STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145771	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bluff Nursing Home	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to care for and transfer a resident in a safe manner to prevent a resident injury for 1 of 3 residents (R1) reviewed for resident safety and supervision in the sample of 3. This failure resulted in R1 falling while being cared for by facility staff. R1 was hospitalized due to the fall where he was diagnosed with an unstable vertebral (spine) fracture. The findings include:A facility incident report dated 2/3/26 showed, on 2/1/26, R1 fell backwards in his wheelchair, just after he was transferred into the chair, by facility staff. R1 began complaining of pain to his back on 2/1/26. R1 continued to complain of back pain on 2/2/6 and 2/3/26. On 2/3/26, R1 was emergently transferred to a local hospital, due to his worsening back pain, where he was diagnosed with a thoracic vertebral fracture. As of 2/5/26, R1 remained hospitalized due to his injury.R1's hospital CT scan (computed tomography scan) results dated 2/3/26 showed R1 sustained an acute fracture to his eighth thoracic vertebrae due to his fall on 2/1/26. The results showed, The findings are suggestive of a hyperextension injury and is considered an unstable fracture and recommended neurosurgical consultation.On 2/5/26, R1 could not be interviewed due to being hospitalized . R1's current care plan showed R1 was cognitively impaired. R1 was at risk for falls due to his impaired cognition, obesity, and impaired balance. On 2/5/26 at 10:15 AM, V7 Certified Nursing Assistant (CNA) stated she was providing cares to R1 at the time of his fall on 2/1/26. V7 CNA stated on 2/1/26, V7 and V8 CNA used a sit-to-stand lift (mechanical lift) to transfer R1 from his bed to his wheelchair. V7 stated V8 CNA left R1's room immediately after R1 was placed in his wheelchair. R1 remained attached to the sit-to-stand lift via a strap around R1's back as he sat in his wheelchair. V7 stated as she began to unhook/disengage the back strap from the sit-to-stand machine, R1 laid back in his wheelchair, causing R1's wheelchair to flip backwards onto the floor. R1 landed directly on his back. V8 CNA stated, I was unhooking the strap from the machine. The lift strap was still behind (R1's) back. No one was holding onto (R1) or his wheelchair. I don't know what happened. He all of a sudden just flipped back. On 2/5/26 at 12:33 PM, V3 Assistant Director of Nursing (ADON) stated two facility staff are to stay with the resident until the resident is completely unhooked from the sit-to-stand lift and securely seated in a wheelchair. V3 stated one staff member is to operate the stand lift while the second staff member makes sure the wheelchair and the resident remains steady until the stand lift is completely unhooked from the resident. It's done that way for safety reasons. On 2/5/26 at 12:10 PM, V13 Nurse Practitioner stated the expectation is that residents are cared for by staff in manner to prevent resident injury. The facility's Safe Lifting and Movement of Residents, Including Mechanical Lifts policy dated 4/12/2022 showed, Purpose: In order to optimize the safety and well-being of staff and residents, and to promote quality care, this facility will assess for and provide the most appropriate technique and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decision regarding the safe lifting and moving of residents. At least two (2) CNAs are required for (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	mechanical lift and stand lift transfers to safely move resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to effectively manage and treat a resident's pain after the resident fell in the facility. The facility failed to notify the attending physician/nurse practitioner of this resident's worsening pain. These failures apply to 1 of 3 residents (R1) reviewed for pain management in the sample of 3. These failures resulted in R1 experiencing worsening, severe lower back pain caused by a thoracic vertebral (spine) fracture he sustained when he fell in the facility. The findings include:A facility incident report dated 2/3/26 showed, on 2/1/26, R1 fell backwards onto the floor while seated in his wheelchair as he was being cared for by staff. R1 fell directly onto his back. R1 began complaining of pain to his lower back on 2/1/26. R1 continued to complain of back pain on 2/2/6 and 2/3/26. On 2/3/26, R1 was transferred to a local hospital, due to