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	06/24/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and monitor a resident after a significant weight loss and failed to ensure a resident's nutritional supplements were implemented after a significant weight loss. This failure resulted in the residents having continued weight loss. This applies to 2 residents (R77, R67) reviewed for weight loss in a sample of 36. The findings include: 1. R77's Face Sheet printed on 6/24/26 showed R77 was initially admitted to the facility on [DATE] with diagnoses which included dementia, Alzheimer's disease, and type 2 diabetes. R77's Weights summary showed R77's weights where: on 4/7/26 at 207.6 pounds (lbs.), on 4/21/26 at 200 lbs., on 4/28/26 at 200 lbs., on 5/1/26 at 189 lbs., on 5/16/26 at 189 lbs., on 5/26/26 at 188 lbs., on 6/17/26 157 lbs. R77's weight loss is calculated as being from 4/7/26 to 5/1/26 as an 8.7% weight loss in 24 days. From 5/26/26 to 6/17/26 as a 16.49 additional decrease in weight in 23 days. Both weight losses are examples of significant weight loss. R77's Nutritional assessment dated [DATE] showed R77 had moderate decrease in food intake and no weight loss in the last 3 months. When comparing the same 3 months to R77's weight/vitals summary R77 had a net weight loss of 9 lbs. R77's Facility assessment dated [DATE] showed R77 had a weight loss greater than 5% in the last month and was not on a physician-prescribed weight-loss regimen. R77's Mini Nutrition Progress note dated 5/16/26 showed R77 was at a risk of malnutrition. On 6/22/26 at 2:40 PM, V28 (R77 family) stated R77 has had some more medical issues over the last 6 months. V28 stated R77 does not like the eating pureed food. V25 stated R77 has been losing weight. V25 stated he noticed a few weeks ago R77's hands and face were thinner. At the Care Plan meetings, we discussed R77's weight loss. It was brought up in the last 2 weeks. V25 could not remember talking about R77 weight loss in April or May (2026). On 6/23/26 at 12:15 PM V26 Certified Nursing Assistant (CNA) stated R77 has been eating poorly off and on since R77 was put on a pureed diet. R77 does not like the pureed food. V26 stated R77 has been eating between 50-75% of her meals. On 6/23/26 at 12:30 PM, V27 Nurse Practitioner stated they had not been notified of any weight loss for R77 until V25 contacted them on 5/26/27. V27 stated they had not been contacted by the dietitian (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 0692 Level of Harm - Actual harm Residents Affected - Few	or have seen any dietary recommendations for R77. On 6/23/26at 2:00 PM, V2 Director of Nursing stated that when a resident triggers for significant weight loss we usually get a notification, and we contact the physician and the dietitian. V2 stated they did not know why R77's charting did not trigger after 5/1/26 (5.5% weight loss). On 6/24/26 at 10:30 AM, V25 Registered Nurse stated R77 has had some changes with her health over the last few months. V25 stated that when we put the weights in the computer it usually triggers a notice if there is a large weight change. V25 does not know why there was not a notice of R77 losing weight. V25 stated they were taking care of R77 on 5/26/26 when they noticed R77 looked like they had lost weight. V25 had the Certified Nursing Assistants weigh R77 three times to double check the weight. V25 stated they entered the weight on 5/26/26 as 188 lbs. V25 stated they contacted V27 Nurse Practitioner and got an order for a shake supplement. R77's medical record showed no additional monitoring of R77 weight was after 5/27/26 when the shake supplement order was placed. R77 continued to lose weight after this intervention with an additional 16.49% weight loss from 5/26/26 to 6/17/26. On 6/25/26 at 10:00 AM, V10 Dietitian stated she does dietary reviews for residents on tube feeding, new admissions, and significant weight loss. V10 stated on 6/22/26 they were informed of R77's decrease in weight and new weight done. V10 stated R77's previous weights over the last year had fluctuated around 200 lbs. V10 stated they had talked about R77 during the weekly Weight Meetings but was not reviewed for significant weight loss. The facility's Weight Monitoring Policy dated 2/3/26 showed the definition for significant weight loss is a loss of 5% change in weight in 1 month (30 days), 7.5% weight change in 3 months (90 days), and 10% weight change in 6 months (180 days). This policy also shows the physician should be notified of the weight change, and the dietitian should be consulted to assist in interventions which should be documented in the resident's chart. 2. R67's face sheet shows she has diagnoses including Alzheimer's, CHF, unspecified dementia, chronic kidney disease stage 3, unspecified protein-calorie malnutrition, and heart disease. R67's Nutrition Note dated 5/1/26 shows she has 20% weight loss in 6 months. BMI (Body Mass Index) is severely underweight. Intake variable 25%-50%. Continue remeron (appetite stimulant), ongoing supplements (mighty shakes) and recommend to start 2 cal (nutritional supplement) 60 ml (milliliters) three times a day. R67's weight report 1/2/26-124.4 lb (pounds)2/1/26- 116 lb.3/24/26- 113.3 lb.4/1/26- 101.9 lb. 5/1/26-101.5 lb. 6/1/26-102.5 lb. On 6/22/26 at 9:36 AM, R67 was in her room lying in bed. She presented with a thin appearance, sunken eyes, sunken cheekbones and bony upper extremities while eating her breakfast meal. Eggs, toast and water served but was not served her nutritional shake (mighty shake). On 6/23/26 at 8:20 AM, R67 was in her recliner chair near the nurse's station, eating breakfast. R67 was served milk, eggs and biscuit and gravy but was not served her nutritional shake. On 6/24/26 at 10:01 AM, V10 (Dietitian) said weights are reviewed weekly. If a resident has weight (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	loss, she puts in the recommendations for supplements. R67 triggered for significant weight loss and she recommended to continue to