

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0044909</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>01/21/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALDEN PARK STRATHMOOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5668 STRATHMOOR DRIVE , ROCKFORD, Illinois, 61107</b>                        |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                        | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         | S0000               |                                                                                                                          |  |                                                 |  |
|                                                              | Complaint Investigation 2610869 / 2721301                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     |                                                                                                                          |  |                                                 |  |
| S9999                                                        | Final Observations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |
|                                                              | Statement of Licensure Violations:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.610a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.1010h)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.1210b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | Section 300.610 Resident Care Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall be<br>formulated by a Resident Care Policy Committee<br>consisting of at least the administrator, the advisory<br>physician or the medical advisory committee, and<br>representatives of nursing and other services in the<br>facility. The policies shall comply with the Act and<br>this Part. The written policies shall be followed in<br>operating the facility and shall be reviewed at least<br>annually by this committee, documented by written,<br>signed and dated minutes of the meeting. |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | Section 300.1010 Medical Care Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | h) The facility shall notify the resident's physician<br>of any accident, injury, or significant change in a<br>resident's condition that threatens the health, safety<br>or welfare of a resident, including, but not limited<br>to, the presence of incipient or manifest decubitus<br>ulcers or a weight loss or gain of five percent or more<br>within a period of 30 days. The facility shall obtain<br>and record the physician's plan of care for the care or<br>treatment of such accident, injury or change in<br>condition at the time of notification.                                                                                                 |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | Section 300.1210 General Requirements for Nursing and<br>Personal Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | b) The facility shall provide the necessary care and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         |                     |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

|                                                                       |       |           |
|-----------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|-----------------------------------------------------------------------|-------|-----------|

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0044909</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>01/21/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALDEN PARK STRATHMOOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5668 STRATHMOOR DRIVE , ROCKFORD, Illinois, 61107</b>                        |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 1<br/>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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to notify a resident's physician and Registered Dietician regarding a significant weight loss. This failure resulted in R2 experiencing a 28.6lb weight loss within a 2 week period with no nutritional interventions for 5 days. This applies to 1 of 3 residents reviewed for nutrition in the sample of 6.</p> <p>The findings include:</p> <p>R2's electronic face sheet, printed on 1/21/26, showed R2 was admitted to the facility on 12/18/25, and has diagnoses including but not limited to encephalopathy, acute respiratory failure with hypoxia, emphysema, and epilepsy.</p> <p>R2's facility assessment, dated 12/25/25, showed R2 has severe cognitive impairment and requires enteral tube feeding.</p> <p>R2's mini nutritional assessment performed by V9 (Registered Dietician), dated 12/19/25, showed R2 is "malnourished."</p> <p>R2's weight log showed the following weights, "12/24/25 121.4lbs, 1/2/26, 96.9lbs, 1/7/26 94lbs, 1/15/26 92.8lbs.", reflecting a significant weight loss of 20% within a 2 week period.</p> <p>R2's nursing progress notes, dated 1/7/26, showed, "Nurse called power of attorney (POA) and updated on weight loss and plans to increase his tube feeding volume and rate. POA was under the impression he was on a continuous feed. Nurse let her know that he is on a total volume and once that is reached he is done with feeding until the restart in the evening. POA understood and was ok with that..."</p> <p>R2's tube feeding assessment performed by V9 (Registered Dietician/RD), dated 1/21/26, showed, "1/15 92.8, BMI 13, IBW (ideal body weight) 170 +/- 5%. Weight loss noted and discussed in IDT</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0044909</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>01/21/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALDEN PARK STRATHMOOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5668 STRATHMOOR DRIVE , ROCKFORD, Illinois, 61107</b>                        |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 2<br/>(Interdisciplinary Team) weight meeting. Tube feeding formula switched to Glucerna 1.5 to provide additional calories. Weight stability/gradual weight gain desired. Caloric needs estimated to encourage weight goals..."</p> <p>On 1/21/26 at 12:41PM, V2 (Director of Nursing) stated, "Our documentation system triggers when there is a significant weight gain/loss. We do weight meetings on Thursdays every week and we talk about everyone that has triggered. Our Dietician, Food Service Director, nursing, and unit manager sit in on the meeting. It should be in the progress notes that there was a weight issue, and it was addressed. If there is a continuous weight loss sometimes, we will do weekly weights, but it's whatever the Dietician recommends or the physician recommends. Tube feedings are the same, there is no "standard" we do for them. We do whatever the recommendation is. (R2) is a pretty sick resident, he has some wounds and has had significant weight loss. We have addressed his significant weight loss in one of our meetings and we have been trying to get family to sign him onto hospice. The day the weights are noted to be significant is when we (management) should be notified so we can notify the Nurse Practitioner and Dietician and get recommendations." At 2:04PM, V2 stated, "(R2) has had some weight fluctuations. He had a new colostomy and now the size has reduced to its normal size. No, I don't think that is the reason for his significant weight change. When there is a weight change the staff are supposed to be notifying the Dietician and physician right away, not days later. We need to act quickly for our residents who are vulnerable to additional weight loss to prevent any further deterioration of their condition. A resident on tube feeding is very high risk for weight fluctuations and should be monitored closely for weight changes."</p> <p>On 1/21/26 at 2:31PM, V9, RD, stated, "We sometimes have people that have fluid related weight loss but (R2) did not have any excess fluid on him. Once a week, I pull the weight and vitals exception report, and we address all of the weight issues in our weight meeting. If a resident has a quarterly or annual assessment, sometimes it will get put in one big note for the notes from the weight meetings, otherwise it should be documented as its own progress note. I was not notified of (R2's) weight loss until I pulled the weight report on 1/7/26 prior to our 1/8 weight meeting. I don't always get notified for a significant weight loss, sometimes I just see it on the report when I pull it. It would be preferable for me to be notified of a weight change, but I also understand when it does not happen because they are busy. I have (R2's) caloric needs calculated as of his weight right now to help</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0044909</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>01/21/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALDEN PARK STRATHMOOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5668 STRATHMOOR DRIVE , ROCKFORD, Illinois, 61107</b>                        |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 3<br/>encourage weight gain. If he continues to tolerate the formula and the rate he's been getting, I can hopefully increase it and help him gain at least some of the weight back. The sooner we start interventions, the better our chances are to get the residents to gain weight back. I do not think that any of (R2's) weights have been inaccurate up to this point in his stay at the facility."</p> <p>The facility's policy titled, "Nutrition Care Significant Weight Loss", dated 1/18, showed, "Residents with a significant weight loss will be assessed by the Licensed Dietician...to reduce the risk of malnutrition...2. A significant weight loss is 5% in one month, 7 1/2% in 3 months and 10% in 6 months..."</p> <p>(B)</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |