

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 04/10/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide timely incontinence care for one of one residents (R83) reviewed for activities of daily living in the sample of 43.</p> <p>Findings include:</p> <p>R83's face sheet printed 4/10/25 showed diagnoses including but not limited to mental disorders due to known physiological condition, chronic kidney disease stage 3, malnutrition, palliative care, insomnia, anxiety, and irritable bowel disease.</p> <p>R83's facility assessment dated [DATE] showed severe cognitive impairment and total to substantial staff assistance needed for toileting hygiene, personal hygiene, dressing, and transfers. The same assessment showed R83 is always incontinent of urine and bowel. The assessment showed R83 is at risk for skin breakdown.</p> <p>On 4/8/25 at 10:34 AM, V17 (Certified Nurse Aide) entered R83's room and said the resident was asking to be changed. V17 said she was not assigned to the hall, but answers call lights whenever she sees them on. V17 said she did not know when R83 was last checked or changed for incontinence. V17 removed R83's bed linens and said these are all wet. V17 opened R83's incontinence brief and it was completely saturated through with urine. The thick blue pad under R83 was saturated. The bed sheet under the pad had a three-foot-wide urine ring on it. The bed alarm safety pad under the sheet was completely saturated. The mattress under the alarm pad was also saturated with urine. V17 said everything is so wet with urine that she needs a complete bed change now. R83 was lightly moaning and stated she was cold and uncomfortable. R83 was questioned regarding when she was last changed and said it was long ago so she could not remember. V17 stated the aides check all incontinent residents every two hours or more. V17 said it is not appropriate that R83 is so saturated. This should have been noticed sooner. There are some newer staff and they may not know to check her often. At 10:54 AM, V4 (Registered Nurse) entered the room to provide medication. V4 said R83 just came to the unit from the other side of the building. Staff are still getting familiar with her needs. V4 said incontinent residents have the potential for the development of moisture associated skin disorders, wound development, and urinary tract infections.</p> <p>R83's care plan showed a focus area related to ADLs (activities of daily living) initiated dated 3/24/25. Interventions included staff to check, change and complete peri/incontinence care upon waking, before & after meals, before bed, during the nighttime bed checks, per her request, and as needed.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/25 at 2:41 PM, V3 (Director of Nurses) stated residents are at risk for skin breakdown and infections if they are left in urine. They should be checked a minimum of every two hours. It is a dignity issue too. They should be changed right away. There is no reason someone should be found soaked with urine. Staff are not checking enough if they are so wet they need a complete bed change.</p> <p>The facility's Activities of Daily Living policy dated 3/24/25 states under the guidelines section: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a physician ordered pressure ulcer dressing/treatment was in place for one of seven residents (R21) reviewed for pressure ulcers in the sample of 43.</p> <p>Findings include:</p> <p>R21's admission Record, provided by the facility on 4/9/2025 showed she had diagnoses including, but not limited to, cerebral palsy, chronic obstructive pulmonary disease, polyneuropathy (a disorder that causes multiple nerves throughout the body to malfunction simultaneously. Symptoms include numbness, pain, tingling, or burning), pain in left shoulder, obesity, generalized osteoarthritis, seizures, peripheral vascular disease, and heart failure.</p> <p>R21's Order Summary Report, provided by the facility on 4/9/2025 showed an order to cleanse the wound with wound cleanser, apply an oil emulsion external gauze pad to wound bed, apply skin prep to periwound, and cover with a bordered gauze dressing three times a week and as needed. The report showed the order date was 4/2/2025 to start on 4/4/2025.</p> <p>R21's Treatment Administration Record (TAR), provided by the facility on 4/9/2025, showed the dressing change was to be done every Monday, Wednesday and Friday, and as needed. The TAR showed the treatment was signed off as being completed on 4/7/2025 on the day shift.