her mighty shakes and added two Cal three times a day. She should be receiving both supplements. R67's Physician Order Sheets dated June 2026 shows orders for two Cal three times day however her orders do not include mighty shakes. R67's Medication Administration Record dated May 2026 shows on 5/6 her mighty shakes were discontinued. The facility's Weight Monitoring Policy revised 2/26 states, To monitor the weight of each resident in order to develop appropriate medical nursing, and/or dietary interventions, while maintaining the dignity of each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure clean kitchen pans and boiling water used for cooking were maintained in a manner to prevent contamination and failed to ensure frozen food items were labeled and dated. This applies to all 150 residents residing in the facility. The findings include:The facility's CMS form 671 dated 6/22/26 shows a census of 150 residents. On 6/22/26 at 9:10 AM, during the initial tour of the kitchen with V17 Dietary Supervisor, the freezer contained multiple plastic bags of chicken like products with no label of what they were or a date to show how old the product was. V17 when asked how do you know what is in the bags, V17 said the cooks know what it is. At 9:32 AM, V19 Dishwasher was working on the clean side of the dishwashing machine. V19 removed brown plastic bins from the clean side and stacked them on the wet floor mats next to the dishwasher. V19 then picked up the stacked bins and stacked them inside another clean plastic bin on the shelf under the clean side of the dishwasher. A brown plastic bin was observed on the clean side of the dishwasher holding lids to resident cups. At 9:41 AM, V18 Assistant Dietary Supervisor was pureeing foods at a prep counter. V18 used a pitcher to obtain hot water from a large kettle type pot and used the water to add to the pureed foods. There were two kettle pots located under an exhaust hood. Directly above the boiling water kettle, which was steaming, water drops had collected on the exhaust hood and were observed dripping back into the hot water used for cooking. On 06/23/2026 at 11:40 AM, V17 said frozen foods should be labeled with what the contents are and the date opened, or the date the box was opened and the bag removed from the box. V17 said the brown bins are used to hold clean dishes temporarily until the dishes are put away and should not be placed on ground to prevent contamination. V17 said the drops of water dripping back into the water kettle can contaminate the water used for cooking. The facility's Food Safey Requirements Policy dated 6/3/2025 shows Contamination means the unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects. Food safety practices shall be followed throughout the facility's entire food handling process. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. Labeling, dating, and monitoring food including, but not limited to leftovers, so it is used by its use-by date.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review the facility failed to ensure pureed food was of a smooth consistency was served for 4 of 4 residents (R70, R77, R110, R125) reviewed for pureed food in the sample of 36. The findings include: On 6/22/26 at 10:00 AM, V18 Assistant Dietary Supervisor was pureeing the noon meal. V18 added pizza burgers, tomato sauce, thickener and water to the puree machine. V18 ran the machine for a few minutes and then poured the pureed contents into a serving pan. The puree did not visibly appear smooth. This surveyor tasted the puree and noted small bits of meat that had to be chewed. V18 did not taste the puree and covered the pan up and put into the warmer to be served for lunch. On 6/22/26 at 12:20 PM, R110 was seating in the dining room for the noon meal. R110 took one bite of pureed pizza burger and chewed for a while before swallowing. R110 did not take another bite of the pizza burger On 6/22/26 at 12:45 PM, the pureed pizza burger was tasted by two surveyors and found to be not smooth with bits of meat that needed to be chewed. At 12:56 PM, V17 Dietary Supervisor tasted the puree and said it was not smooth and needed to be pureed longer. The facility's People Roster Report sorted by diet order dated 6/22/26 shows R70, R77, R110 and R125 are on a pureed diet. The facility's Puree Food Preparation Policy dated 6/11/26 shows Puree means that all food has been ground, pressed, and/or strained to a consistency of a soft, smooth, thick paste similar to a thick pudding.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a wider bed for a resident upon request. This applies to 1 of 36 residents (R78) reviewed for accommodation of needs in the sample of 36. The findings include: On 6/22/26 at 12:59 PM R78 stated that she had asked for a wider bed on admission, and no one has gotten her anything. (R78 was admitted to the facility on [DATE]). R78 stated that she fell out of bed at the hospital and now has a fear of falling out of bed. R78's Progress Notes dated 6/10/26 written by V28 (RN- Registered Nurse) state, Patient admitted yesterday afternoon from (Rehab Hospital), alert and oriented x 3. Anxious. States she is anxious because of her bed. The bed is not comfortable for her. Transferred to recliner which was also not comfortable and opted to return to bed. States she is afraid of rolling out of bed. Bed lowered all the way to floor. Patient states she has previously inadvertently rolled out of bed. Hand holds in place on either side of bed, which patient has used to reposition, however states she wishes she had full side rails. Asked for ice cream and assistance to eat it, provided. Asked several times if another bed is available. Apologized and informed her that all available beds are the same model at present. She has been calling out as well. On 6/24/26 at 9:35AM a call was placed to V28 requesting her to return the call to Surveyor. No return call was received prior to survey exit. On 6/24/2026 at 12:35 PM V1 (Administrator) stated with V2 (Director of Nursing) present, That is not true. We have some beds inhouse that the frames expand to a bariatric bed. If we do not have one available, we can order one from (DME supply company). This is the first I am hearing about this this.