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	10/11/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure a resident's physician was notified when blood glucose levels were out of the set parameters ordered by the physician for 1 of 1 resident (R5) reviewed for blood glucose levels in the sample of 14. The findings include: R5's Physician's Orders, provided by the facility on 10/10/24, showed an order dated 5/21/24 for Accucheck (blood glucose check) twice daily. Call doctor if greater than 250 or less than 70. R5's Plan of Care, provided by the facility on 10/10/24, showed she has the potential for hyperglycemic or hypoglycemic (high and low blood glucose level episodes secondary to diabetes). The plan of care showed to Monitor blood sugar levels per MD/NP (Doctor/Nurse Practitioner) order, notify MD/NP of abnormal findings with follow up as indicated. R5's facility assessment dated [DATE] showed she had short-term and long-term memory problems, moderately impaired cognitive skills, was dependent on staff for all activities of daily living, except eating, and had a diagnosis of type II diabetes mellitus. R5's Blood Glucose Report from July 9, 2024, through October 9, 2024 were reviewed. The report showed the following days with blood glucose levels outside the parameters set by R5's physician: 7/15/24 290 7/16/24 281 7/17/24 288 7/20/24 270 7/21/24 301 8/5/24 322 8/13/24 371 9/1/24 321 9/23/24 292 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/8/24 318 10/9/24 273 On 10/9/24, R5's Nurse Progress notes and mediprocity notes (communication portal between the facility and the physicians/nurse practitioner) were requested for the above listed days. The notes showed no documentation of R5's doctor or the nurse practitioner being notified of R5's blood sugar levels on 7/15/24, 7/16/24, 7/17/24, 7/20/24, 9/1/24, 9/23/24, 10/8/24, or 10/9/24. On 10/10/24 at 8:20 AM, V1 (Administrator) was provided the list of days showing blood glucose levels out of the parameters order by R5's physician, and asked to show documentation that R5's Doctor or the NP (nurse practitioner) was notified. V1 said she thinks what was already provided is all they found; however they would keep looking. At 1:21 PM, V1 said no further information showing that the doctor or the nurse practitioner had been updated had been provided to her. At 1:58 PM, V1 said she spoke with the nurse's that were working on the days listed, to see if they could find any documentation. V1 said V2 (Director of Nursing-DON) and the nurses did not provide her with any further documentation than what she already provided this surveyor. V1 said she expects the nurse on duty to call the doctor, not use mediprocity to communicate, and to report blood glucose levels above 250 for R5, adding, that is what her orders say-to call the doctor. The facility's undated policy and procedure titled Hypoglycemia/Hyperglycemia showed, Hyperglycemia-resident: 1. Check the victim's [sic] capillary blood glucose level with an accu-check. Assess resident condition for signs and symptoms of hyperglycemia .2. Be aware of any infections, or changes that would be useful information to share with the physician. 3. Notify physician of condition change and follow orders .5. document condition, interventions and response in resident's record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to assess pressure wounds weekly for 2 of 4 residents (R23, R15) reviewed for pressure ulcers in the sample of 14. The findings include: 1. R23's face sheet showed he was admitted to the facility on [DATE]. R23's client diagnoses report printed 10/10/24 showed R23 had diagnoses of orthopedic aftercare following surgical amputation, atrial fibrillation, atherosclerotic heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, and Alzheimer's disease. R23's care plan initiated 6/26/24 showed, Resident has a Stage 3 Pressure Injury to right hip . Observe for changes in pressure ulcer, report to MD if there is an increase in size or stage and follow up as indicated . R23's 6/25/24 wound assessment showed a wound to R23's right hip was identified on 6/24/24 and the first assessment was completed 6/25/24. R23's next wound assessments were completed as follows: 7/7/24 (11 days between assessments), 7/31/24 (24 days between assessments), 8/9/24 (9 days between assessments), 8/28/24 (19 days between assessments), 9/8/24 (12 days between assessments), 9/17/24 (9 days between assessments), and 9/29/24 (12 days between assessments). On 10/09/24 at 1:59 PM, V4 (Wound Care Nurse) said, I usually do the measuring once a week. I document on paper sheets and we scan them into the residents record under documents. If am off like I was this summer, our Infection Preventionist nurse did them. They would all be in the record under documents. I do weekly assessments monitor the progress of the wound and see if there is anything that needs to be changed. [R23]'s wound assessments were done 6/25/24, 7/7/24, 7/31/24, 8/9/24, 8/28/24, 9/8/24, 9/17/24, 9/29/24, and 10/6/24. On 10/10/24 at 9:27 AM, V2 DON (Director of Nursing) said they typically assess and measure wounds weekly. [V4] does them but if she is not here our floor nurses are very good with wounds too and we ask the floor nurse to measure. The facility's undated policy titled Wound Management Policy showed, Responsibility: Charge Nurse, or Director of Nursing or designee . Residents with pressure sores, skin lesions/wounds will be monitored and documented . 