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	12/10/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure bed hold notices were provided for 2 residents (R1, R38) and failed to notify the ombudsman of resident transfers and discharges for 3 of 3 residents (R1, R38, R40) reviewed for discharge requirements in the sample of 12. The findings include: R38's face sheet and transfer packet shows he was transferred from the facility to the hospital on [DATE]. R38 did not return to the facility he was discharged to another placement. There is no bed hold or documentation in his electronic medical record (EMR) that one was provided on transfer or during hospitalization to R38 or to his representative. There is no documentation in the EMR that V14 (Ombudsman) was notified of his transfer or discharge. R40's face sheet and discharge summary shows he was a planned discharge from the facility on [DATE]. There is no documentation showing V14 was notified of his discharge. R1's facesheet and transfer packet shows she was transferred from the facility to the hospital on [DATE]. There is no documentation that a bed hold was provided to R1 or to her representative during or after the transfer, and no documentation that V14 was notified of R1's transfer. On [DATE] at 8:22 AM, V14 said facilities should be notifying the ombudsman program with resident discharges and this facility is one that has not be doing so. On [DATE] at 11:58 AM, V6 (Social Services) said she has not been notifying the Ombudsman office of resident transfers or discharges because she was not aware she was suppose to do so. V6 said V5 (admission Liason) is the person who speaks with the hospital after a resident is transferred so she is not sure if she provides any additional documentation or bed hold notices after they are transferred. V6 confirmed that R1 had been transferred to the hospital and did not return she later expired in the hospital, R38 was transferred from the hospital to another placement with his family and R40 was a planned discharge from the facility. On [DATE] at 12:07 PM, V2 (Director Of Nursing) said nursing does not send out bed hold notices on transfer and they also do not notify the Ombudsman of any discharges or transfers. V2 said she was unaware if anyone else in the facility, if V5 does or not. On [DATE] at 12:13 PM, V5 said she is not directly involved at the time of a resident transfer. V5 said she does follow up calls once a resident is in the hospital. V5 confirmed that no additional bed hold is sent because the residents receive a copy in their admission contract. V5 also said she do not send anything to V14. On [DATE] at 2:48 PM, V1 (Administrator) said bed holds are given to residents on admit to the facility. V1 also said she was unaware that the notices should be sent to the Ombudsman for all transfers and discharges and there is no facility policy for Ombudsman notification. The facility provided and not dated Bed Hold policy explains what the bed hold policy is, but does not address when an actual copy of the bed hold should be provided to a resident or their representative. The facility was unable to provide a policy on Ombudsman notifications.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) care was provided timely for a resident that requires assistance for one of 12 residents (R32) reviewed for ADL care in the sample of 12.The findings include:R32's Record of admission shows she was admitted to the facility on [DATE].R32's Physician Orders show she was admitted to the facility with diagnoses including anorexia, polyarthritis, excoriation disorder, difficulty walking, and paranoid schizophrenia.On December 8, 2025, at 11:20 AM, V9 Certified Nursing Assistant (CNA) stood R32 up via the mechanical stand lift. There was a large wet circle to the back of R32's pants. V9 placed R32 onto the toilet and removed R32's incontinence brief. R32 had a thick disposable incontinence pad plus an incontinence brief on. Both the pad and the brief were saturated with urine. There was a strong urine smell. V9 said that R32 has an incontinence pad and incontinence brief on because R32 is a heavy wetter. V9 said R32 has been up in her wheelchair since about 8:00 AM.R32's Care plan effective September 20, 2025, shows she is at risk for skin breakdown related to bowel and bladder incontinence. Make sure resident is clean and dry, changed as needed.On December 9, 2025, at 11:29 AM, V12 CNA said incontinence care should be done at least every two hours and as needed. V12 said residents should only have on one incontinence brief on at a time. V12 said if a resident is a heavy wetter, then they should be checked and changed more often.The facility's Activities of Daily Living (ADLs) policy not dated shows, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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** Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for a resident with a pressure injury for one of two residents (R3) reviewed for pressure injuries in the sample of 12.The findings include:R3's Record of admission shows she was admitted to the facility on [DATE]. R3's Diagnoses Report shows she was admitted with diagnoses including sepsis, urinary tract infection, dementia, and pressure injury of sacral region.R3's Potential for skin breakdown assessment dated [DATE], shows she is a high risk for pressure injuries. R3 has an air mattress.R3's Physician Orders dated December 1, 2025-December 31, 2025, shows orders for waffle boots while in bed.R3's Care plan dated December 9, 2025, shows, Encourage resident to float heels while in bed and air mattress in bed.R3's Weekly Wound Assessment and Summary dated December 5, 2025, shows she has two stage 4 pressure injuries to her sacrum. These assessments show that R3 uses a low air loss mattress in bed. On December 8, 2025, at 1:03 PM, V9 and V10 Certified Nursing Assistants (CNAs) used a mechanical lift to put R3 into her bed. There was a dressing in place to R3's sacrum. There was a pump hooked up to the foot of R3's bed. The pump was not on. R3's feet were placed onto the mattress. At 1:38 PM, R3's air mattress pump was still off. V10 CNA went into R3's room to look at the mattress pump. V10 turned the air mattress pump on, and it made a loud noise. V10 said she did not know what was wrong with R3's air mattress and shut it off. V10 said she will notify maintenance to come look at the mattress. R3's air mattress was still shut off at 2:38 PM and R3 was asleep in bed.On December 9, 2025, at 11:29 AM, V12 CNA said pressure injury prevention interventions include repositioning, laying down, air mattresses, and elevating the residents' feet. At 11:35 AM, there were waffle boots on R3's floor on the side of her recliner.The facility's Wound Care Policy undated shows, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.

