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 01/21/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from misappropriation of monies. This applies to 1 of 3 residents (R2) reviewed for misappropriation in the sample of 8. The findings include:On 1/20/26 at 11:55 AM, R2 stated, she wanted to get her hair done but wasn't sure what day the hairdresser would be in. She asked her son to bring her some money so she could pay for her hair to be done. He brought the money in and put it in her purse in the bottom drawer of a dresser in her room. A day or two later, she went to get the money out of her purse and found the money was gone. She told her son the money was gone and asked him to bring her more so she could get her hair done. On 1/20/26 at 1:02 PM, V14 R2's son stated, his mom had asked him to bring $90.00 on Tuesday (1/6/26) because she wanted to get a hair cut and perm. Her hair appointment was scheduled for Thursday morning (1/8/26). He brought the money to her that evening and put it in her purse in the bottom drawer of a dresser in her room. Her purse also had a $10.00 and couple of $5.00 bills in there. On Thursday his mom went to get the money to go to the hairdresser when she found all the money was gone. His mom texted him and told him the money was gone and she needed more money. He came to the facility with more money and they reported it to the staff. He guessed there was another $15-20.00 in there so about a total loss of $120.00. He is the one who put the money in the purse so he knows the money was in her purse in her room at the facility. The facility's reported incident (no date) for R2 shows, Incident category: Financial. Incident Description: Resident reported that she is missing approximately $110.00. She stated that her son recently brought her $90.00. Final description: On 1/08/2026 Resident (R2) reported that she was missing approximately $110.00. Resident's son/POAH (power of attorney healthcare), V14 was present during interview. Resident reported that her son brought $90.00 to her on 1/06/2026 which she put in her purse along with other monies, that she believed was approximately another $20.00. Resident stated that in the morning of 1/08/2026 she was looking in her purse and the money was missing. Resident stated that she kept the money in her purse, in bottom drawer of the dresser. Resident's room searched. Monies not located.On 1/20/26 at 2:24 PM, V7 Social Service Designee stated, R2 reported she had money and it went missing. They were not able to find the money or replace the money.R2's electronic medical record showed, her Minimum Data Set, dated [DATE] that she is cognitively intact. The facility's investigating incident of theft and/or misappropriation of resident property policy (no date) shows, Policy Interpretation and Implementation: .2. Misappropriation of resident property is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to thoroughly investigate an allegation of misappropriation of a resident's monies. This applies to 1 of 3 residents (R2) reviewed for misappropriation in the sample of 8. The findings include:On 1/20/26 at 11:55 AM, R2 stated, she had money stolen from the facility. The facility's reported incident report (no date) shows, R2 had money missing from her room. The same report continues to show, Several staff of varying departments and across all shifts were interviewed. No reports of questionable behavior reported. Cameras reviewed between the time Resident's son reportedly provided the $90.00 and the time of initial report. All staff that entered the room were assigned to the Resident. The times that each staff entered the room are appropriate for each staff's assigned responsibility. Staff that entered the room were interviewed, no concerns were identified. On 1/21/26 facility surveillance video footage from 1/6/26 starting at approximately 4:30 PM to 1/8/26 at approximately 8:30 AM was viewed with V16 Dietary Manager/IT and V15 Certified Nursing Assistant (CNA) Supervisor. The surveillance video footage was of R2's hallway. R2's room was visible and anyone who entered or exited the room could be seen in the video footage. During the timeframe viewed, 4 staff members (V17, V18, V19 and V20 all Certified Nursing Assistants (CNAs)) were seen entering R2's room when R2 was NOT in the room. On 1/21/26 at 11:21 AM, V7 Social Service Designee stated, she was the one who interviewed staff after R2 reported her money was missing. V15 CNA supervisor watched the surveillance video footage and did not tell her she saw anyone in the room when they shouldn't have been. She interviewed staff but only asked them a few questions. She was never told that V17, V18, V19 and V20 all CNAs were in R2's room when R2 was not so she did not ask any specific questions about why they were in her room during the timeframe R2's money went missing. On 1/21/26 at 11:21 AM, V15 CNA Supervisor stated, she watched the video footage but could not remember what she saw and needed to see the video again. This surveyor and V15 CNA supervisor watched some of the video footage again and V15 stated, she was just watching who was going in and out of the rooms but not when or if R2 was in the room or not. She also stated, everyone that went in the room was assigned to R2 so she didn't think anymore of it. She understood, they could have done a better investigation after viewing the video footage again. V17, V18 and V20 all CNAs typewritten interview forms show the following questions were asked: Have you heard or seen any inappropriate or questionable interactions between any of your residents and staff? Have you noticed that any change in the mood or demeanor of the residents you care for recently? Have you noticed that any of your co-workers are exhibiting signs of stress and or burnout? They all answered No to all three questions. The facility did not provide a typewritten statement for V19 CNA. None of the forms show, they were asked specifically why they were in R2's room when she was not and what they were doing. The facility's investigating incident of theft and/or misappropriation of resident property policy (no date) shows, Policy Statement: All reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview and record review the facility failed to ensure a resident with the diagnosis of dementia and known aggressive behaviors was cared for in a manner to prevent injury. This applies to 1 of 3 residents (R1) reviewed for dementia in the sample of 8. The findings include:R1's electronic medical records list his diagnoses to include: vascular dementia, major depressive disorder, cerebrovascular disease, chronic kidney disease, chronic obstructive pulmonary disease and benign prostatic hypertension. On 1/20/26 at 10:15 