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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C IL6000103 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE **ALDEN DEBES REHAB & HCC** ROCKFORD, IL 61108 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation: 2313633/IL159373 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b)4) 300.1210d)6) 300.2090b) 300.2090c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for **Nursing and Personal Care** b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing Attachment A care and personal care shall be provided to each Statement of Licensure Violations resident to meet the total nursing and personal care needs of the resident.

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

(X3) DATE SURVEY

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	<del></del>	COM	LETED
		IL6000103	B. WING		05/0	)4/2023
	PROVIDER OR SUPPLIER	550 SOUT	DRESS, CITY, ST H MULFORD RD, IL 61108	TATE, ZIP CODE  AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	4) All nursing poencourage resident in activities of daily circumstances of the demonstrate that didenonstrate speech functional community who is unable to cashall receive the segood nutrition, grood didenonstrate shall include, and shall be practice seven-day-a-week left of the second assure that the reas free of accident nursing personnel second in the second second shall be practiced.	ersonnel shall assist and as so that a resident's abilities living do not diminish unless e individual's clinical condition minution was unavoidable. sident's abilities to bathe, ransfer and ambulate; toilet, n, language, or other cation systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene.	S9999			
± €	b) Foods shall be proper temperature individual needs.  c) All residents shor multi-purpose rowith a temporary illrivalid reasons.  This REQUIREMENT	food Preparation and Service attractively served at the s and in a form to meet all be served in a dining room om except for an individual ness, who is too ill, or for other all to the served in a dining room on except for an individual ness, who is too ill, or for other all to the served in a dining room on except for an individual ness, who is too ill, or for other all to the served in a dining room on, interview, and record				

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING	·			
		IL6000103	B. WING	VING 05/			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
ALDEN	DEBES REHAB & HCC	ī	'H MULFOR RD, IL 6110				
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
S9999	resident with a hot t reviewed for safety of 5. This failure re	ge 2 illed to supervise a confused ray for 1 of 3 residents (R1) and supervision in the sample sulted with the resident second degree burns to her	S9999				
M.	to the facility on 2/2 diagnoses including R1's 4/5/23 quarterl has severe cognitive extensive assistance mobility and transfermals also requires supernafter setting up her R1's nursing progre PM documents R1 I hot bouillon broth an next to the bed and attempted to drink the neck and chest area of the neck to center to the second to the	ord shows she was admitted 0/2017 with multiple 1 schizophrenia and dementia. 2 y assessment documents she impairment. She requires e of two persons for bed 1 rs between surfaces. She wision with eating and drinking tray.  Se notes for 2/27/23 at 6:29 and a dinner tray containing and was at on the bedside table she was laying down and the broth and spilled on her a. The area was the right side repart of her chest just above					
	On 5/4/23 at 10:30 At the incident or if she the burn. She said Assistant/CNA) help morning. She had hand she needs to si or drink. R1 was obgeriatric chair with a She reached out an	was red in color with a small ling noted.  AM, R1 said she did not recall the had any pain associated with V4 (Certified Nursing sed her with breakfast this not coffee but not too hot. It up straight in the bed to eat eserved sitting up in her a bedside table next to her. It do picked up her coffee cup was able to drink on her own.		. 2			

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CONIF	CETED	
		IL6000103	B. WING		1 '	C 05/04/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ALDEN	DEBES REHAB & HC	~	TH MULFOR				
		ROCKFO	RD, IL 6110		<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
\$9999	Continued From pa	nge 3	S9999				
				*)		1	
	On 5/4/23 at 10:30	, V4 said R1 needs to be				1.6	
	sitting up straight ir	bed to eat or drink, and the					
		the bedside table in front of					
		has foods or liquids that are					
		ould be held back until it is		22	=	173	
	and grab at the tray	use she is able to reach out				140	
	and grap at the tray	<b>y.</b>		==			
	On 5/4/23 at 2:10 F	PM, V10 (CNA) said on the					
		she was passing meal trays	- 8				
	and placed R1's tra	ay on the bedside table. She				1	
= 3	thought the tray wa	is out of R1's reach. She said					
		at a distance because R1	8				
		n when she is eating and				*1);	
		in an upright position in bed.					
(8)		ter placing the tray in R1's ar a voice calling out for the					
		R1 had somehow reached out,		5.0			
že:		and had spilled it over herself.					
		passing all the trays to the					
		ned on returning to R1 to assist					
		but she had already grabbed					
	and spilled her sou	p before she could get back to		200			
	her.					1	
	0- 5/4/00 40-45	ANA ME /Desistered					
	On 5/4/23 at 10:45	AM, V5 (Registered can feed herself, after she is					
		up in the bed or chair. She		1	**		
		of 2/27/23 occurring at the		E		10	
		he could hear a voice yelling				<u>=</u>	
		she found R1 in bed calling		100			
	out. V5 said R1 ha	ad reached out and grabbed					
		meal tray and spilled it over					
		upon assessment the skin		·2"			
		no open areas were visible and					
	no blistering.			20			
	0-010100 1444 (11	Desettioner de sum este					
		urse Practitioner) documents ing a nursing report of a new				1.1	

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPL	COMPLETED		
	17	IL6000103	B. WING	N			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
ALDEN	ALDEN DEBES REHAB & HCC 550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	and spilled her sough for it off her tray. The have a first degree burn on her anterior open with pink area.  The facility's 9/2020 documents 4. To as receives the amounts.	urred when she was in bed o onto her chest. She reached he assessment shows R1 to and area of second degree r (front) chest, blistered and	S9999				
	"B"	19 (3)			15 E		
			28			×	
a l						SE(	

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