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure PRN (when needed) psychotropic medications had stop dates. This applies to 3 of 6 residents (R12, R13 & R113) reviewed for unnecessary medications in the sample of 36. The findings include:1. R113's June MAR (medication administration record) shows, Quetiapine fumarate (anti-psychotic) oral tablet 50 MG (milligram), give 1 tablet by mouth every 24 hours as need for agitation PRN for agitation at HS (hour of sleep). Start date: 6/5/26. There is no stop date. She has received the medication 6 times since ordered. The pharmacist's recommendation to prescriber for R113 dated 6/16/26 shows, Findings/recommendation: this resident has new order(s) or was admitted /readmitted with order(s) for QUETIAPINE 50 milligrams QHS PRN. According to federal nursing facility regulations, PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. If this is the case, the prescriber should document the rationale in the medical record and indicate their duration for the PRN order(s). There are no exclusions for Hospice or end of life care. May we discontinue the above order(s) 14 days after the start date to help the facility maintain regulatory compliance.2. R12's June MAR shows, lorazepam intensol oral concentrate 2 mg/ml (milligram/milliter), give 0.25 ml by mouth every 3 hours as needed for agitation/anxiety, restlessness, uncontrolled seizures. Start date: 5/19/26. There is no stop date.The pharmacist's recommendation to prescriber for R12 dated 6/2/26 shows, Findings/recommendation; this resident has new order(s) or was admitted /readmitted with order(s) for Lorazepam 0.5mg Q3hrs PRN. According to federal nursing facility regulations, PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. If this is the case, the prescriber should document the rationale in the medical record and indicate their duration for the PRN order(s). There are no exclusions for Hospice or end of life care. May we discontinue the above order(s) 14 days after the start date to help the facility maintain regulatory compliance.3. R13's June MAR shows, lorazepam intensol oral concentrate 2 mg/ml, give 0.25 ml by mouth every 3 hours as needed for anxiety. Start date: 5/29/26. There is no stop date. The pharmacist's recommendation to prescriber for R13 dated 6/16/26 shows, Findings/recommendation; this resident has new order(s) or was admitted /readmitted with order(s) for Lorazepam 2mg/ml-give 0.25ml Q3hrs PRN. According to federal nursing facility regulations, PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. If this is the case, the prescriber should document the rationale in the medical record and indicate their duration for the PRN order(s). There are no exclusions for Hospice or end of life care. May we discontinue the above order(s) 14 days after the start date to help the facility maintain regulatory compliance.On 6/24/26 at 11:15 AM, V2 Director of Nursing stated, all PRN antipsychotic medications have to have a stop date of no more than 14 days. The facility's use of psychotropic medications policy dated 1202026 shows, Policy: it is the intent of this policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the residents' medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Policy explanation and compliance guidelines: .16. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for PRN use documented in the resident's medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical records should include documentation from the physician or prescriber for the rationale for the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extended time period and indicate a specific duration. b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no access no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat a resident experiencing a change of condition in a timely manner. The facility also failed to ensure resident's ace wraps were applied to their legs as ordered. This applies to 3 of 36 residents (R2, R23, R95) reviewed for quality of care in the sample of 36. The findings include: R2's EMR (Electronic Medical Record) shows that R2 was admitted to the facility last on 4/27/26 with diagnoses including Respiratory Failure, Pneumonia and Hypertensive Heart Disease. R2's Progress Notes dated 6/19/26 at 8:15 PM written by V26 (LPN- Licensed Practical Nurse) state, Lethargy noted. Able to arouse for brief moments at a time. Skin warm and clammy. Upper trunk and facial diaphoresis noted. Afebrile. Increased audible congestion noted with occasional moist cough. Pulse ox 88-89% with O2 @ 2L/min. via N.C. HOB (Head of Bed) elevated for the ease of breathing. PRN (As needed) nebulizer with some effectiveness noted. B/P; 88/68. RN supervisor notified and evaluated. The same Progress Notes shows that V26 attempted to contact R2's POA (Power of Attorney) at 8:50PM. Then show at 10:50PM she had still not heard back from the POA so she contacted another family member (R2's sister). It is documented that V26 will continue to follow up and call back if condition does not improve. Sister will call back facility in the early AM. Finally, at 11:15PM (3 hours after initial assessment) V26 documents, Texted (Nurse Practitioner) in regard to condition change. At 11:45PM V26 documented, Received new orders from (Nurse Practitioner) to send resident out to ER for evaluation. R2 was transported to the hospital via private ambulance company at 1:20AM (5 hours after initial assessment) on 6/20/26. R2's Progress Notes dated 6/20/26 state that R2 was admitted (to the hospital) with diagnoses including hypoxia, AMS (Altered Mental Status), sepsis and elevated troponin. (Primary marker for a heart attack but can also be triggered by other conditions like heart failure.) On 6/24/26 at 11:00AM V26 (LPN) stated, The day before (R2) had been not acting right. I