</p> <p>On 4/8/2025 at 10:08 AM, V16 and V7 (Certified Nursing Assistants-CNAs) entered R21's room to provide incontinent care for R21. When R21 was rolled onto her right side, no dressing was in place to the pressure wound on her coccyx area and no dressing was in the brief. V16 verified that no dressing was on R21. V16 said this was the first time since she started her shift on 4/8/2025 that incontinence care was provided to R21. V16 said she checked R21 at 7:00 AM to see if she needed changed. R21 was dry, so no incontinent care was provided at 7:00 AM.</p> <p>On 4/09/2025 at 8:45 AM, V6 (Unit Manager/Registered Nurse-RN) said staff should make sure the dressing is in place so no bacteria can enter the wound and cause an infection.</p> <p>R21's wound assessment dated [DATE] showed she had a stage III pressure ulcer to her sacrum measuring 1.1 centimeters (cm) x 0.7 cm x 0.3 cm, with 70% granulation tissue, and 20% slough (white or yellowish non-viable tissue). The assessment showed the treatment in place was skin prep periwound, xeroform gauze, bordered gauze 3x/week (three times per week).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R21's ADL (activities of daily living) care plan, with a revision date of 10/29/2024, showed she needed assistance with ADLs related to a self-care performance deficit. The care plan showed R21 needed substantial/maximal assistance from 1-2 staff members to reposition in bed, utilizing the use of the single-grab bar on her bed to participate and complete task. The care plan showed R21 required extensive assistance from one staff member to dress and undress daily. The ADL care plan showed R21 does not use the toilet. Staff will offer to check, change her and provide incontinent care upon waking, before and after meals as needed, before bed, and during the nighttime bed checks. R21's pressure ulcer care plan showed she has the potential for developing pressure ulcers related to impaired mobility and physical functioning, cerebral palsy, heart failure, arthritis, and incontinence. The care plan showed R21 had a stage III pressure ulcer on her coccyx. The care plan showed, Administer treatments as ordered and monitor for effectiveness. R21's 2/19/2025 facility assessment showed she is cognitively intact, is dependent on staff for toilet hygiene and transfers, is always incontinent of bowel and bladder, and is at risk of developing pressure ulcers.</p> <p>The facility's 3/25/2024 policy and procedure titled Pressure Injury Prevention Guidelines showed To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present .3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them . 6. c. When physician orders are present, the facility will follow the specific physician orders. 7. Interventions will be documented in the care plan and communicated to all relevant staff.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. R84's admission Record, printed by the facility on 4/9/2025, showed she had diagnoses including, but not limited to, hemiplegia and hemiparesis following a cerebral infarction (paralysis and weakness on one side of the body after a stroke) affecting her left non-dominant side, unspecified dementia, disorder of muscle, weakness, iron deficiency anemia, type II diabetes mellitus with hyperglycemia, major depressive disorder, diastolic (congestive) heart failure, aphasia (language disorder) following cerebral infarction, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, and stage 3 chronic kidney disease.</p> <p>R84's Order Summary Report, printed on 4/9/2025, showed an order dated 2/24/2025 for occupational therapy three times a week for 12 weeks for ADL (activities of daily living) training, therapeutic exercises, therapeutic activities, transfer training, patient/caregiver education safety training and modalities as needed.</p> <p>R84's ADL self-care deficit care plan created on 10/3/2024 showed she requires two staff assist with transfers using a mechanical stand lift. R84's care plan created on 10/3/2024 showed she is at risk for falls related to gait/balance problems, non-ambulatory status, poor trunk control, incontinence, decreased strength and mobility, cognitive loss, and is dependent on staff for completion of bed mobility, transfers, and locomotion. The care plan showed Bed alarm when in bed. R84's facility assessment dated [DATE] showed she has a bed and chair alarm that monitors her movement and alerts staff when movement is detected.