STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146066	A. Building B. Wing	12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Fireside Health Center	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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify a pressure wound before developing into an unstageable pressure injury for one (R1). The facility also failed to prevent the development of three facility acquired State 2 pressure ulcers and one facility acquired unstageable pressure ulcer, a Stage 2 pressure ulcer worsening to unstageable, prevent cross contamination during dressing changes and apply pressure reduction devices for one (R2). This failure applies to two of three residents (R1 & R2) reviewed for pressure on the total sample of three. The findings include:1. The Physician Orders for August 2025 for R1 showed he was admitted to the facility on [DATE]. The facility's Body Check Form dated 8/14/25 for R1 documented R1 did not have a pressure injury to his coccyx.A Note dated 8/26/25 at 10:27 PM for R1 documented, R1 has a wound to the coccyx. It was covered with a dressing. Will notify power of attorney - POA tomorrow and do documentation. Initiated treatment to clean and cover. The Note dated 8/27/25 at 2:19 PM from V5 Nurse Practitioner stated to cleanse the wound with wound cleanser, apply, collagenase ointment and cover with a foam dressing daily.The Weekly Wound Assessment and Summary dated 8/26/25 for R1 showed a facility acquired unstageable pressure injury that was identified on 8/26/25 when the area was unstageable. The area measured 6.5 cm x 4.5 cm: granulation and slough present to the wound bed. Scant exudate present. The Weekly Summary note dated 8/26/25 for R1 showed there was 40% slough tissue in the center of the wound surrounded by 60 % granulation tissue. Irregular shape and the edges were not defined. Add air mattress and cushion to his wheelchair. Nurse practitioner notified.On 12/7/25 at 1:00 PM V6 Registered Nurse - RN/Wound Care Nurse stated, R1's skin check when he was admitted showed a scar. V6 stated she reviewed R1's admission skin check. V6 stated she works the floor on Mondays and Tuesdays, and she thinks she saw R1 on 8/18/25 but she did not put a note in. V6 stated when she saw R1 he did not have a pressure injury. V6 stated she found the wound on 8/26/25 and it was unstageable when she found it. V6 stated R1's wound was open with slough tissue present, and did not have any depth. V6 stated when she found R1's wound it was superficial and creamy. V6 stated she cleaned the wound, covered it and notified V5 Nurse Practitioner. V6 stated because it was late at night she did not call R1's wife and told V7 Assistant Director of Nursing (ADON) to notify R1's wife the next morning. V6 stated V5 gave orders. V6 stated the therapy department added a cushion on 8/28/25; the air mattress was added on the same date. R1 was started on a supplement and repositioning every two hours to help with healing. V6 confirmed pressure ulcers should be identified prior to becoming a stage two. V6 stated residents' skin is assessed every time staff does a shower. Skin is to be monitored with repositioning and incontinence care. V6 stated all the facilities mattresses are pressure reliving for stage 1 and 2. V6 stated air mattresses are added for residents that are bony, bedridden, not moving, etc.; it is added for prevention. V6 stated R1 was skinny and now that she has thought about it; it would have been a good idea for him.On 12/7/25 at 2:05 PM V5 Nurse Practitioner reviewed R1's notes and stated she saw R1's wound through telehealth and when she saw the wound it was unstageable. V5 stated she couldn't see the wound bed because of the slough. V5 stated R1's wound was identified on 8/26/25 and she gave orders on 8/27/25. V5 stated they do a skin check on admission then skin checks are done twice per week with showers and when skin care is done. If there are any areas of concerns, then staff should alert the nurse. V5 stated she did not have an opinion on what happened for R1 until she talked to V1 Administrator. V5 came back and stated R1 didn't have anything (pressure injury) and then a few weeks later there was an unstageable area. V5 stated this is what she is supposed to say. V5 stated when there is an area of concern it should be identified when the area is red.On 12/7/25 at 4:00 PM, V2 Director of Nursing - DON stated, staff are to monitor skin when providing care. Staff are to monitor skin with changing, washing, etc. V2 stated anything unusual and/or not there previously should be reported to nursing. Areas of redness should be reported to nursing. Stage 1 and Stage 2 should be identified and reported right away. V2 stated R2 had a blister when it was identified. V2 stated in general they put preventative measures in place such as pressure relief mattress, supplements, floating heels, and wound care clinic referral.The Care Plan dated 8/26/25 for R1 showed, resident has unstageable pressure injury to coccyx (identified on 8/26/25). Air mattress to bed. Cushion to chair. Reposition at least every 2 hours as needed.The Minimum Data Set - MDS dated [DATE] for R1 showed severe cognitive impairment; dependent for toileting hygiene, shower/bath, and lower body dressing. Substantial/maximal assistance needed for personal hygiene, and upper body dressing. Transfers and rolling in bed were not attempted due

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure staff wore personal protective equipment when providing a dressing change for 1 of 3 residents (R3) reviewed for wounds in the sample of three.The findings include:On 12/7/25 at 2:25 PM, R3 was laying in bed and V3 Registered Nurse - RN was at bedside with gloves on and had just completed the wound vac dressing change to R3's right knee. V3 did not have a gown on. V6 RN/Wound Care Nurse entered R3's room wearing a gown and gloves to troubleshoot the wound vac dressing. After V3 and V6 left R3's room, R3 stated V3 did not have a gown on when she did her dressing change. On 12/7/25 at 4:00 PM, V2 Director of Nursing stated gown and gloves are to be worn when doing close contact care to prevent contamination and infection. The Care Plan dated 11/6/25 for R3 showed, resident on isolation related to methicillin resistant staphylococcus aureus - MRSA of nares, MRSA of right knee surgical wound revision. Protective personal equipment to be worn during cares. The Physician Orders dated 11/6/25 for R3 showed maintain contact isolation precautions for MRSA in right knee wound every shift.The Minimum Data Set - MDS dated [DATE] for R3 showed no cognitive impairment. The facility Health care Body Check Form dated 12/3/25 for R3 showed she has a surgical wound to her right knee. The wound measured 8.4 cm x 1.6 cm and had 13 cm of tunneling present at 12 o'clock. R3 had a wound vac in place that is changed on Monday, Wednesday, and Friday.The facility's Policy: Infection Control (no date) showed, all staff who have contact with residents and/or their environments must wear personal protective equipment - PPE as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. Wear PPE (e.g. gloves, gowns, etc.) when handling resident care equipment and instruments/devices that are visibly soiled or may have been in contact with blood or body fluids.The Facility's Contact Precautions policy (no date) showed gloves and gown are to be worn if there is contact with or potential contact with body fluids (except sweat), secretions, excretions, and mucous membranes are to be worn when administering direct patient care.The facility's Policy: Enhance Barrier Precautions showed enhance barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities. High contact resident care activities include: h. Wound care: any skin opening requiring a dressing.