work with him all the time and sometimes you just know. He was more congested, but the nebulizers were working the day before. He is usually coherent but, on the 19th, he was mumbling, and incoherent. He was more lethargic. He was awake for a moment and then he would fall back to sleep again. He was more congested and he has a history of pneumonia. He did not have a fever, but he was sweating profusely. I asked the CNAs to clean him up and dry him off and then he was wet again from sweating. His Blood Pressure was low- it is usually low, but it was lower than usual. His O2 saturation usually runs between 89 and 92%, and I could not get it past 89%. I had the RN supervisor (V27) take a look at him and she said he did not have any rhonchi or rales, but his lungs were diminished in the bases. She wanted me to get a hold of the family and see what they wanted to do. I could not get a hold of the POA, but I got a hold of the sister who didn't want to put him through that this late at night (sending him to the hospital) and said to monitor him and she would call back in the morning to check on him. His symptoms did not come on all at once. A little later I texted (one Nurse Practitioner) but I didn't get a response so I texted (the other Nurse Practitioner) and she said we would not be able to get a stat chest X-ray, so we needed to send him out. I called the sister back and told her we had an order to send him out and she agreed. The sister stated she would get ahold of the POA- (R2's niece). I was monitoring him the whole time and his symptoms did not come on all at once. I contacted the supervisor and the family and then the MD. If they are a DNR I call the family first and see what they want to do. This family is pretty involved. (Surveyor asked about admitting diagnoses) V26 was able to tell Surveyor diagnoses but stated, I am not sure I know what that means. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy entitled Notification of Changes dated 4/7/26 states, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: Significant change in a resident's physical, mental or psychosocial status. This may include: a. Life threatening conditions, or b. Clinical complications 2. R23's face sheet shows she has diagnoses including neuromuscular dysfunction of bladder, polyneuropathy, chronic kidney disease, personal history of urinary tract infections, and presence of urogenital implants. On 6/22/26 at 1:30 PM, V13 (Certified Nursing Assistant-CNA) transferred R23 with the mechanical stand lift from her wheelchair to her recliner. R23 was positioned in her recliner with moderate amount of edema to her lower legs. R23 stated, I don't have my wraps on my legs. V13 said she would let the nurse know. R23 said they should put my leg wraps on every day. They wraps should be placed on in the morning and removed at night. On 6/23/26 at 8:13 AM, R23 was in the main dining room sitting in her wheelchair during the breakfast meal. R23 said they never put on my leg wraps yesterday after she reported to V13 her wraps were not on. On 6/23/26 at 12:18 PM, V12 (Licensed Practical Nurse-LPN) said R23 is alert and oriented, she transfers using the mechanical stand lift. Her elastic wraps should be applied in the morning and removed at night for her edema. R23's Physician Order Sheets dated June 2026 shows orders including apply elastic wraps to both lower legs on in AM and off at bedtime for edema. 3. R95's Facility assessment dated [DATE] showed R95 is cognitively intact and does not have any behaviors with being resistive to care. On 6/22/26 at 9:15 AM, R95 was sitting in their recliner. R95'a lower extremities could be seen from knee to foot. R95's lower legs were swollen with dry, cracked, thick skin. R95's circumference of their lower leg appeared to be the same from the knee to the foot. R95's feet were swollen. 2 elastic wraps were rolled up on R95's table. On 6/22/26 at 12:30 PM, R95's elastic wraps were in the same location as before. R95 stated she did not know why the nurse did not put them on this morning. R95 stated she thought the wraps were supposed to be put on every day. She stated the morning nurse is usually the one who does it. R95 stated the staff had gotten her up before breakfast and did not put them on. R95's Physician Order Sheet printed on 6/24/26 showed R95 has an order for wraps to both lower extremities on in the morning and off at bedtime related to heart failure. On 6/22/26 at 2:00 PM, V2 Director of Nursing stated wraps should be placed on as ordered.

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	145771	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bluff Nursing Home	4401 North Main Street Rockford, IL 61103

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure appropriate assessment, treatment and care planning for a newly acquired pressure injury and failed to implement interventions to promote healing and prevent worsening of wounds for 2 of 7 residents (R7 and R82) reviewed for pressure in the sample of 36.The findings include: 1. R7's Face Sheet printed on 6/24/26 documented R7 was admitted to the facility and has diagnoses that include hemiplegia, cerebral infarction, gastronomy and colostomy status, aphasia and dysphagia. There is no documented diagnosis for pressure injury or wound. R7's Clinical Physician Orders reviewed on 6/22/26 includes orders to monitor wound of right outer ankle/float every shift for pressure ulcer (started 2/23/26) and to cleanse and dress right outer ankle every M-W-F (Monday, Wednesday, Friday/started 6/1/26). On 6/22/26 at 11:32 AM and 6/23/26 at 2:47PM, R7 was observed in bed with right ankle lying on bed, not floated or elevated. On 6/23/26 at 12:11 PM, V31 Licensed Practical Nurse provided wound care to R7's right ankle. Foam bandage dated 6/21/26 was removed, site cleansed with wound cleanser, and a foam dressing was applied. The site was observed to have a circular, reddened wound, with a purple indentation in the center. V31 did not measure the wound during the dressing change, however stated that the wound appeared to be a Stage 1. V31 did not attempt to float or elevate R7's right ankle following the dressing change. V31 stated based on care experience with R7 and previous refusal, V31 did not attempt floating of the ankle. 