</p> <p>On 4/8/2025 at 10:00 AM, R84 was lying in bed. R84's eyes were closed, and she appeared to be sleeping. R84 did not respond when this surveyor knocked on the door. A bed alarm was at the end of R84's bed, on top of the blankets. There was no bed alarm under R84 at the time of observation.</p> <p>On 4/9/2025 at 8:48 AM, V6 (Unit Manager) said the pad alarm should have been under R84 because she is a fall risk.</p> <p>R84's 4/4/2025 Fall Risk Evaluation showed she had 1-2 falls in the past three months, had intermittent confusion, and 1-2 predisposing conditions that may affect her risk for falls, such as a stroke.</p> <p>R84's 3/19/2025 Fall incident report showed R84 had an unwitnessed fall in her room. The report showed R84 was found lying on her back on the floor in front of her bed. The report also showed R84's bed alarm was not on, or not activated.</p> <p>R84's communication note dated 3/19/2025 showed communication with Physician - Situation: Notified NP (Nurse Practitioner) that (R84) had an unwitnessed fall and is on Plavix and aspirin. Requested order to send to emergency department (ED). Order received to send out to ED for evaluation and treatment. The communication notes of 3/19/2025 showed R84 returned to the facility the same day with no injuries.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy and procedure titled Fall Prevention Program, with a revision date of 2/13/2025, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. The policy showed 3. The nurse will indicate in the care plan the resident's fall risk and initiate interventions on the resident's care plan, in accordance with the resident's level of risk.</p> <p>Based on observation, interview, and record review the facility failed to ensure fall interventions were in place. This failure applies to three of seven residents (R95, R38, R84) reviewed for falls in the sample of 43.</p> <p>Findings include:</p> <p>1. R95's admission Record (Face Sheet) showed an admission date of 5/3/24 with diagnoses of dementia, stroke, and weakness.</p> <p>On 4/8/25 at 10:02 AM, R95 was in his bed and alone in his room. R95's call light was lying on the empty bed next to him. The call light was not in R95's reach.</p> <p>On 4/8/25 at 10:02 AM, R95 stated he had fallen while getting up in his room. R95 said he did not know where his call light was. R95 then called out of his room for V7 Certified Nursing Assistant. R95 asked V7 a question regarding previous hospital admissions. V7 stated he would get the nurse. V7 did not provide R95 with his call light prior to exiting the room.</p> <p>R95's Care Plan says he is .at risk for falls .Be sure [R95's] call light is within reach and encourage him to use it for assistance .[R95] needs a safe environment with: even floor free from spills and/or clutter; adequate, glare free light; a working and reachable call light . R95's care plan showed no interventions regarding him removing his call light.</p> <p>2. R38's Face Sheet showed he was admitted to the facility on [DATE].</p> <p>On 4/8/25 at 11:07 AM, R38 was in his room, alone and lying in bed. R38's call light was out of his reach on the bed next to him. R38 said he did not know where his call light was. R38 stated, If I needed something, I guess I would just tell the staff the next time they came around.</p> <p>On 4/9/25 at 9:02 AM, R38's call light was on the floor between his bed and the empty bed next to him. The call light was not in reach and the door was shut.</p> <p>On 4/9/25 at 1:09 PM, V7 (Certified Nursing Assistant) stated R38 can use his call light.</p> <p>On 4/9/25 at 1:40 PM, V6 (Unit Manager/Registered Nurse) stated staff should ensure all safety measures are in place prior to exiting a room including resident access to call lights. V6 stated she was not aware of any residents who had a behavior or removing call lights from their bed and if there were she should be aware. V6 said the behavior of removing call lights should be care planned.</p> <p>R38's Care Plan says he is .at risk for falls .Be sure [R38's] call light is within reach and encourage him to use it for assistance . R38's care plan showed no interventions regarding him removing his call light.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Call Lights: Accessibility and Timely Response (reviewed 12/18/24) .Staff will ensure the call light is within reach of the resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room .</p> <p>The facility's Fall Prevention Program (Reviewed 2/13/25) showed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .Implement standard environmental interventions that decrease the risk of resident falling, including, but not limited to .call light and frequently used items in reach .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling catheter was below the level of the resident's bladder. This applies to one of two residents (R127) reviewed for indwelling urinary catheters in the sample of 43.</p> <p>Findings include:</p> <p>R127 admission Record (Face Sheet) showed an admission date of 3/3/25 with diagnoses including stroke, dementia and a stage IV pressure injury.</p> <p>On 4/10/25 at 10:30 AM, V15 Licensed Practical Nurse (LPN) entered R127's room to provide wound care. V6 (Unit Manager/Registered Nurse) was present for positioning assistance. R127 was in bed and on her back. R127's feet were elevated, and her indwelling urinary catheter bag was attached to the frame of her footboard. R127's catheter drainage bag was even with her feet and above the level of her bladder. R127's drainage tubing was on her bed. During wound care, especially when R127 was moved, urine in R127's tubing was flowing back toward her and away from the bag. At the conclusion of wound care V15 and V6 exited R127's room and they did not move her urinary drainage bag and tubing below the level of her bladder.</p> <p>On 4/10/25 at 11:20 AM, V15 stated, while observing R127's catheter bag, Oh god no, it should not be hanging there. It's too high. It's going to flow back to her bladder. I didn't put it there, one of the CNAs (certified nursing assistants) must have. It should be hanging lower, off the bed frame. It (having the catheter above the level of the bladder) could cause all sorts of problems like a UTI (Urinary Tract Infection).</p> <p>R127's Care Plan showed, [R127] has an indwelling [urinary] catheter .position catheter bag and tubing below the level of the bladder .</p> <p>The facility's Catheter Care policy (reviewed 3/19/25) showed, .Ensure drainage bag is located below the level of the bladder to discourage backflow of urine .</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to verify tube placement of a gastric tube using an approved method prior to giving medications and a bolus feeding. This applies to one of one resident (R62) in the sample of 43 reviewed for feeding tubes.</p> <p>Findings include:</p> <p>The facility face sheet for R62 shows he was admitted to the facility with diagnoses to include colon cancer, cerebral infarction (stroke), high blood pressure and hemiplegia (loss of motor skills on one side of the body). The facility assessment dated [DATE] for R62 shows him to have short and long term memory problems and is dependent on staff for all care. The same assessment shows R62 is fed by staff through a feeding tube. The care plan for R62 regarding his feeding tube shows to check for tube placement and gastric/residual volume per facility protocol.</p> <p>On 4/9/2025 at 7:09 AM, V4 (Registered Nurse - RN) was observed preparing to give R62 his morning medications and feeding into his feeding tube. V4 attached a large syringe onto the feeding tube and pushed air into the tube while listening with a stethoscope placed near the feeding tube. V4 then proceeded to give R62 his medications and feeding.</p> <p>On 4/9/2025 at 12:50 PM, V4 said she wasn't sure of the facility policy for checking for placement prior to administering medications and feedings, and usually just did what the nurse before her did. V4 said she looked for the policy and only found to check placement per facility policy. V4 said she asked another nurse (V5) for help and she was not able to find the policy either.</p> <p>On 4/9/2025 at 12:56 PM, V5 (RN) said V4 had come to her and had asked for help finding the policy for checking tube placement, but she was not able to find one.</p> <p>On 4/9/2025 at 1:36 PM, V3 (Director of Nursing) said the policy for tube feedings is very vague and it is being updated now. V3 said air installation is not the best practice anymore for checking tube placement.</p> <p>The Physician Order Sheet (POS) for R62 dated 4/9/2025 shows orders for nothing by mouth, all medications and feedings to be given by the feeding tube.</p> <p>The facility Medication Pass guideline dated 9/2022 shows check tube placement before the administration of medications or feedings. (The guideline does not show how this is to happen.)</p> <p>The care and treatment of feeding tubes provided by the facility with a revision date of 3/15/2025 shows, In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location (eg stomach) A. tube placement will be verified before beginning a feeding and before administering medications. (The policy does not show how tube placement is to be verified.)