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	05/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure medications were given as ordered for 1 of 3 residents (R2) reviewed for medication administration in the sample of 3.The findings include:R1 was admitted to the facility on [DATE] with multiple diagnoses including but not limited to unspecified psychosis, other specified depressive episodes.R1's November 2025 Medication Administration Record (MAR) documents an order for quetiapine (an antipsychotic medication) 12.5 mg (milligrams) in the morning. The MAR shows the medication was ordered and discontinued on 11/19/25. R1's progress notes show the power of attorney did not consent to the medication. R2's admission record shows she was admitted to the facility on [DATE]. R2's order summary sheet shows a 4/17/26 order for quetiapine 12.5 mg at bedtime related to generalized anxiety disorder. Her April 2026 MAR shows she began receiving the medication on 4/17/26. None of the doses were marked as not given or medication not available.The proof of delivery slip from the pharmacy shows R2's quetiapine tablets were not delivered until 4/26/26. The facility stock supply receipt for quetiapine shows only 1 dose was taken for R2 on 4/22/26On 5/13/26 at 9:00 AM, V4 (Licensed Practical Nurse-LPN) said he found a card of quetiapine for R1 in the medication cart with a note written by V3 (Unit Coordinator/Registered Nurse-RN) to use R1s card of medication for R2 until her supply came in from pharmacy. V4 said he removed the card and attempted to locate the house supervisor. When he could not find her, he turned the card into V1 (Administrator). V4 said as a nurse you are not allowed to use other residents' medications for someone else. V4 said the quetiapine is in the stock cubex it should have been used until R2's medication card came in from the pharmacy.On 5/13/26 at 11:12 AM, V1 stated she knew nothing about the card, and referred to the director of nursing.On 5/13/26 at 10:40 AM, V3 said she did recall the incident. R2's medication was originally ordered quetiapine 25 mg, and that was the same day her husband was being buried. We had to send her out to the hospital for anxiety, and we did not know if it was the quetiapine, or everything she had going on with her family. So we stopped the medication. Then a few days later R2 was insisting the medication helped her anxiety and wanted it back, so the Nurse Practitioner re-ordered the quetiapine at 12.5 mg. V3 said We sent it in (the prescription), the insurance said they were not going to send it, so we went several days without it, and she was not doing well. So, I grabbed the card (R1's) out of the return bin, and said it could be used until hers comes in. V3 said she should not have done that and was aware it is not the protocol. V3 said she did not think about checking the cubex to see if it was in stock.On 5/13/26 at 10:10 AM, V7 (RN) said resident cards can be changed for the time of day it may be given but it is never right to change the resident. It would not meet the criteria for the 5 rights of medication administration. Right medication for the right patient. V7 said all of the medication goes into the return bin to go back to pharmacy, you cannot use it for other residents.A photograph of R1s card for quetiapine shows his name crossed out and a note written by V3 stating Dcd (discontinued) for (R1) use for (R2) until hers comes in.On 5/13/26 at 11:15 AM, V2 (Director of Nursing) said no staff had reported an incident of medication cards being used for other residents. She said medication cards should only be used for the residents they are prescribed. V2 called the (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

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	05/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy to verify when R2's medication card arrived. The card arrived on 4/26/26. V2 reviewed the cubex report to see if any doses had been signed out. She said only one dose was signed out by V4 on 4/22/26. She said the other nurses should have been getting the medication out of the cubex.The facility's 4/16/26 policy for medication administration shows, 10. Ensure that the six rights of medication administration are followed: a. right resident b. right drug c. right dose 12. Compare medication source (bubble pack) with MAR to verify resident name, medication name, form, dose, route, and time.