

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER River Bluff Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 North Main Street Rockford, IL 61103	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on observation, interview and record review the facility failed to ensure a resident was free from physical abuse for 1 of 4 residents (R3) reviewed for abuse in the sample of 5.</p> <p>The findings include:</p> <p>R3's Face Sheet shows that he is a [AGE] year old who admitted to the facility on [DATE] with diagnoses of: Alzheimer's disease, seizures, severe dementia with agitation, depression and anxiety.</p> <p>R3's Care Plan shows, has potential to be physically aggressive r/t (related to) anger, dementia, poor impulse control .Interventions: Give [R3] as many choices as possible about care. If/When [R3] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>On 12/23/24, R3 was walking the hallways with a slow shuffled gait. R3 had tremors to both of his hands. R3 was unable to answer questions with logical answers. R3 was easily re-directed away from other residents and resident rooms by V17, (Certified Nursing Assistant/CNA).</p> <p>On 12/23/24 at 9:01 AM, V5 (CNA) said that she was doing 1:1 supervision with R3 on 12/17/24. V5 said that she walked with him out to the nurse's station where he has a reclining chair that he sits in and asked him to have a seat in the chair. V5 said that R3 did not sit in the chair and kept walking around the area. V5 said that V9 (Housekeeper) came up to R3 and asked him to sit down and R3 attempted to hit V9. V5 said that R3 had his fist raised so V9 grabbed his fists and walked him backwards in a fast manner in the direction of R3's recliner and that is when he fell . V5 said that she thinks that V9 was trying to defend himself but went about it in the wrong way. V5 said that V9 should have just walked away once R3 attempted to hit him. V5 said that if R3 is combative, walking around usually helps him calm down. V5 said that there were no other residents in the area when the incident occurred.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/23/24 at 11:51 AM, V7 (Licensed Practical Nurse/LPN) said that she was at her medication cart when she looked to her left and saw V9 holding onto R3's wrists and walking him backwards. V7 said that she could see that R3 was having trouble walking backwards. V7 said that she yelled, [V9], you can't do that, he is going to fall. V7 said that R3 appeared scared during the incident. V7 said that she then saw R3 fall to the ground and V9 still had a hold of R3's wrists. V7 said that she then told V9 that he could not be doing what he did and he responded with, Well, I am not going to let him hit me. V7 said that V9's face was reddened. V7 said that the incident that occurred would be considered abuse because he was physically forcing him to sit down in a chair by grabbing his wrist and forcefully guiding him backwards. V7 said that if R3 is agitated, the best thing to do is let him walk around, talk to him about his family or re-direct him to a different activity. V7 said that R3 gets agitated if you want him to do something that he does not want to do.</p> <p>On 12/23/24 at 9:30 AM, V6 (Unit Attendant) said that she witnessed the incident on 12/17/24 between R3 and V9. V6 said that she saw V9 holding R3's wrists and walking him backwards and it was kinda forceful. V6 said that R3 then fell to the ground while V9 was still holding his wrists.</p> <p>On 12/23/24 at 10:09 AM, V8 (Housekeeper) said that he was cleaning the bathroom at the nurse's station area and he heard V7 say, [V9], let him go so he turned around and saw V9 holding both of R3's wrists and moving him backwards towards a chair and then he fell . V8 said that if a resident tries to hit him, he is supposed to back away and let the nurse know. V8 said that housekeepers should never touch a resident.</p> <p>On 12/23/24 at 11:31 AM, V17 (CNA) said that R3 likes to walk around the unit and tinker with things. V17 said that R3 also likes to talk about his family. V17 said that R3 will sometimes get agitated but it is usually provoked by something. V17 said that R3 has signs that he is becoming agitated. V17 said that his tone of voice changes and his answers to questions changes. V17 said that R3 does not like to be told what to do and he will get combative if you tell him what to do or do something to him that he does not want to do. V17 said that if he is combative, the best thing to do is walk away and give him a minute to calm down and then re-approach him and talk with him. V17 said that if R3 does not want to sit down, they find something else that R3 wants to do.</p> <p>On 12/23/24 at 8:45 AM, V3 (Registered Nurse-Unit Manager) said that he heard there was an incident between R3 and V9 while he was in a morning meeting. V3 said that he left the meeting and went to investigate what had happened. V3 said that as he was walking to the unit, he saw V9 and V9 said that he was in trouble. V3 said that he asked him why and he said that R3 was trying to hit him so he grabbed his wrists and tried to direct him to his chair and he fell . V3 said that he knew he was in trouble because staff should never put their hands on a resident like that. V3 said that if a resident tries to hit them, they should just walk away.</p> <p>The facility provided Abuse Investigation shows that V9 was interviewed on 12/17/24 at 10:15 AM and V9 stated, I was at nurses' station when [R3] attempted to hit me in my privates. I grabbed his wrists to prevent him from striking me. Holding him by his hands I walked him backwards towards the recliner, to sit him in the recliner. [R3] lost his footing and started to fall backwards. I continued to hold on to [R3's] wrists and he landed on his butt on the floor then laid down on his back and side.</p> <p>The facility provided Abuse Investigation shows that V4 was interviewed on 12/17/24 at 1:00 PM and stated, [V9] walked past me, he was visibly upset, stated I am getting fired today.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/23/24 at 12:59 PM, V2 (Director of Nursing) said that she does not feel that V9 acted appropriately to the situation. V2 said that V9 should have just walked away from R3 if he tried to hit him and not grab him in self-defense and force him back to the chair. V2 said that she does feel that what V9 did to R3 was abuse.</p> <p>On 12/23/24 at 3:00 PM, V1 (Administrator) said that during her investigation, it was found that V9 grabbed R3's wrists and walked him backwards towards his chair and he fell . V1 said that V9 was terminated due to the incident.</p> <p>The location of the incident was observed. The incident was re-enacted by V7 (LPN). After V9 grabbed R3's wrists, he was forcefully walked backwards approximately 11 feet before he fell .</p> <p>The facility's Abuse, Neglect and Exploitation Policy revised 11/14/24 shows, This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff .Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		