AM, R1 was sitting up in a reclining wheelchair in his room. He had a yellow, green and purple bruise under his right eye. A small red spot on the upper left side of his lip with some faint bruising to his chin. The spot appeared as if it was scabbed over and the scab recently fell off. R1 was very confused and incoherent. V3 R1's wife was in the room with R1. She stated, R1 got the bruising about a week prior. She had visited him on a Friday evening (1/9/26) and the facility called on 1/11/26 saying they found R1 with bruising to his right eye and a swollen lip. The facility was not sure how R1 received the injuries. The facility's reported incident (no date) for R1 shows, Incident Category: Bruise of unknown origin. Incident description: On the morning of 1/11/2026 staff reported that they identified bruising on Resident's face. Resident is unable to be interviewed related to impaired cognitive, memory and communication impairment. Final Description: On the morning of 01/11/2026 staff reported bruise of unknown origin. Nursing team reported that resident has bruising to face, hand and buttock. Resident has a diagnosis of Dementia, severe, end stage. Related to cognitive impairment, resident is unable to communicate effectively and often does not fully understand commands. Resident gave a nonsensical response when interview was attempted by SSD (social service designee). 2nd shift Nurse reported that resident was combative during evening care and that 2 staff were required to assist with his care. Nurse reported that she observed that resident did not have any bruising during her shift. 3rd shift CNA (V9 CNA-Certified Nursing Assistant) interviewed. She stated that resident was very combative during care. She stated that is was especially difficult to remove his shirt that was soiled. She reported that his arm kept getting stuck in his shirt. She stated that his arms were moving all over. She stated that she informed the nurse. She stated that when she completed a later bed check on resident, she did not observe any bruising; however, resident does lay in bed with covers over face. On 1/20/26 at 2:16 PM, V8 CNA stated, she worked a double on Saturday 1/10/26 (day and evening shift). She came back on 1/11/26 for day shift. She put R1 to bed on 1/10/26 and he did not have any bruising to his face. When she came back on Sunday (1/11/26) V9 CNA reported to her that when she was changing him overnight he some how bit his lip. She advised V9 CNA to not change R1 by herself because of his behaviors. V9 CNA did not report any bruising to R1's face to V8 CNA. When V8 CNA went to get R1 up she noticed he had a black eye and cut on his lip. She reported the injuries to the nurse. She continued to state, R1 can be combative, and she always has another person with her when she is caring for him which is why she told V9 CNA to get help when R1 is being combative. On 1/20/26 at 1:33 PM, V9 CNA stated, she worked with R1 on 3rd shift on 1/10/26. When she checked on R1 he had clothes on and they were soiled/wet. She had to change him out of his clothes. He was combative as he usually is. She stated, they were short a CNA so she did not stop and get help. She did report to the nurse that he was combative. She did not see any bruising on his face. She also stated, the facility suspended her following the incident. She has not returned to work since. On 1/20/26 at 1:23 PM, V12 Registered Nurse stated, she worked with R1 on 3rd shift on 1/10/26. V9 CNA reported to her that R1 was combative but nothing else. She did not give R1 any medication to help with his behaviors. On 1/20/26 at 10:15 AM, V4 Hospice Nurse Case Manager stated, R1 has been getting more combative with cares that last (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	couple of weeks. On Friday 1/9/26 they met with R1's family and had a care plan meeting. They discussed his behaviors and some tools to put in place to help. He has medication ordered that could be given to help and some other non-pharmacological interventions. She was aware of the bruising and stated, R1 can be aggressive when you are trying to care for him. She felt the staff needed more training on how to care for R1 with his dementia. They could give him medications or even re-approach later. R1's progress notes dated 1/9/26 shows, On 01/09/2026, this writer, SSD and DON (Director of Nursing), CNA supervisor, and Activity Director met with spouse/POA (power of attorney) and daughter, and hospice nurse case manager for a care plan meeting. Resident was unable to participate in meeting, related to cognitive impairment. Resident is also unable to communicate effectively and, although occasionally can put sentences together, most often speaks nonsensically. Reviewed resident's overall decline in cognition, ADLs (activities of daily living), and increase in agitation/behaviors, likely due to progressing Dementia. Hospice Nurse Case Manager confirmed that she has also observed these changes. Discussed strategies for staff approaches regarding care and comfort. Made medication changes. Family reported that they may bring in a recliner for his comfort. Staff are aware of non-pharm approach of Rubik's cube and resident pulling covers over his face for self-soothing. R1's progress notes dated 1/11/26 shows, early in morning I was told by the CNA, the resident has bruising bellow the right eye and lips swell. CNA stated she worked last night and she did not left him like that during my report the night shift nurse did not mention anything about this incident. She only said he was doing fine. (sic (statement is correct). R1's January medication administration record shows, he has an order for haloperidol (anti-anxiety) to be given every 6 hours as needed. The medication was ordered on 1/8/26 and has not been used since ordered. R1's care plan dated 1/9/26 shows, Problems/Strengths: Episodes of physical behaviors towards others as evidenced by resident gets agitated during the care, and becomes physical aggressive towards staff. Interventions: administer medications and monitor for side effects. When resident is showing physical behaviors attempt to refocus to positive behaviors. If appropriate, stop care when resident is agitated and try again later. The facility's dementia training policy dated 2026 shows, Policy Statement: Dementia poses unique challenges in long-term settings, necessitating specialized approaches to ensure residents receive the best possible support. Understanding the complexities of dementia and implementing person-centered care strategies are crucial for enhancing quality of life and well-being for those with dementia. Training new staff and ongoing training is essential to ensure the specialized care those with dementia need.