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F 0689 Level of Harm - Minimal harm or potential for 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 supervise a resident with a high risk of falls and a history of falls for 1 of 12 residents (R2) reviewed for safety and supervision in the sample of 12.The findings include:R2's Record of admission shows she was admitted to the facility June 7, 2024. R2's Client Diagnosis Report shows she has diagnoses including depression, dysphagia, major depressive disorder, urinary tract infection, dementia, and nondisplaced fracture of lateral malleolus.R2's Fall Incidences shows that she fell five times in the last four months. R2's Fall Risk assessment dated [DATE], shows she is at risk for falls.R2's Care Plan effective October 30, 2025, shows R2 is at risk for falls and R2 self-transfers at times. Alarms on chair and bed to alert staff of unplanned movement and will receive oversight assistance with transfers to reduce the risk of falls.On December 8, 2025, at 1:33 PM there was a chair alarm going off in R2's room. V16 Certified Nursing Assistant (CNA) went into R2 room. R2 was transferring herself from her wheelchair to the toilet. V16 told R2 she's not supposed to get up on her own and R2 said she has to go to the bathroom. V16 shut off R2's alarm and then left R2's room after shutting R2's bedroom door (leaving R2 alone in the bathroom). On December 9, 2025, at 11:29 AM, V12 CNA said that R2 should not be left in her bathroom alone. V12 said that R2 does not always remember to use the call light.The facility's Fall Prevention Policy revised on January 12, 2023, shows, Interventions will be implemented for those residents assessed at risk for falls. These measures will be documented in the Plan of Care.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer medications as ordered. There were 28 opportunities with three errors resulting in a 10.71% error rate. This applies to two of five residents (R30, R24) observed in the medication pass. The findings include:1. R30's Record of admission shows she was admitted to the facility on [DATE].R30's Client Diagnosis Report shows she was admitted to the facility with diagnoses including dementia, alcohol use with alcohol induced persisting dementia, anemia, hypertensive heart and chronic kidney disease with heart failure, moderate protein malnutrition, Alzheimer's disease, major depressive disorder, delusional disorder, hypokalemia, anorexia, and dementia.R30's Medication Record dated December 1, 2025-December 31, 2025 shows orders for phosphorus/potassium/sodium give one packet by mouth four times daily at 8:00 AM, 12:00 PM, 5:00 PM, and 8:00 PM and calcium 600 mg (milligrams) + vitamin D3 20 mcg (micrograms) daily.On December 8, 2025, at 10:34 AM, V11 Licensed Practical Nurse (LPN) was preparing medications to administer to R30. V11 administered calcium 600 mg + vitamin D3 10 mcg. (Order was for calcium 600 mg + vitamin D3 20 mcg). V11 also administered R30's 8:00 AM dose of phosphorus/potassium/sodium at 10:34 AM. 2. R24's Record of admission shows she was admitted to the facility on [DATE].R24's Client Diagnosis Report shows she was admitted to the facility with diagnoses including traumatic subdural hemorrhage, atrial fibrillation, Alzheimer's disease, anorexia, dementia, anxiety disorder, major depressive disorder, osteoarthritis, delusional disorders, and poly-osteoarthritis.R24's Medication Record dated December 1, 2025-December 31, 2025, shows acetaminophen 325 mg give 650 mg by mouth three times per day at 8:00 AM, 12:00 PM, and 5:00 PM. On December 8, 2025, at 10:20 AM, V11 LPN administered R24's 8:00 AM scheduled dose of acetaminophen. R24's next scheduled dose was at 12:00 PM.The facility's Medication Administration Policy not dated shows, Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes of scheduled time.