worsening back pain, where he was diagnosed with a thoracic vertebral (spine) fracture. R1's hospital CT scan (computed tomography scan) results dated 2/3/26 showed R1 sustained an acute fracture to his eighth thoracic vertebrae due to his fall on 2/1/26. The results showed, The findings are suggestive of a hyperextension injury and is considered an unstable fracture and recommended neurosurgical consultation.R1's progress notes dated 2/1/26 were reviewed. At 1:54 PM, a note showed at 6:44 AM, R1 had fallen backwards onto the floor in his wheelchair. The note showed a facility nurse practitioner was notified via phone of R1's fall. R1's nurse practitioner (NP) ordered pain medication for R1. R1's February 2026 Order Summary Report showed a physician order, dated 2/1/26, that R1 was prescribed Tramadol (pain medication) 50 mg (milligrams) every four hours as needed for pain, after his fall in the facility. The report showed R1 was also received scheduled doses of Tramadol, three times a day. The notes showed no documentation of R1 being seen or assessed by a physician or nurse practitioner on 2/1/26. R1's progress notes dated 2/2/26 were reviewed. At 10:14 AM, a note showed R1 began complaining of increased back pain with movement. The note showed R1 yells when HOB (head of bed) is elevated or lowered or when staff assist with repositioning. R1's progress notes dated 2/2/26 showed no documentation that R1's physician or nurse practitioner were notified of R1's worsening lower back pain. The notes showed no documentation of R1 being seen or assessed by a physician or nurse practitioner on 2/2/26. R1's progress notes dated 2/3/26 were reviewed. At 3:59 AM, a note showed, Resident continues to have pain in the back from fall Sunday am. Slowly turn for pericare. At 7:29 AM, a note showed, Patient received in pain. Yelling out when staff attempts to provide cares. Refused shower this morning from staff. Patient states he hurts too bad. (V13 Nurse Practitioner/NP) notified regarding patient's condition. Stated she was on the way to the facility to assess if needing to send patient to ER (emergency room). At 11:25 AM, a note showed V14 NP and V5 (R1's POA) were also notified by staff of R1's uncontrollable pain. V5 requested R1 be sent to the hospital. R1 was sent to the hospital by ambulance. On 2/5/26, R1 could not be interviewed due to being hospitalized . R1's current care plan showed R1 was cognitively impaired. R1 was at risk for falls due to his impaired cognition, obesity, and impaired balance. On 2/5/26 at 10:34 AM, V9 Licensed Practical Nurse (LPN) stated she was the nurse caring for R1 when he fell on 2/1/26. V9 stated she immediately assessed R1 after his fall. V9 stated R1 had no complaints of pain. V9 stated when she reassessed R1 later on 2/1/26, R1 began complaining of pain all over. V9 stated R1's pain was not worse with movement. V9 stated she notified the nurse practitioner of R1's pain on 2/1/26. On 2/5/26 at 10:55 AM, V10 LPN stated she cared for R1 during the day shift on 2/2/26 and 2/3/26. V10 stated on 2/2/26 R1 was in pain. He stayed in bed. He would yell if we moved him because of his pain. His pain was in his back. He refused cares because he would be in pain if we tried to move him. V10 stated she did not notify R1's physician or nurse practitioner on 2/2/26 of R1's worsening pain with movement or that he was refusing (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	cares due to pain. V10 stated on 2/3/26, (R1) was yelling out in his room due to his pain when I arrived for my shift that morning. You could hear him down the hall. No one was even touching him. I called the nurse practitioner to have him sent to the hospital. On 2/5/26 at 2:00 PM, V11 Registered Nurse (RN) stated she cared for R1 during the night shift on 2/1/26 and 2/2/26. V11 stated R1 complained of back pain and refused cares from staff because any movement made R1's pain worse. V11 stated she never called or notified R1's physician or nurse practitioner of R1's worsening pain or that he was refusing cares due to pain. On 2/5/26 at 12:35 PM, V14 NP stated the facility notified her of R1's fall on 2/1/26. V14 stated she was told by staff that R1 did not want to go to the hospital at that time so V14 ordered an X-ray of R1's lower back and increased the frequency of R1's pain medication (Tramadol). V14 stated the facility did not notify or inform her of R1's worsening back pain on 2/1/26 or 2/2/26. V14 stated she had not seen or examined R1 from 2/1/26-2/3/26. V14 stated, I was