

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018275		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/07/2025	
NAME OF PROVIDER OR SUPPLIER ALPINE FIRESIDE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3650 NORTH ALPINE ROAD , ROCKFORD, Illinois, 61114			
(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)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			12/18/2025	
	Complaint Investigation 2519746/2636136						
S9999	Final Observations		S9999			12/18/2025	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	300.1210d)5)						
	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						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to identify a pressure wound before developing into an unstageable pressure injury for one (R1). The facility also failed to prevent the development of three facility acquired State 2 pressure ulcers and one facility acquired unstageable pressure ulcer, a Stage 2 pressure ulcer worsening to unstageable, prevent cross contamination during dressing changes and apply pressure reduction devices for one (R2). This failure applies to two of three residents (R1 & R2) reviewed for pressure on the total sample of three. The findings include: 1. The Physician Orders for August 2025 for R1 showed		S9999				

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S9999	Continued from page 2 he was admitted to the facility on 8/14/25. The facility's Body Check Form dated 8/14/25 for R1 documented R1 did not have a pressure injury to his coccyx. A Note dated 8/26/25 at 10:27 PM for R1 documented, R1 has a wound to the coccyx. It was covered with a dressing. Will notify power of attorney – POA tomorrow and do documentation. Initiated treatment to clean and cover. The Note dated 8/27/25 at 2:19 PM from V5 Nurse Practitioner stated to cleanse the wound with wound cleanser, apply, collagenase ointment and cover with a foam dressing daily. The Weekly Wound Assessment and Summary dated 8/26/25 for R1 showed a facility acquired unstageable pressure injury that was identified on 8/26/25 when the area was unstageable. The area measured 6.5 cm x 4.5 cm: granulation and slough present to the wound bed. Scant exudate present. The Weekly Summary note dated 8/26/25 for R1 showed there was 40% slough tissue in the center of the wound surrounded by 60 % granulation tissue. Irregular shape and the edges were not defined. Add air mattress and cushion to his wheelchair. Nurse practitioner notified. On 12/7/25 at 1:00 PM V6 Registered Nurse – RN/Wound Care Nurse stated, R1's skin check when he was admitted showed a scar. V6 stated she reviewed R1's admission skin check. V6 stated she works the floor on Mondays and Tuesdays, and she thinks she saw R1 on 8/18/25 but she did not put a note in. V6 stated when she saw R1 he did not have a pressure injury. V6 stated she found the wound on 8/26/25 and it was unstageable when she found it. V6 stated R1's wound was open with slough tissue present, and did not have any depth. V6 stated when she found R1's wound it was superficial and creamy. V6 stated she cleaned the wound, covered it and notified V5 Nurse Practitioner. V6 stated because it was late at night she did not call R1's wife and told V7 Assistant Director of Nursing (ADON) to notify R1's wife the next morning. V6 stated V5 gave orders. V6 stated the therapy department added a cushion on 8/28/25; the air mattress was added on the same date. R1 was started on a supplement and repositioning every two hours to help with healing. V6 confirmed pressure ulcers should be identified prior to becoming a stage two. V6 stated residents' skin is assessed every time staff does a shower. Skin is to be monitored with repositioning and incontinence care. V6 stated all the facilities mattresses are pressure relieving for stage 1 and 2. V6 stated air mattresses are added for residents that are bony, bedridden, not moving, etc.; it is added for		S9999				

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S9999	Continued from page 3 prevention. V6 stated R1 was skinny and now that she has thought about it; it would have been a good idea for him. On 12/7/25 at 2:05 PM V5 Nurse Practitioner reviewed R1's notes and stated she saw R1's wound through telehealth and when she saw the wound it was unstageable. V5 stated she couldn't see the wound bed because of the slough. V5 stated R1's wound was identified on 8/26/25 and she gave orders on 8/27/25. V5 stated they do a skin check on admission then skin checks are done twice per week with showers and when skin care is done. If there are any areas of concerns, then staff should alert the nurse. V5 stated she did not have an opinion on what happened for R1 until she talked to V1 Administrator. V5 came back and stated R1 didn't have anything (pressure injury) and then a few weeks later there was an unstageable area. V5 stated this is what she is supposed to say. V5 stated when there is an area of concern it should be identified when the area is red. On 12/7/25 at 4:00 PM, V2 Director of Nursing – DON stated, staff are to monitor skin when providing care. Staff are to monitor skin with changing, washing, etc. V2 stated anything unusual and/or not there previously should be reported to nursing. Areas of redness should be reported to nursing. Stage 1 and Stage 2 should be identified and reported right away. V2 stated R2 had a blister when it was identified. V2 stated in general they put preventative measures in place such as pressure relief mattress, supplements, floating heels, and wound care clinic referral. The Care Plan dated 8/26/25 for R1 showed, resident has unstageable pressure injury to coccyx (identified on 8/26/25). Air mattress to bed. Cushion to chair. Reposition at least every 2 hours as needed. The Minimum Data Set – MDS dated 8/21/25 for R1 showed severe cognitive impairment; dependent for toileting hygiene, shower/bath, and lower body dressing. Substantial/maximal assistance needed for personal hygiene, and upper body dressing. Transfers and rolling in bed were not attempted due to medical condition or safety concerns. The facility's Pressure Ulcer Prevention Policy Protocol (no date) showed, Plan: Reduce or eliminate pressure. Promote optimum mobility. Prevent skin breakdown. Intervention: Implement change of position on resident individual basis. Use preventive intervention support surfaces (as pressure-relieving heel devices, pillows, chair cushions, pressure		S9999				