06/24/2026 at 11:03 AM, V30 Assistant Director of Nursing stated V30 became aware of R7's pressure injury upon gathering surveyor requested documents. V30 stated no previous wound consult order was entered upon identification of pressure injury, which resulted in R7's wound not being assessed or treated by the wound physician. V30 stated that when a pressure injury is identified, the primary physician should be informed to place a referral to be seen by wound care physician. Subsequently, V30 stated V30 entered a wound consult order on 6/24/26. 06/24/2026 at 11:52 AM, V20 Unit Coordinator stated that V20 recently (date/time not expressed) became aware of R7's pressure injury and does not know when it was first identified. V20 stated that the facility's process for identified skin concerns is that a risk management assessment is completed, the provider is notified to implement treatment orders, referral for wound consult and the residents care plan will be updated to include pressure and interventions. In addition, V20 stated that a weekly wound observation tool would be completed by the nurse. Additionally, V20 stated that interventions are offered regardless of previous resident refusals, and refusals and attempted interventions need to be charted within the resident's medical record. R7's Clinical Physician Orders reviewed on 6/22/26 includes orders to monitor would right outer ankle/float every shift for pressure ulcer that started on 2/23/26 and to cleanse and dress right outer ankle every M-W-F (Monday, Wednesday, Friday). On 6/23/26 at 10:30 PM, the orders were updated to include float bilateral heels while in bed or apply heel boots, chart refusals. On 6/24/26, an additional order for wound consultation to evaluate and treatment including debridement if needed to right outer ankle was entered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's medical record was reviewed for Wound-Weekly Observation Tools and there was only one completed on 2/21/26. The tool documents that a facility acquired pressure ulcer, unstaged, was identified on 2/21/26 to R7's right outer ankle. No additional observation tools were available for review. Additionally, the record did not document R6's refusal of intervention to float ankle. R7's Skin Check's (between 2/21/26-6/21/26) were reviewed and documents a facility acquired right ankle pressure injury with no skin issue education, notification or clinical suggestions documented. R7's Care plan Report printed on 6/24/26 documents that R7 has the potential for pressure ulcer development, however, has not been updated to include the acquired pressure injury to the right ankle with goal and interventions. The facility's Pressure List Current provided on 6/23/26 did not include R7. 2.R82's face sheet shows he has diagnoses including pressure ulcer left elbow stage 3, intellectual disabilities, legal blindless, heart disease and generalized anxiety. On 6/22/26 at 12:07 PM, R82 was sitting in a chair in the hallway eating the noon meal. A round open area was visible to his left elbow without a dressing in place. At 1:24 PM, R82 was in his room lying in bed, there was no dressing to his left elbow and there were no elbow pads in place. On 6/23/26 at 9:48 AM, V14 (Certified Nursing Assistant-CNA) said R82 has a wound to his left elbow. He did have elbow pads, but she has not seen the elbow pads, and no one has told her to put on his elbow pads. On 6/23/26 at 12:18 PM, V12 (Licensed Practical Nurse-LPN) said R82 is blind, he has a wound to his left elbow and should have a dressing in place. R82's Wound Physician Note dated 6/18/26 shows a stage 3 pressure wound to the left elbow measuring 1.1 cm (centimeters) x 0.5 cm x 0.1 cm with moderate serous drainage. Treatment plan includes apply calcium alginate daily with bordered foam dressing daily. Off load wound with elbow pads. The facility's Pressure Injury Prevention and Management Policy revised 4/2026 states, The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure a residents indwelling drainage bag was positioned below the level of the bladder to prevent the backflow of urine. This applies to 1 of 6 residents (R23) reviewed for catheters in the sample of 36. The findings include: R23's face sheet shows she has diagnoses including neuromuscular dysfunction of bladder, polyneuropathy, chronic kidney disease, personal history of urinary tract infections, and presence of urogenital implants. On 6/22/26 at 1:30 PM, R23 was sitting in her wheelchair. V13 and V34 (Certified Nursing Assistant-CNA's) transferred her from her wheelchair to her recliner chair using the mechanical stand lift. R23 requesting for her leg bag to be emptied. R23's leg bag was not positioned below the level of the bladder. The drainage bag was secured to the lower thigh, overlapping the kneecap and was not positioned downward. V13 emptied the urine into the urinal and did not secure the drainage cap. Urine was dripping down R23's leg. This surveyor asked V13 to check the cap. V13 said she closed the cap then stated, Oops, I thought it was closed. On 6/23/26 at 9:48 AM, V14 (CNA) said the CNA's change the urinary drainage bag to leg bags. Leg bags should be used for residents who are ambulatory. Drainage bags should be placed below the level of the bladder for the urine to drain and to prevent infections. R23's current care plan shows she has a activity daily living deficit related to absence of balance with non-ambulatory status. Her care plan also shows she has a indwelling urinary catheter related to urinary retention. Interventions include to position catheter bag and tubing below the level of the bladder. Her care plan shows she was treated for a Urinary Tract Infection on 5/1/26. The facility's Catheter Care Policy dated It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate treatment catheter care.leg bags may be used for ambulatory residents.leg bags will be attached to the residents thigh or calf making sure to have slack on the tubing to minimize pressure and retention.