R94 then flushed the toilet and pushed R94's wheelchair in front of the sink. V22 did not perform hand hygiene, nor did she wash her hands.</p> <p>On 5/13/25 at 10:27 AM, V14, Corporate Registered Nurse, said, Staff should change their gloves when they are dirty. Gloves should be changed prior to touching anything clean.</p> <p>The facility's Hand Hygiene Policy, dated October 2024, shows, It is the policy of the facility that hand hygiene is to be performed to reduce the potential spread of pathogens. There are two methods for hand hygiene: Alcohol based hand sanitizer (ABHS) is the preferred method of use in most clinical situation. ABHS should be used: When caring for a resident, when moving from a soiled body site to a clean body site of the same resident.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541</p> <p>Based on interview and record review, the facility failed to screen residents for and offer the influenza vaccine to residents during influenza season; failed to screen residents for and offer the pneumococcal vaccine to residents upon admission; and failed to administer the pneumococcal vaccine to a resident who consented to receive the vaccine. These failures apply to 5 of 5 residents (R84, R137, R144, R145, R360) reviewed for influenza and pneumococcal vaccines in the sample of 31.</p> <p>The findings include:</p> <ol style="list-style-type: none"> R84's admission record showed R84 was admitted to the facility on [DATE]. R84's consent for the pneumococcal vaccine, dated 9/3/24, showed R84 consented to receive a pneumococcal vaccine. On 5/13/25 at 11:47 AM, V8, Infection Preventionist, stated R84 had never received a pneumococcal vaccine in the facility. R137's admission record showed R137 was admitted to the facility on [DATE]. R137's immunization record, dated 5/13/25, showed no documentation R137 was ever screened for or educated on the influenza or pneumococcal vaccines. The record showed no documentation R137 ever received either vaccine. R144's admission record showed R144 was admitted to the facility on [DATE]. R144's immunization record, dated 5/13/25, showed no documentation R144 was ever screened for or educated on the influenza or pneumococcal vaccines. The record showed no documentation R144 ever received either vaccine. R145's admission record showed R145 was admitted to the facility on [DATE]. R145's immunization record, dated 5/13/25, showed no documentation R145 was ever screened for or educated on the influenza or pneumococcal vaccines. The record showed no documentation R145 ever received either vaccine. R360's admission record showed R360 was admitted to the facility on [DATE]. R360's immunization record, dated 5/13/25, showed no documentation R360 was ever screened for or educated on the influenza or pneumococcal vaccines. The record showed no documentation R360 ever received either vaccine. <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/13/25 at 11:47 AM, V8, Infection Preventionist, stated the facility had no documentation to support R137, R144, R145, and R360 had ever been screened for, educated on, or offered the influenza or pneumococcal vaccines while in the facility. V8 stated all residents should be screened for and offered the influenza vaccine from October-March annually. V8 stated all residents should be screened for and offered the pneumococcal vaccine upon admission to the facility by nursing staff.</p> <p>The facility's Influenza Vaccination policy, dated 12/14/2023, showed, The facility follows recommendations of the Center of Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) for influenza vaccinations to be offered October 1 through March 31 annually unless the immunization is medically contraindicated; the resident is already immunized; or after the provision of education on risks and benefits is reviewed with the resident/and or responsible party or chooses to refuse . All new admissions will be offered the influenza vaccine during October 1st through March 31st unless ordered otherwise or has already received the influenza vaccine .</p> <p>The facility's Pneumococcal Vaccination policy dated 12/2023 showed, It is the policy of this facility that residents will be offered immunization against pneumococcal disease in accordance with The Advisory Committee on Immunization Practices (ACIP) recommendations .</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541</p> <p>Based on interview and record review, the facility failed to screen residents for, educate them on, or offer the COVID-19 vaccine/booster to residents upon admission to the facility for 3 of 5 residents (R137, R144, R145) reviewed for the COVID-19 vaccination in the sample of 31.</p> <p>The findings include:</p> <ol style="list-style-type: none"> R137's admission record showed R137 was admitted to the facility on [DATE]. R137's immunization record, dated 5/13/25, showed no documentation R137 was ever screened for, educated on, or offered the COVID-19 vaccine/booster. The record showed no documentation R137 ever received the vaccine. R144's admission record showed R144 was admitted to the facility on [DATE]. R144's immunization record, dated 5/13/25, showed no documentation R144 was ever screened for, educated on, or offered the COVID-19 vaccine/booster. The record showed no documentation R144 ever received the vaccine. R145's admission record showed R145 was admitted to the facility on [DATE]. R145's immunization record, dated 5/13/25, showed no documentation R145 was ever screened for, educated on, or offered the COVID-19 vaccine/booster. The record showed no documentation R145 ever received the vaccine. <p>On 5/13/25 at 11:47 AM, V8, Infection Preventionist, stated the facility had no documentation to support R137, R144, and R145 had ever been screened for, educated on, or offered the COVID-19 vaccine/booster while in the facility. V8 stated all residents should be screened for and offered the COVID-19 vaccine upon admission to the facility by nursing staff.</p> <p>The facility's COVID-19 Vaccinations policy, dated 2/2025, showed, When recommended vaccines are available, the facility will ensure COVID-19 vaccines are readily accessible to both residents and staff . The residents medical record includes documentation that indicates, at a minimum the following: a. That the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine: and b. Each dose of COVID-19 vaccine administered to the resident; or c. If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal .</p>