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S9999	Continued from page 4 relieving mattresses). Use of proper positioning, transferring, and turning techniques. Skin inspections. Manage urinary and/or fecal incontinence. Evaluation: Monitor skin as appropriate. The facility's Pressure Sore Policy (no date) stated residents with pressure sores, skin lesions/wounds will be monitored and documented. When the nurse is aware of pressure sores, skin lesions, wounds, venous ulcers or other skin abnormalities, the area is to be assessed, reported to clinician and documented. 2. On 12/7/25 at 10:10 AM V3 Registered Nurse -RN and V4 Certified Nursing Assistant - CNA put on gown and gloves and went into R2's room for the dressing change to his right heel. V3 stated R2 has diabetes and edema; the edema led to a blister on his heel that opened. V3 stated she had seen R2 two days before the blister opened and he didn't have anything on his right heel. V3 stated R2 has a paste impregnated gauze bandage to his right leg/foot. V3 took her scissors and cut the elastic bandage from his right leg and foot. V3 then cut the paste impregnated gauze bandage from R2's right lower leg/foot and discarded it. V3 grabbed the wound cleanser from the table in his room, sprayed R2's right heel and the rest of the adhered dressing came off R2's heel. The dressing had black and yellow substance on it. V3 grabbed the collagenase ointment and applied it with her finger to the heel wound. V3 applied collagenase to two small open areas on R2's right lower leg. V3 applied abdominal pads to R2's right heel and over the two open areas on R2's leg. V3 took the paste impregnated gauze bandage with zinc and applied it to R2 's right heel/foot and lower leg. V3 took the paste impregnated gauze bandage with zinc and applied it to his left foot/heel and lower leg. V3 applied self-adherent elastic wrap over the top of the paste impregnated gauze bandage. V4 held R2's leg during the dressing change. V3 picked up trash in room and discarded it. V3 picked up the wound cleanser, zinc, and her scissors from the table, sat them down on R2's nightstand, removed her gloves, picked up the wound cleanser, scissors and zinc, and left the room. V3 stopped just outside the door of R2's room, sat the wound cleanser, collagenase, and her scissors down on a PPE (personal protective equipment) container, used hand sanitizer and then picked the items up. V3 carried the items to the wound cart and sat them on top of the cart. V3 put the wound cleanser in the cart and the collagenase. V3 grabbed alcohol wipes and cleaned off her scissors. V3 was asked when gloves are to be changed, and she stated she could have changed her gloves between legs. V3 was asked if she could have changed her gloves after removing the soiled dressing		S9999				

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S9999	Continued from page 5 and before putting on the clean one for infection control etc. V3 replied yes and said that made sense. V3 stated R2's feet are checked daily; the paste impregnated gauze bandage doesn't come off unless there is a reason to remove them. V3 stated the paste impregnated gauze bandage is done twice a week. The offloading boot was not put back on R2's heel before staff left the room and a soiled blue foot cover was left laying on a table in his room. The foot cover had some type of drainage on the inside of it where his heel would have been. R2 stated staff do not reposition him every two hours; he stated he is transferred from bed to recliner to wheelchair for meals and back to his recliner and/or bed. On 12/7/25 at 1:00 PM, V6 RN/Wound care Nurse stated, R2's pressure ulcer started as a blister on his right heel and was a blister when it was first identified. V6 stated the blister ruptured, the skin fell off, and there was a wound bed that was dry with necrotic tissue. It changed to an unstageable pressure injury, and he went to the wound clinic for that. V6 stated R2 is supposed to have both heels offloaded to prevent a pressure ulcer to the left side too. V6 stated gloves are to be changed during dressing changes/wound care after the old dressing is taken off gloves should be removed, hand sanitizer used, and new gloves applied. This is important to prevent contamination and infection. On 12/7/25 at 4:00 PM, V2 Director of Nursing – DON stated, staff are to monitor skin when providing care. Staff are to monitor skin with changing, washing, etc. V2 stated anything unusual and/or not there previously should be reported to nursing. Areas of redness should be reported to nursing. Stage 1 and Stage 2 should be identified and reported right away. V2 stated R2 had a blister when it was identified. V2 stated in general they put preventative measures in place such as pressure relief mattress, supplements, floating heels, and wound care clinic referral. The Monthly Pressure Injury Report dated November 2025 showed R2 had a stage 2 facility acquired pressure injury to his right buttock that was identified at the facility on 10/2/25. R2 had an unstageable facility acquired pressure injury to his right great toe that was identified on 11/13/25 that was later put at a stage 2. R2 had a facility acquired right heel pressure injury that was identified at a stage 2 on 11/13/25 and changed to unstageable on 11/24/25. R2 had a facility acquired stage 2 right groin pressure injury that was identified at a stage 2 on 11/17/25.		S9999				

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S9999	Continued from page 6 The Weekly Wound Assessment and Summary for R2 showed right heel pressure ulcer stage 2 with an onset date of 11/13/25. The measurements on 11/13/25 were 9.0 cm x 10.0 cm; wound bed with granulation tissue; moderate serosanguinous exudate; surrounding skin reddened. The Weekly Summary dated 11/13/25 for R2 showed the blister ruptured to his right heel. The upper half of the skin peeled back and put back over granulation tissue. R1's foot was swollen, and the skin appeared white/macerated from the drainage. Floating heels and a wound clinic referral were recommended. The Weekly Wound Assessment and Summary for R2 on 11/24/25 showed R2's right heel wound was changed to unstageable due to necrotic tissue. The Weekly Summary dated 11/24/25 for R2 showed there was 70 percent dry necrotic tissue in the center of the wound of his right heel that was surrounded by 30 percent granulation tissue. The edges of the wound were dry with some skin from the blister intact. The wound was changed to an unstageable pressure injury. Floating heels, monitoring of swelling to bilateral lower extremities was recommended and wound clinic appointment on 11/25/25. The Physician Order's for R2 showed, 11/23/25 - float heels every shift, Collagenase topical every evening shift weekly on Tuesday and Friday. Apply nickel thick collagenase to right great toe wound. Apply abdominal pad and wrap leg in paste impregnated gauze bandage from toes to bend in knee. The Care Plan dated 11/25/25 for R2 showed, resident has an unstageable pressure injury to his right heel (stage 2 when identified on 11/13/25; became unstageable on 11/24/25). Resident has a stage 2 pressure injury to right buttock (identified on 10/2/25). Reposition resident at least every two hours and as needed. Recliner for repositioning during the day. Resident has a stage 2 pressure injury to the right great toe. No shoes. Reposition at least every two hours. Encourage resident to float heels while in bed. Resident has a stage 2 pressure injury to the right groin (identified on 11/17/25). Reposition resident at least every two hours and as needed. Monitor positioning of briefs. Every pressure injury stated to provide treatment as ordered; monitor and report if ineffective. R2's care plan did not show any behaviors to include refusal of care. The Progress Notes for November 2025 through 12/6/25 for R2 did not show any non-compliance with care.		S9999				

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S9999	Continued from page 7 The Minimum Data Set (MDS) dated 11/20/25 for R2 showed no cognitive impairment; substantial/maximal assistance with rolling in bed; dependent for transfers, toileting hygiene, lower body dressing, and putting on/taking off footwear. The facility's Pressure Ulcer Prevention Policy Protocol (no date) showed, Plan: Reduce or eliminate pressure. Promote optimum mobility. Prevent skin breakdown. Intervention: Implement change of position on resident individual basis. Use preventive intervention support surfaces (as pressure-relieving heel devices, pillows, chair cushions, pressure relieving mattresses). Use of proper positioning, transferring, and turning techniques. Skin inspections. Manage urinary and/or fecal incontinence. Evaluation: Monitor skin as appropriate. The facility's Wound Dressing Change Policy (no date) showed, put on gloves. Remove soiled dressings and discard in appropriate container. Remove gloves, wash hands or use no rinse sanitizer and put on clean gloves. Cleanse wound with prescribed solution. Remove gloves and wash hands with soap and water. Apply prescribed dressings. Date and initial dressing. Remove gloves and assist resident to a comfortable position. Clean and return equipment to designated area. (B)		S9999				