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff knew how to appropriately respond, assess and address behaviors for residents exhibiting behavioral symptoms with a diagnoses of dementia. This applies to 3 of 6 residents (R72, R75 & R113) reviewed for dementia care in the sample of 36.The findings include:1. R113's face sheet lists her diagnoses to include: dementia and agoraphobia with panic disorder. She was admitted to the facility on [DATE] from home. R113 resides on a locked memory care unit. On 6/22/26 at 12:22 PM, R113 was wandering around the unit independently with no assistive devices. She went out a door at the end of one of the hallways. The door goes to another enclosed area that goes through another door to the outside. The outside is an area enclosed with a fence and another exit door with an alarm. She was adamant about going outside. Several staff members responded to the door alarm and were trying to get her back inside. R113 refused to come back inside. After a minute or two, R113 turned around and came back inside. She was very upset and getting aggressive with staff. V8 Registered Nurse (RN) went to get V3 Licensed Practical Nurse (LPN) to give R113 medication to calm her down. V8 RN then went back to R113 and was trying to get her to calm down and come with her, while V9 Certified Nursing Assistant (CNA) had a piece of paper and pen trying to get her to come with her to write down her complaints. V3 LPN then approached and was trying to help as well. R113 was getting more frustrated and upset, yelling, I don't have to f*****g do anything! She walked to the other hall and tried to exit that door but staff (V8 RN, V9 CNA) would not let her. She just wanted to go outside. After about 5 minutes she agreed to walk to the small dining room and sat down asking for water. She calmed down and drank some water. V3 LPN got R113's PRN (when needed) medication and tried to have her take it (once she was already calmed down) but R113 refused. V3 LPN stated, they try to re-direct her otherwise they just give her PRN medication hoping the medication would calm her down. They don't usually let her go outside or walk with her even though the area is available. V9 CNA stated, R113 is always trying to get out the doors. They just let the nurse know so they can give her medication. They don't go outside with her.R113's progress notes dated 6/22/26 shows, Data: I was told that R113 was on 4 hall trying to get out of the building. We tried to redirect and get her to come back down the hall. She was yelling at staff, and we could not distinguish what she was saying during her yelling. Action: We finally got her into the tv lounge on hall 1, she sat in a recliner and calmed down a bit She did refuse her PRN medications as well. Response: She did finally calm down and was no longer being verbally aggressive toward staff. R113's progress notes dated 6/20/26, 6/16/26 & 6/13/26 shows, R113 having aggressive behaviors and exit seeking. The interventions: PRN medications. R113's care plan dated 6/7/26 shows, Focus: R113 is an elopement risk/wanderer r/t (related to) disoriented. Interventions: disguise exits: cover door knobs and handles, tape floor, distract R113 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. R113 prefers (left blank and there is nothing listed), identify R113's triggers for wandering/eloping and what de-escalates behavior.R113's care plan dated 6/18/26 shows, Focus: R113 is/has potential to be verbally aggressive r/t dementia. Interventions: Identify R113's triggers for verbal aggression. Determine what R113 behaviors is de-escalated by, When R113 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. 2. R75's face sheet lists his diagnoses to include: dementia and anxiety disorders. On 6/22/26 at 11:28 AM, R75 was sitting in the main dining room. V8 RN was heard in a loud stern voice saying, why did you do that?, stop doing that!, Don't do that. They need all new silverware now because of him. On 6/23/26 at 8:52 AM, V8 RN stated, R75 had taken all of the silverware off of the table and was wrapping them up in a napkin, sticking them in his shirt. He has these behaviors so she took the utensils and told the unit aide to get clean ones. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R75's progress notes do not show, he had this behavior on 6/22/26. On 6/24/26 at 11:15 AM, V2 Director of Nursing (DON) stated, she knows you have to talk to him calm otherwise it will work him up more. R75's care plan does not address this specific behavior however a care plan dated 2/10/26 shows, Focus: R75 can be verbally and physically sexually inappropriate at times. R75 at times has a tendency to put small items in his mouth, nursing will monitor. Interventions: If reasonable, discuss R75's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to R75. 3. R72's face sheet lists his diagnoses to include: dementia. He was admitted to the facility on [DATE] from home. On 6/22/26 & 6/23/26, R72 was wheeling himself around the unit. He was alert to himself only.On 6/22/26 at 11:27 AM, V35 R72's sister stated, she came into the facility to visit her brother. When she arrived to the unit, a staff member (V4 LPN) asked who she was there to visit. She responded R72 and V4 LPN stated, Oh well thank god, he's been wandering in and out of ladies rooms and trying to take his clothes off. We had to keep the other residents safe and put him in the room with the male nurse (V5 LPN). V35 found R72 sitting with V5 LPN and was very agitated and upset. She was able to get R72 to calm down. She reported the incident and filed a grievance. She was considered that the staff didn't have the training for people with dementia and felt like they were shocked he was wandering considering he has dementia. On 6/23/26 at 12:57 PM, V7 CNA