PRINTED: 05/27/2021 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				·	C		
IL6000103		B. WING		03/18/2021			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ALDEN	DEBES REHAB & HCC		TH MULFOR RD, IL 6110				
(X4) ID							
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE		
S 000	Initial Comments		S 000			-	
	Facility Reported Inc	cident IL#6000103			n.		
S9999	9999 Final Observations		\$9999				
	Statement of Licens	ure Violations:			19 (1)		
	300.610a) 300.1210b)						
	300.1210d)6)						
2	300.2900d)2) 300.3100d)2)						
ŀ	300.3100dj2j		3				
	300.610a) Resident					į	
İ	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		İ				
	administrator, the ac	lvisory 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.					
		shall be followed in operating be reviewed at least annually					
		ocumented by written, signed					
	and dated minutes o						
	300.1210b) General and Personal Care	Requirements for Nursing					
	The facility sha	Il provide the necessary care					
		n or maintain the highest mental, and psychological			12.		
		ident, in accordance with	į				
		prehensive resident care				j	
		properly supervised nursing are shall be provided to each		Attachus			
ļ	resident to meet the	total nursing and personal		Attachment A Statement of Licensure Violations			
'	care needs of the res	sident.		· · · · · · · · · · · · · · · · · · ·	•		
ingia Departs	nent of Public Health						

Illinois Department of Public Health

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

TITLE

(X6) DATE

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY	
			A. BUILDING	S:		PLETED	
		IL6000103	B. WING			C 03/18/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	, ,		
I ALDEN DEDES KENAD & NCC			TH MULFOR RD, IL 6110	··· · · · · · · · · · · · · · · · · ·			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMMITTEE OF THE APPROPRIATE OF			
S9999	Continued From page 1		S9999				
	300.1210d)6) General All necessary passure that the residuant free of accident in nursing personnel signal that each resident reand assistance to possignal that will alert the building. Any expuring certain period device for part-time hour a day supervisive required. (B) There Regulations as Based on interview a failed to ensure a defailed to supervise a elopement attempts R1 exiting the building inactivated door alar 3/12/21. This applies to 1 of 3 safety/supervision in The findings include. The facility's reportal Illinois Department of 3/12/21 R1 exited the same and the same and the same and the facility's reportal Illinois Department of 3/12/21 R1 exited the same and precautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision revent accidents. 3100d)2) General Building ars shall be equipped with a the staff if a resident leaves atterior door that is supervised as may have a disconnect use. If there is constant 24 ion of the door, a signal is not are not met as evidenced by: and record review the facility for alarm was activated and resident that had previous. These failures resulted in the pathony the door with an arm unknown to staff on the sample of 3.						
		-					
	K1's Face Sheet sho	owed R1 had the diagnosis of					

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OTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		IL6000103	B. WING _		1	C /18/2021			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE					
ALDEN	ALDEN DEBES REHAB & HCC 550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108								
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
S9999	Continued From page 2		S9999						
	Alzheimer's disease.								
	from V11 (Nurse Practitioner) and V1. dated 2/2/21 and she demential and due to cannot live alone. R1's Progress Note AM, "[R1] attempted pushed the back does sound. Redirected blooking for his car to Note dated 3/8/21 at "Elopement attempt on assisting his wife moving. He was infostatus and of his [diadisease" Part of R Pre-admission Screet Progress Note from passed away in 2012	ening information was a letter 2 (Physician). The letter was owed R1 had, "Severe of this medical condition, R1 dated 3/8/21 showed at 6:03 to leave the facility. He or causing the alarm to back to room, said he was go home." R1's Progress							
		acility and was angry with his							
	On 3/17/21 at 10:28	AM, V4 (Certified Nursing vas familiar with R1 and that							
	On 3/17/21 at 10:15 A Nurse) also said R1 v	AM, V3 (Licensed Practical was confused.	į						
	exited the building the said no alarm sounde the door. R1 said he	AM, R1 said on 3/12/21 he rough the D wing door. R1 ed when he exited through wanted to go outside for a know where he was going."							

Illinois Department Of Public Health

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: _ IL6000103 B. WING 03/18/2021 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 PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 R1 said he was standing in the south end of the parking lot by the facility's sign near a busy four lane road when the local police picked him up. R1 could not recall what the police said to him or how long he was outside. R1 added the police put him in the police car and brought him back to the facility's entrance. On 3/17/21 at 8:55 AM, V1 (Administrator) said on 3/12/21 R1 exited the building through the D wing door. V1 said the alarm on the D wing door was turned off and did not alarm when R1 exited through the door. V1 said the facility was not aware R1 exited the building. V1 said when the D wing exit door alarm is activated a key is used to turn off/silence it and the key needs to be used to turn the alarm back on. V1 said the local police brought R1 back to the building after the police received a phone call about a confused looking man by Mulford road. V1 said R1 was back in the building no later than 3:50 PM. On 3/17/21 at 9:43 AM, V2 (Vice President of Operations) said the D wing door alarm should have been active/turned on. V2 said the last time staff saw R1 in the building on 3/12/21 was at 3:10 PM. On 3/17/21 at 12:30 PM, V5 (Police Dispatcher) said on 3/12/21 at 3:27 PM they received a welfare check call for someone near the corner of Mulford road, and Newburg road. On 3/17/21 at 10:46 AM, V9 (R1's Daughter) said she received a phone call on 3/12/21 at 3:46 PM from the local police saving they had R1. V9 informed the police R1 was a resident of the facility. V9 said once she hung up the phone she called the facility.

FORM APPROVED 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 B. WING IL6000103 03/18/2021 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 PROVIDER'S PLAN OF CORRECTIO IN (X4) ID COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 On 3/17/21 at 11:38 AM, V6 (Receptionist) said on 3/12/21 she started work at 3:30 PM and shortly after starting work she received a phone call from V9. According to V6, V9 said the police found R1 outside and they were bringing him back. V6 said within 20 seconds of hanging up the police where at the door with R1. A written statement provided by V13 (Maintenance) showed on 3/12/21 after R1 was brought back to the facility by the police a door audit was done. The statement showed the D wing door alarm was found to be turned off. 1. Checked all exterior door for proper alarm and function done on 3/12/21. Additional door alarm added for higher level of auditory recognition by staff done on 3/12/21. 3. Maintenance immediately came and assessed the alarm and supervision of the door was maintained until a root cause could be identified and corrected done on 3/12/21 4. All staff in-serviced by the administrator, social services, and director of nursing (DON) on the need to 1) keep an eye out for any resident loitering around an exit door or other exit seeking behavior and report the behavior immediately for a quick intervention. 2) Immediately report any door that is not alarming correctly. 3) Report these behaviors and malfunctions to the administrator and/or DON done one 3/13/12.

3/12/21.

5. All staff in-serviced on the proper procedures for door alarm silencing and rearming done on

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