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure physician prescribed medications were administered as ordered for two of two residents (R30, R62) reviewed for medication administration in the sample of 43.</p> <p>Findings include:</p> <p>1. R30's face sheet printed on 4/9/25 showed diagnoses including but not limited to dementia with other behavioral disturbance, diabetes mellitus, depressive episodes, anxiety disorder, hypertensive heart disease, chronic kidney disease, and chronic obstructive pulmonary disease.</p> <p>On 4/9/25 at 9:00 AM, R30 was in bed and alone in the room. Four assorted colored pills were on her bedside table. An empty medication cup was next to the tablets. R30 stated the pills were her morning medicines. She gets around 16 pills total each morning and she had already taken the other pills. R30 said the nurse just leaves them with her and she takes them when she gets around to it. R30 was not able to identify what the tablets were and why she needed them.</p> <p>R30's Medication Administration Record (MAR) was reviewed and showed 15 medications scheduled to be given between 8 AM and 9 AM daily. The medical record did not reflect any assessment or screening to ensure R30 was capable to self-administer her own medications.</p> <p>On 4/9/25 at 1:04 PM, V1 (Administrator) and V3 (Director of Nurses) were interviewed together. V1 and V3 said residents can take medications on their own after the nursing department does an assessment to ensure they are capable. The assessment is needed to ensure safety. Residents need to show they understand when, how much, and what the medicine is for. The assessment should be done before any resident is left with medications. V3 reviewed R30's electronic medical record and was unable to provide any assessment to self-administer her medications. V3 said the care plan should reflect it too, but there is nothing there. Leaving medications with a resident increases the potential of someone else taking them or the resident may not take it and lose out on the therapeutic effects of the medications.</p> <p>The facility's Resident Self-Administration of Medication policy dated 3/19/25 states: 4. Nursing will perform a Self-Administration of Medication Assessment within the Electronic Health Record (EMR) upon desire to self-administer medications and quarterly. 5. Upon notification of the use of beside medication by the resident, the medication nurse records the self-administration on the Medication Administration Record (MAR) 7. The care plan will reflect resident self-administration and storage arrangements for such medications.</p> <p>2. The facility face sheet for R62 shows he was admitted to the facility with diagnoses to include colon cancer, cerebral infarction (stroke), high blood pressure and hemiplegia (loss of motor skills on one side of the body). The facility assessment dated [DATE] for R62 shows him to have short and long term memory problems and is dependent on staff for all care.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/2025 at 7:09 AM, V4 Registered Nurse (RN) was observed preparing R62's morning medications and tube feeding to be given into his feeding tube. V4 prepared six different medications into six different medication cups and added small amounts of water to the pills to help dissolve them. The six medications were amlodipine (blood pressure medication), clopidogrel (platelet inhibitor), furosemide (water pill), lansoprazole (decrease acid in the stomach), simethicone (gas relief) and acetaminophen (pain reliever). V4 gave the medications and the tube feeding formula to R62.</p> <p>The Medication Administration Record (MAR) dated April 2025 shows in addition to the above medications, R62 has an order for Lisinopril (blood pressure medication) was to be given with the morning medication pass.</p> <p>On 4/9/2025 at 12:50 PM, V4 said she was sure she had given the lisinopril to R62. Later at 1:00 PM, V4 said she had been thinking about the lisinopril, and realized the lisinopril was usually being given at 6 PM, and someone had changed the time. V4 said she really wasn't sure if she had given the lisinopril to R62 or not. V4 said a nurse who does not usually work this unit must have changed the time. V4 said she knows what medications to give based on what is on the MAR.</p> <p>On 4/9/2025 at 1:36 PM, V3 Director of Nursing said the MAR needs to be referenced when giving the medications to ensure all medications are given as ordered. V3 said she could not determine why R62's lisinopril was changed to a different time.</p> <p>The Physician orders for R62 dated 4/9/2025 shows an order for lisinopril 20 mg one time a day. The MAR for April 2025 shows on 4/9/25 the lisinopril was scheduled to be given at 8 AM and was not signed as given. Review of the same MAR shows the time was changed for the lisinopril on 4/7/25 from 10 mg at 6 PM to 20 mg at 8 AM. The MAR shows no lisinopril was given to R62 on that day, 4/7/25.</p> <p>The facility policy for Medication Administration with a revision date of 3/14/25 shows to review the MAR to identify medications to be administered. Compare the medication with the MAR to verify resident name, medication name, form, does, route and time.</p>		

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 04/10/2025
NAME OF PROVIDER OR SUPPLIER River Bluff Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 North Main Street Rockford, IL 61103	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) while providing incontinent care and doing a dressing change for one of six residents (R21) reviewed for infection control in the sample of 43.</p> <p>Findings include:</p> <p>R21's admission Record, provided by the facility on 4/9/2025 showed she had diagnoses including, but not limited to, cerebral palsy, polyneuropathy (a disorder that causes multiple nerves throughout the body to malfunction simultaneously. Symptoms include numbness, pain, tingling, or burning), obesity, generalized osteoarthritis, seizures, peripheral vascular disease, and heart failure.</p> <p>R21's care plan dated 4/8/2025 showed she was on enhanced barrier precautions for a sacral wound. The care plan showed staff/family/visitors should wear a disposable gown and gloves during physical contact with R21.</p> <p>On 4/8/2025 at 10:08 AM, V7 and V16 (Certified Nursing Assistants-CNAs) performed hand hygiene and entered R21's room to provide incontinence care. Signage on the wall outside of R21's room showed R21 was on enhanced barrier precautions. V7 and V16 donned gloves, then performed incontinent care for R21, who had been incontinent of urine and stool. At 10:19 AM, V15 (Licensed Practical Nurse-LPN) entered R21's room to do a dressing change for the pressure wound on R21's coccyx area. V15 put gloves on and did the dressing change to R21's coccyx area. At no time during the observed incontinent care, or the dressing change, did V7, V16, or V15 wear a gown while providing high-contact resident care for R21.</p> <p>The signage on the wall outside of R21's room showed Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and Staff must also wear gloves and a gown for high-contact resident care activities. The signage showed the following high-contact activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, Device care or use, and wound care: any skin opening requiring a dressing.</p> <p>On 4/09/25 at 8:39 AM, V6 (Unit Manager-Registered Nurse-RN) said if a resident is on enhanced barrier precautions (EBP) and staff go in to provide incontinent care they need to wear a gown and gloves. V6 said if the nurse is doing a dressing change, the nurse needs to wear a gown and gloves if the resident is on EBP precautions. V6 said it is important to wear a gown and gloves, so staff do not transmit organisms to other residents.</p> <p>R21's Order Summary Report, provided by the facility on 4/9/2025 showed an order to cleanse the wound with wound cleanser, apply an oil emulsion external gauze pad to wound bed, apply skin prep to periwound, and cover with a bordered gauze dressing three times a week and as needed. The report showed the order date was 4/2/2025, to start on 4/4/2025.</p> <p>R21's wound assessment dated [DATE] showed she had a stage III pressure ulcer to her sacrum measuring 1.1 centimeters (cm) x 0.7 cm x 0.3 cm.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's 2/5/2025 policy and procedure titled Clean Dressing Change showed It is the policy of (the facility) to provide wound care in a manner to decrease potential for infection and/or cross-contamination .1. [NAME] appropriate personal protective equipment (PPE) such as gown, gloves, mask and face shield if appropriate. Ensure Enhanced Barrier Precautions (EBP) are in place for residents having an open wound.</p> <p>The facility's 7/15/2024 policy and procedure titled Enhanced Barrier Precautions showed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high-contact resident care activities .1. a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. all staff receive training on high-risk activities and common organisms that require enhanced barrier precautions.</p>