34491 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R15's Client Diagnostic Report, provided by the facility on 10/10/24 showed she had diagnoses including, but not limited to, chronic diastolic (congestive heart failure, chronic kidney disease, venous insufficiency, anemia, ulcerative (chronic) pancolitis, diarrhea, acute kidney failure, essential tremor, Alzheimer's disease, and dementia. R15's facility assessment dated [DATE] showed she had short-term and long-term memory problems, and moderate cognitive impairment. The assessment showed R15 was dependent on staff for toileting and bathing and was at risk of developing pressure injuries. R15's Physician's Orders show apply calmoseptine to buttocks and coccyx twice daily for protection. The orders also show Proheal (protein supplement) Give 30 milliliters twice daily to support improved skin integrity. R15's Plan of Care, provided by the facility on 10/10/24 showed she is at risk for skin breakdown related to bowel/bladder incontinence. The plan of care showed to monitor the skin for any changes i.e. dry spots, red areas. The plan of care showed R15 needs extensive assistance with two staff for bed mobility and toilet use related to weakness and deconditioning. On 10/10/24 at 9:59 AM, incontinence care was observed for R15. R15 had dark discoloration on both her left and right buttocks that blanched when pressure was applied during care. No open areas were observed during care. The untitled document provided by the facility on 10/10/24, showed on 7/21/24 six open areas were identified on R15's left buttocks (3), right buttocks (2) and coccyx area (1). The document showed the open areas were all stage II pressure injuries. R15's wound assessments were reviewed showing assessments were completed on 7/21/24 and 7/24/24. R15's progress notes showed she had been sent out to the hospital on 7/24/24 (not related to the pressure injuries) and returned to the facility on [DATE]. The next assessment provided by the facility of R15's wounds was on 7/31/24. There was no assessment provided by the facility to show any assessments done on R15's pressure wounds, after the 7/31/24 assessment until 8/13/24 (13 days later). The next assessment provided by the facility for R15's pressure wounds was on 8/29/24 (16 days later). The next assessment provided by the facility of R15's pressure wounds was on 9/8/24 (10 days later). the next assessment provided by the facility of R15's pressure wounds was on 9/17/24 (9 days later). The next assessment provided by the facility of R15's pressure wounds was on 9/30/24 (13 days later). R15's Interdisciplinary Progress Notes (IPN) and Mediprocity Notes (communication portal between the facility and the doctors/nurse practitioner) were reviewed from 7/21/24 through 9/30/24. Assessments for R15's pressure wounds in Mediprocity Notes were on 7/21/24, 7/31/24, 8/13/24. There were no wound assessments in R15's Interdisciplinary Progress Notes, other than to document when one of the six pressure wounds was resolved. The other existing wound assessments were not documented on those days in the IPN notes. On 10/10/24 at 9:03 AM, V4 (RN/Wound Nurse) said R15 had bad diarrhea and she thinks that contributed to the skin breakdown. V4 said R15 was sent out to the hospital on 7/24/24 and returned to the facility on [DATE]. V4 said the six pressure injuries were identified on 7/21/24. V4 said interventions had been in place prior to R15 developing the pressure injuries. V4 said she had been on vacation from 7/13/24-8/25/24. V1 (Administrator) was present during the interview and at 9:14 AM, she said R15 had high comorbidities. V1 said R15 had a decline at the time she developed the pressure injuries. V1 (Administrator) said R15 was sent out to the hospital and came back to the facility more deconditioned than when she left. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 9:26 AM, V4 said It does not look the assessments were done weekly after they were identified. It is important to make sure they are done to monitor progress and deterioration of the wound, and to update the Doctor, to see if new orders are needed. This surveyor requested a copy of all the assessments for the pressure injuries for R15 from 7/21/24-9/30/24 (when the last of the pressure injuries were resolved). On 10/10/24 at 10:44 AM, V1 (Administrator) brought the assessments for R15's pressure injuries to her buttocks/coccyx areas. The assessments provided to surveyor were dated: 7/21/24; 7/24/24; 7/31/24; 8/13/24; 8/29/24; 9/8/24; 9/17/24; and 9/30/24. On 10/10/24 at 1:21 PM, V1 said she believes she has provided all of the assessments that the facility has to provide for R15's pressure injuries. The facility's undated policy and procedure titled Wound Management Policy showed Residents with pressure sores, skin lesions/wounds will be monitored and documented. The policy showed 3. Documentation of pressure sores and other skin conditions must include A. Characteristics (i.e. size, shape, depth, color, slough, presence of granulation tissue, necrotic (non-viable skin) tissue). B. Treatment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34491 Based on observation, interview and record review, the facility failed to ensure staff covered an open wound, and failed to ensure food was prepared and served in a sanitary manner. These failures have the potential to affect all of the residents in the facility. The findings include: The CMS Long-Term Care Facility Application for Medicare and Medicaid form CMS-671 dated 10/8/24 showed 39 residents resided in the facility. The facility's undated list of residents' Diet Orders, provided by the facility on 10/10/24 showed all 39 residents take food by mouth. No residents on the list had a feeding tube. On 10/8/24 at 9:57 AM, V6 (Dietary Manager) was preparing the lunch meal. V6 said he and V12 (Cook) were both preparing the lunch meal. V6 had an open wound to his right inner forearm that was not covered. There was a small smear next to the open wound that appeared to be blood. At 12:11 PM V6 obtained the food temperatures prior to serving. V6 still had the open wound uncovered. At 12:27 PM, V6 was asked about the wound on his right inner forearm. V6 said he scratched himself on something. V6 was asked what the facility's policy was on open wounds, and if he should cover the area. V6 said he could cover it. On 10/8/24 at 12:11 PM, V12 (Cook) was asked to take the temperatures of the foods on the steam table. V6 (Dietary Manager) walked up and said he (V6) would check the food temperatures. V6 grabbed a sanitation bucket and placed in on the steam table. V6 picked up the food thermometer and dipped it into the sanitation bucket, then ran the thermometer across the washcloth that was on the side of the sanitation bucket. V6 took the temperatures of the 5 different chicken food consistencies, then dipped the thermometer back into the sanitation bucket and ran the thermometer across the washcloth. V6 took the temperatures of the regular noodles and the pureed noodles and then dipped the thermometer back into the sanitation bucket and across the washcloth. V6 repeated this process to clean the thermometer 4 more times in between different food items. On 10/08/24 At 12:24 PM, V6 was asked to test the chemical sanitation level in the sanitation bucket. V6 used a Hydrion QT-40 test strip to test the sanitation level. The test strip was yellow after dipping into the bucket. V6 said the test result was between 150 ppm (parts per million) and 200 ppm. V6 was asked if he was sure about that because the test strip was yellow. V6 insisted that the results were between 150 ppm (parts per million)-200 ppm, adding that he could see a hint of green on the test strip. V7 (dietary aide) was walking by. This surveyor asked V6 if V7 had worked at the facility a long time. V6 said yes. V7 was asked to look at the test strip that V6 had against the test strip container, and asked if it looked light green in color, or close to the 150 ppm color. V7 said No, not at all, it is yellow. (For reference: The first color on the chart to compare the test strip to is orange, which is zero ppm; the second color on the chart is a light green, which is 150 ppm; the remaining three colors on the chart are darker shades of green showing 200 ppm-500 ppm of chemical sanitation). (continued on next page)

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	146066	A. Building B. Wing	10/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/10/24 at 9:41 AM, V6 was said the facility's policy for open wound is to have the wound covered while working. Needs to be covered without draining. V6 said he did not have the area on his arm covered the other day. V6 said he should have had it covered to make sure that no bodily fluids contaminate the area or the food. At 9:46 AM, V6 was asked about dipping the thermometer into the sanitation bucket to clean between taking the temperatures of the food items on the steam table on 10/8/24. V6 said in previous inspections the facility used alcohol wipes for cleaning the thermometer and was advised to do it differently. V6 said that was years ago, so we went to using the sanitation bucket with quat (quaternary Ammonium Compound) sanitizer. V6 said he should have checked the sanitation level of the bucket prior to using. On 10/10/24 the facility provided their undated policy and procedure titled Quat Sanitizer Testing Policy. the policy showed Quat sanitizing solution dispenser will be tested daily by dietary manager .Quat sanitizer solution for surface sanitizing will be changed every four hours or when visibly soiled to assure effective concentration. The facility also provided instructions for the hydrion QT-40 test strip. The instructions showed EPA-registered sanitizer for use on hard, non-porous food prep surfaces and wares, kills foodborne organisms as listed on product label. The instructions showed uses for the sanitizer were for a three-comparment sink sanitizer and food contact surface sanitizer. The facility's undated policy titled Dietary Staff Wound Policy showed Dietary staff will cover any open wound with adequate dressing to avoid contact and/or seepage. Additional coverage may be required and provided dependent on location of wound, i.e. finger cut, wrapping, etc.