stated, she was working the same night this incident happened. R72 likes to exit seek more on the PM shift. She didn't know exactly what happened but knows he tried hitting some staff and was being aggressive. V5 LPN told him loudly that he can't do that. He took R72 to the medication room with him. The sister came in right after and was upset. V7 CNA stated, she felt staff needed more dementia training and how to approach residents having behaviors. Yelling at them, telling them not to do something doesn't work for them. They need to try to offer ice cream, take him for a walk. She thought the way V5 LPN said that to R72 just escalated things and made him worse. On 6/23/26 at 1:42 PM, V5 LPN stated, R72 was being aggressive and wandering into female resident rooms. He brought him to the medication room with him to decrease the stimuli and get some work done. He stated, he believed he told R72 not to be hitting staff. R72's reaction to that was by hitting him. The sister came in a few minutes after he got him to the medication room. The grievance form dated 6/8/26 for R72 shows, When I arrived to visit R72 in the lobby a staff member asked me who are you here to visit. I said R72. She said Oh thank god, he's been going in and out of ladies rooms. He tried taking his cloths off. We told no you can't do that but he kept doing it so we had to protect the ladies and we put him n the room with the male nurse (med (medication) room?). I found him in a w/c (wheelchair) he was very upset trying to get out. He saw me and asked me to get him out of there. He was trying to stand so I asked about his walker. Female staff said we took it away he could fall on the slippery floors and he can't be going in the ladies rooms. I asked for the walker as he was trying to stand the female staff said to R72 use both hands to push up as he was holding the w/c one hand and walker the other but he was so worked up and up se he ws saying things to her to mind her own business and leave hi alone. She then said to the other resident there something about We have to keep you all safe from people like him. We went to his room and I was able to get him calmed down after about 20 min (minutes) and of course he forget it shortly after. My concern is that he was clearing sundowning yet the staff did not seem to know how to handle it. Do they not get special training? OT me they seemed to think he was just a difficult person that they did not have the time or patience to deal with him. He is easily distracted if you are calm and talk to him. They way the female staff member talked to me was [ineligible] very excitable frustrated and one and expressive action. I do not consider it abuse but proper training is questionable.The facility's follow up letter to V35 R72's sister dated 6/11/26 shows, Dear V35, In response to your grievance of June 8, 2026 regarding a nurse's approach to R72 during a sundowning period, thank you for brining this matter our attention. You stated when you entered the unit and identified yourself, a staff person blurted out some of R72's current behaviors and how she was managing them. This included removing his walker so he couldn't get in and out of resident rooms, and telling a female that she needed to be protected form him. You mentioned that (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you were able to calm him after about 20 minutes, that you did not think the staff was abusing, but appeared to be lacking the proper training to manager the situation. Your grievance was founded. We are hopeful that reminders to staff will resolve this matter, but will remain watchful on all shifts. R72's progress notes dated 6/8/26 shows, Resident wandering into female peers' rooms and undressing. Looking for his wife. Redirected and assisted. Became combative with this writer and team 2 nurse. Removed from stimuli and provided support. Sister arrived and provided comfort to resident who was looking for his wife. R72's care plan dated 6/16/26 shows, Focus: R72 has a behavior problem r/t facility. Interventions: caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by, intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, minimize potential for R72's disruptive behaviors by offering tasks which divert attention, provide a program of activities that is of interest and accommodates R72's status. On 6/24/26 at 11:15 AM, V2 Director of Nursing stated, the staff should be talking to all the residents in a calm, kind and gentle way is better than scolding them and making it worse. They haven't had a unit coordinator down there for about a month and they need one. There has been a few personality difficulties with staff since. The facility's dementia care policy dated 1/20/26 shows, Policy: It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or diagnosed with dementia, to meet his or her highest practical physical, mental, and psychosocial well-being. Definition: Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with variant symptomology and rates of progression. Policy explanation and complex compliance guidelines: .Care and services will be person-centered and reflected each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. If needed, the environment will be modified to accommodate individual resident care needs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to administer medications as ordered. There were 40 opportunities with 2 errors resulting in a 5% error rate. This applies to 2 of 6 residents (R113 & R120) observed in the medication pass. The findings include: 1. On 6/22/26 at 12:32 PM, V3 Licensed Practical Nurse (LPN) was giving R113 a PRN (when needed) anti-psychotic medication. She stated, R113 had home medications they were using. She pulled out a bottle from a local pharmacy with R113's name on it. The medication was for Seroquel 25 mg (milligrams). V3 LPN stated, R113's orders were for 50 mg so she would give her 2 tablets. She put 2 tablets in a medication cup. It was observed there were 2 different pills in the bottle. V3 LPN said she hadn't noticed that before. 