in the facility seeing other residents on Monday (2/2/26). I don't know why they (the facility) didn't call me to let me know about his pain. I would have gone to see him then. On 2/5/26 at 12:10 PM, V13 NP stated she was notified on 2/1/26 that R1 had fallen in the facility. V13 stated the facility did not notify or inform her of R1's worsening back pain on 2/2/26. V13 stated she did not see or examine R1 on 2/1/26 or 2/2/26. V13 stated, The facility called me on Tuesday (2/3/26) morning, telling me (R1) need to be sent to the hospital due to his pain. I got to the facility to see (R1) just as the paramedics were putting him on the cot. V13 stated facility staff should have notified her or V14 NP of R1's worsening pain on 2/1/26 and 2/2/26. V13 stated had known this information, she would have come in to assess (R1). Possibly changed his pain medications or treatment.On 2/5/26 at 9:31 AM, V5 (R1's POA) stated she was notified on 2/1/26 that R1 had fallen in the facility. V5 stated on 2/1/26, They told me (R1) did fall on his back in his wheelchair. I was told he was given pain medication. V5 stated the facility did not call her again on 2/1/26 or at any time on 2/2/26 to give her an update on R1. V5 stated on the morning of 2/3/26, she received a call from facility staff stating R1 was yelling out due to his back pain. V5 stated, Had I known he was in that much pain yesterday (2/2/26), I would have sent him to the hospital then. The facility's Pain Management policy dated 4/15/25 showed, (Facility) in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain. If re-assessment findings indicate pain in not adequately controlled, the pain management regimen and plan of care will be revised as indicated.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's radiology studies (X-ray) were completed as ordered for 1 of 1 residents (R1) reviewed for radiology and diagnostic services in the sample of 3.The findings include:A facility incident report dated 2/3/26 showed, on 2/1/26, R1 fell backwards onto the floor while seated in his wheelchair as he was being cared for by staff. R1 fell directly onto his back. R1 began complaining of pain to his lower back on 2/1/26. R1 continued to complain of back pain on 2/2/6 and 2/3/26. On 2/3/26, R1 was transferred to a local hospital, due to worsening back pain, where he was diagnosed with a thoracic vertebral (spine) fracture. R1's progress notes dated 2/1/26 were reviewed. At 1:54 PM, a note showed R1 had fallen backwards onto the floor while seated in his wheelchair. R1's nurse practitioner (NP) ordered an X-ray of R1's lower back, to be completed in the facility, due to his complaint of pain from his fall.R1's physician order dated 2/1/26 showed a radiology order for R1 to have 2-3 views of the lower lumbar (back) area related to trauma/pain.R1's progress note dated 2/2/26 at 2:03 PM, showed, X-ray tech arrived to complete X-ray. Unable to complete due to weight concerns. Stated she will have to await an additional tech with board that would hold him (R1). The notes showed the X-ray staff never returned to the facility to complete R1's X-ray. R1's progress notes dated 2/2/26 showed no documentation that R1's physician, nurse practitioner, or V5 (R1's POA) were notified that R1's X-ray was not completed. R1's progress notes dated 2/3/26 showed R1 was sent to a local hospital for an evaluation due to his worsening back pain. R1's lumbar X-ray was never completed in the facility prior to R1 being sent out to the hospital.On 2/5/26 at 10:55 AM, V10 Licensed Practical Nurse (LPN) stated she provided cares to R1 on 2/2/26. V10 stated she did not notify V5 (R1's POA), V13 Nurse Practitioner (NP), or V14 NP that R1's X-ray was not completed on 2/2/26.On 2/5/26 at 9:31 AM, V5 (R1's POA) stated the facility did not notify her until 2/3/26 that R1 had never received his lumbar X-ray. On 2/5/26 at 12:35 PM, V14 Nurse Practitioner (NP) stated facility staff did not inform her until the morning of 2/3/26, right before R1 was sent to the hospital, that R1 did not receive his X-[NAME] 2/5/26 at 12:10 PM, V13 NP stated she was notified on 2/3/26 that R1 did not receive his X-ray as ordered. V13 stated staff should have notified her on 2/2/26 that R1's back X-ray was not completed in the facility. V13 stated had known this information, she would have looked into him getting his X-ray done somewhere else. The facility's Diagnostic Testing Services policy dated 6/30/25 showed, (Facility) will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines.