

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Alpine Fireside Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3650 North Alpine Road Rockford, IL 61114	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 staff safely transferred a resident who has history of falls. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3.</p> <p>The findings include:</p> <p>R1's face sheet shows she is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including right hip fracture, hypertension, chronic kidney disease and congestive heart failure.</p> <p>On 2/18/25 at 9:05 AM, R1 was in her room sitting in her wheelchair. R1 had a dark purple hematoma to her right forehead and bruising surrounding her right eye, and bruising to her right side of her face. R1 said she fell transferring from her bed to the wheelchair. She said V5 (Certified Nursing Assistant-CNA) was on the opposite side of the wheelchair, away from her, and did not apply a gait belt during the transfer. When she stood up she lost her balance and fell on her knees and hit her head on the corner of the bedside table. R1 said she fell at home prior to coming and broke her right hip.</p> <p>On 2/18/25 at 10:49 AM, V5 (CNA) said she was R1's CNA when she fell. R1 had her call light on to use the bathroom. She said she put on R1's shoes and socks and positioned the wheelchair next to the bed. When R1 stood up, she went down on her knees and her head hit the corner of the bedside table. V5 said R1 is a stand pivot and she did not need a gait belt to transfer. R1 is very alert and not a fall risk, she does not self transfer and uses her call light and waits for staff to assist.</p> <p>On 2/18/25 at 11:30 AM, V7 (COTA-Certified Occupational Therapist Assistant) said R1 is alert and oriented, she has generalized weakness, is a one person assist for transfers, and is not independent on transfers. Staff should use a gait belt with contact guard assistance, hands on the gait belt, during transfers and walking for safety.</p> <p>On 2/18/25 at 1:07 PM, V2 (DON) said staff should use a gait belt when transferring a resident and confirmed V5 did not use a gait belt while transferring R1.</p> <p>R1's Minimum Data Set assessment dated [DATE] shows she is cognitively intact, has limited range of motion to one side of her lower extremity and requires moderate assistance with transfers.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Fall Risk assessment dated [DATE] shows she had a fall on 2/10/25 and fell at home and had surgery for a right femur fracture.</p> <p>R1's Fall Incident report dated 2/12/2025 documents on 2/11/25 {V5-CNA} reported (R1) fell while transferring from bed to the wheelchair and hit her head with bruising to face. R1 sent out to the hospital for evaluation CT of the head showed a right scalp hematoma.</p> <p>The facility's undated Fall Policy states, On admission and re-admission a Fall Risk Assessment will be completed, interventions will then be implemented for those residents assessed at risk for falls. These measures will be documented in the plan of care.</p>		