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	01/05/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure fall prevention interventions were in place for a resident with a history of falls for 1 of 3 residents (R1) reviewed for falls in the sample of 6. This failure resulted in R1 falling and sustaining a right hip fracture and right knee fracture.The findings include:R1's Progress Note dated 12/23/25 shows Approximately 1:30 AM, R1 alarm was sounding and Certified Nursing Assistant (CNA) observed R1 on floor, lying on right side. R1 complained of pain to right hip during range of motion. R1 is alert and oriented to self, has a history of falls, and has diagnosis Alzheimer's ad Dementia. R1 has poor safety awareness, has impaired decision making and requires frequent redirection from staff.R1's Emergency Department Provider Note dated 12/23/25 shows R1 presents to the Emergency Department following a fall at the skilled nursing facility. The patient has sustained a right intertrochanteric (hip) fracture. She also sustained a right patellar (knee) fracture. Patient will need admission to hospital for further management. Care Timeline: 12/23/25 admitted from Emergency Department, 12/24/25 Surgery with Gamma Nail for Right Hip Fracture, 12/27/25 Discharge.On 12/31/25 at 8:55 AM, R1 was in bed sleeping.On 12/31/25 at 8:58 AM, V3 (Registered Nurse/RN) said R1 had a rough night, had been very anxious, and kept touching her right hip surgery site. V3 said R1 got a pain pill at 3:30 AM, so she was letting her rest.On 12/31/25 at 9:05 AM, V6 (R1's Daughter/Power of Attorney) said R1 had hip surgery on 12/24/25 and came back to the facility on [DATE]. V6 said R1 had been screaming, pulling at her surgical dressing and seemed like she couldn't get comfortable for the first 48 hours at the facility. V6 said they increase R1's pain medications and R1 seems to be resting better.On 12/31/25 at 10:43 AM, V8 (CNA) said on 12/23/25, R1 had been up and busy all night and was sitting up at the nurse's station with V10 (Licensed Practical Nurse/LPN). V8 said she was sitting at table at the beginning of hall 1, around the corner from the hall 2 nurse's station. V8 said V10 got up and went out the front door to go on break. V8 said within minutes she heard screaming, and she went to the nurse's station where R1 was on the floor on her right side. V8 said she was close by at a table at the end of hall 1, but she couldn't see R1 get up or how she fell.On 12/31/25 at 11:05 AM, V9 (CNA) said the night of R1's fall, she was coming out of the restroom by the nurse's station and heard an alarm going off and screaming. V9 said V8 was coming around the corner at the same time from hall 1. V9 said R1 was on the floor by the nurse's station. V9 said the nurse was not at the station.On 12/31/25 at 11:13 AM, V10 (LPN) said on 12/23/25, R1 had been at the nurse's station with her due to R1's behaviors (not sleeping, trying to get out of bed). V10 said she left the nurse's station to go on break. V10 said she left R1 at the nurse's station by herself and told V8 (CNA) who was around the corner from the nurse's station, that she was going on break. V10 said she left the building out the front door and when she came back in, an alarm was sounding, and R1 was on the floor at the nurse's station. On 12/31/25 at 11:19 AM, V2 (Director of Nursing) said R1 is alert to self and to her daughter. V2 said R1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	doesn't understand what is going on and has behaviors of getting anxious and trying to stand up. V2 said R1 was on 1:1 care before this fall most of the time due to her anxiousness. V2 said per her care plan interventions, R1 is to have 1:1 care if she is anxious and trying to stand up. V2 said staff will keep R1 at the nurse's station to keep an eye on her but she shouldn't be left alone at the nurse's station if she is having these behaviors and is on 1:1.R1's Progress Note dated 12/22/25 at 11:01 PM, shows Entered during treatment pass of Monitor for behavior related to psychotropic medications (key 1-wandering, key 2-verbally abusive, key 3- socially inappropriate, key 4- paranoia, key 5- delusions, key 6-physically abusive, key 7- disruptive, key 8-pacing, key 9-crying, key 10-yelling/screaming, key 11-hallucinations, key 12- striking out, key 13-throwing things, key 14-self-inflicting injury, key 15-feeling down, key 16-not eating adequately, key 17-change in interest or activity, key 18-sleeping problems, key 19- felling angry/anxious, key 20-feeling restlessness/anxious. The results charted were 7-disruptive, 9-crying, 10-yelling/screaming, 18-sleeping problems. 19- feeling angry/anxious, 20-feeling restlessness/anxious.R1's Progress Note dated 12/23/25 at 4:44 AM, shows Entered during treatment pass of Monitor if resident is sleeping at night. (Key 1 - awake most of the night, Key 2- Awake few times at night, Key 3-slept good at 6:00 AM). Result -1 Awake all shift.R1's Care Plan dated 12/12/25 shows Resident behavior as exhibited by not staying in chair, removing her alarms and needing to be 1:1 by staff throughout the day due to increased anxiety/behavior such as restlessness and yelling.R1's Fall Risk assessment dated [DATE] shows R1 is a high risk/potential for falls based on resident gait or balance abnormal either with or without a device, resident is on medications that could impair balance, resident has a disease or condition that impacts ambulation, and resident has cognitive impairments/poor decision making.R1's Minimum Data Set, dated [DATE] shows R1 is cognitively impaired, has behaviors, and has history of falls.On 1/5/26 at 8:02 AM, V11 (Nurse Practitioner) said R1 has dementia, is alert to self only, unable to follow commands and has behaviors of restlessness and agitation. V11 said if R1 is having behaviors, R1 should have 1:1 care according to her care plan. The facility's undated Fall Policy shows 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.