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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** 34491 Based on observation, interview, and record review the facility failed to perform incontinence care in a manner to prevent cross contamination (R15), failed to initiate enhanced barrier precautions for a resident with an indwelling catheter and open wounds (R25), and failed to administer medications in a manner to prevent cross contamination (R18) for 3 of 3 residents (R15, R25, and R18) reviewed for infection control in the sample of 14. The findings include: 1. R15's Client Diagnostic Report, provided by the facility on 10/10/24 showed she had diagnoses including, but not limited to, chronic diastolic (congestive heart failure, chronic kidney disease, venous insufficiency, anemia, ulcerative (chronic) pancolitis, diarrhea, acute kidney failure, essential tremor, Alzheimer's disease, and dementia. R15's facility assessment dated [DATE] showed she had short-term and long-term memory problems, and moderate cognitive impairment. The assessment showed R15 was dependent on staff for toileting and bathing and was at risk of developing pressure injuries. R15's Physician's Orders show apply calmoseptine to buttocks and coccyx twice daily for protection. The orders also show Proheal (protein supplement) Give 30 milliliters twice daily to support improved skin integrity. R15's Plan of Care, provided by the facility on 10/10/24 showed she is at risk for skin breakdown related to bowel/bladder incontinence. The plan of care showed to monitor the skin for any changes i.e., dry spots, red areas. The plan of care showed R15 needs extensive assistance with two staff for bed mobility and toilet use related to weakness and deconditioning. On 10/10/24 at 9:59 AM, V10 and V11 (Certified Nursing Assistants-CNAs) provided incontinence care for R15. V10 and V11 rolled R15 onto her right side to remove her pants and incontinent brief. Stool was observed above the top of R15's brief in the back. V10 and V11 rolled R15 onto her back side and removed the soiled brief. non-formed liquid stool was also observed in R15's pubic and groin areas. V10 used a wet wipe to wipe across R15's pubic area, then down her left groin area in one motion. V10 grabbed another wet wipe and wipe R15's pubic area, then down her right groin in one motion. V10 grabbed a wet wipe and wiped R15's left groin, then her vaginal area using the same wet wipe, the same side of the wipe. V10 and V11 rolled R15 back onto her right side. V10 grabbed a few wet wipes from the package and wiped the stool from R15 in a back to front motion. repeating this direction two more times using the same wet wipes. At 10:19 AM, V11 was asked if she would have done anything different during care. V11 said she she would have used a different wipe for each area, and she would have wiped front to back, not back to front to prevent cross-contamination and prevent infection. At 10:23 AM, V10 said she should have used a clean wipe for each area, and she should have wiped front to back, so she did not spread bacteria to the opening of R15's vaginal area. The facility's undated policy and procedure titled Perineal Care showed Prolonged exposure to urine and feces produces excessive hydration of the sin which causes increased coefficient of friction, increased epidermal permeability and increased microbial flora. the interaction of urine and feces increases the ph of the skin. All these factors compromise skin integrity/Infections. The policy and procedure showed Procedure: Wash all areas that may come in contact with urine and/or stool. Wash with soap and water. Wipe skin gently using a front to back motion. Repeat if necessary. Always remember that when you touch dirty, you must change your gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31615 2. R25's record of admission shows she was admitted to the facility on [DATE]. Her physician order sheet for October 2024 shows an order for a right heel wound dressing daily, and an indwelling catheter. The orders do not include enhanced barrier precautions. On 10/8/24, R25 was observed sitting in her room with her husband. Her wheelchair had a catheter drainage dignity bag hanging below her seat. The door to her room did not have any signs for enhanced barrier or contact isolation requirements. R25's husband stated there was a catheter present, and a wound to R25's foot. On 10/10/24 at 9:14 AM V9 CNA said she was responsible for R25's care for her shift. She said R25 was not on any type of isolation, and she did not need to put on any PPE (Personal Protective Equipment) such as a gown. She said R25 has an indwelling catheter and is changed to a leg bag everyday. V9 went to the desk to refer to a list of residents and isolation requirements, and said R25 was not on the list. On 10/10/24 at 10:30 AM, V1 said the doctors will determine what type of isolation a resident requires. We do have enhanced barrier precautions, we went ahead and placed residents on contact isolation, such as those with wounds and catheters. The facility's undated policy for Enhanced Barrier Precautions documents it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wound (such as pressure ulcers) and/or indwelling medical devices (e.g. urinary catheters) even if the resident is not known to be infected or colonized with a MDRO (Multi-drug-resistant organism). 38488 3. R18's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include congestive heart failure, Type 2 Diabetes, hyperlipidemia, and hypertension. On 10/10/24 at 8:16 AM, V5 LPN (Licensed Practical Nurse) was passing medications in the dining room. V5 was preparing R18's medications at the cart. V5 pushed each individual medication from the residents medication card directly into her hand and then dropped the pills into the medication cup. On 10/10/24 at 9:21 AM, V2 DON (Director of Nursing) said the nurses should never touch any medication, it should be put directly into the medication cup because you never know what is on your hands. The facility's undated policy and procedure titled Medication Administration showed, . 12. Remove medication from source, taking care not to touch medication with bare hand .