1 pill was the pill that should be in the bottle. The other pill she wasn't sure of. She pulled her phone out and googled what the tablet was. Google showed, it was a Seroquel tablet. V3 LPN, ok she would give the medication because google confirmed it was Seroquel. R113's June MAR shows, Quetiapine fumarate (anti-psychotic) oral tablet 50 MG (milligram), give 1 tablet by mouth every 24 hours as need for agitation PRN for agitation at HS (hour of sleep). 2. On 6/22/26 at 11:57 AM, V3 LPN was giving R120 her noon medications. She was asked to inform this surveyor if she had already given something or would hold any medications. She gave her a Wellbutrin 75 mg tablet, Tylenol 500 mg tablet, metformin 500 mg tablet, a senna plus tablet, tramadol 50 mg tablet and 0.25 ml (milliters) of liquid lorazepam. V3 LPN, did not say she had already given R120 any medication or that she had any other medication due at that time. R120's June MAR shows the following medications due at 12:00 PM: Tylenol 500 mg, bupropion HCl (Wellbutrin) 75 mg, lorazepam 0.25 ml, metformin 500 mg, senna plus, tramadol 50 mg, voltaren external gel 1% to bilateral knees 4 times per day. She did not apply any voltaren gel to R120's knees. On 6/23/26 at 8:56 AM, V3 LPN stated, she had already gave the volatren gel prior to doing the medication pass. The facility's Medication administration policy dated 4/16/2000 and six shows, policy explanation and compliance guidelines: 10. Ensure that the six rights of medication administration are followed: a. right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure medication was labeled with an open date, discarded once expired and failed to verify a resident's home medications prior to use. This applies to 3 of 6 residents (R10, R113 & R131) reviewed for medication storage in the sample of 36. The findings include:1. On [DATE] at 12:32 PM, V3 Licensed Practical Nurse (LPN) was giving R113 a PRN (when needed) anti-psychotic medication. She stated, R113 had home medications they were using. She pulled out a bottle from a local pharmacy with R113's name on it. The medication was for Seroquel 25 mg (milligram). It was observed there were 2 different pills in the bottle. V3 LPN said she hadn't noticed that before. R113's folic acid and metoprolol mediation bottles also had 2 different pills in the bottles. V3 LPN stated, she was told to use R113's home medications until they were gone. Those were the medications she was using. R113's June MAR showed, a physician order for Seroquel 50 mg PRN, folic acid 1 mg, metoprolol 50 mg. 2. R131's long acting insulin pen was opened and being used. There was no open date on the pen. The insulin pen had a dispensed date of [DATE] on it. V3 LPN stated, insulin pens are only good for 28 days, it was probably expired and should be thrown away. 3. R10's short acting insulin pen was opened and dated [DATE] (more than 28 days). V3 LPN stated, the pen was expired and should be thrown away. Nurses are supposed to label the pens when they are opened so you know how long they are good for. The pharmacies med room/nursing station inspection reports for February and March of 2026 show, concerns with meds being used within expiration dates and not being labeled with open dates. These labeling of medications policy dated [DATE] shows, Policy: All medications used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Policy explanation and compliance guidelines: 1. All medications will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.

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	06/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that staff followed infection prevention and control practices, including the use of personal protective equipment and hand hygiene, to prevent cross contamination for 1 of 36 residents (R6) reviewed for infection control in the sample of 36.Findings include:R6's Care Plan Report documents R6 is on enhanced barrier precautions related to Klebsiella Pneumoniae (bacteria in urine) and to ensure extra hand hygiene and cleaning of supplies.On 6/22/2026 at 1:08 PM, an Enhanced Barrier Precaution (EBP) sign was present outside of R6's room. V32 Certified Nursing Assistant transported a cart containing resident's meal trays into R6's room. While in R6's room, V32 touched R6's pillow, sheets and bed controls without wearing personal protective equipment. V32 then picked up a towel from the floor and placed it on the cart. The cart was subsequently wheeled out of R6's room and into the common area (where unit hallways meet) of the unit. V32 then removed another resident's (R70) meal tray from the cart and delivered it to R70. No hand hygiene was observed before or after contact with R6's environment, upon exiting the resident's room, or prior to handling R70's meal tray. No sanitization of the cart was observed.On 6/22/2026 at 1:25PM, V32 Certified Nursing Assistant states not knowing why R6 was on EBP. V32 confirmed that V32 brought cart containing meal trays into R6's room, touched R6's pillow, bedding, and bed controls, picked up a towel from the floor and placed on the cart and did not perform hand hygiene prior to providing R70's meal tray from the same cart. V32 stated that the cart should have remained outside of R6's room and hand hygiene should have been performed.On 6/24/26 at 9:30AM, V33 Unit Coordinator states that carts should remain outside of resident rooms with isolation precautions, that gloves should be worn when delivering resident trays as a precaution and hand hygiene should be performed upon exiting the resident room to prevent cross contamination. V33 stated that there are designated bins in the resident rooms to place linens and towels, and the towel should not have been placed on the tray containing resident meals.The facility's Enhanced Barrier Precautions (reviewed/revised 11/4/2025) documents implementation of enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms during high contact resident care activities that include handling linens.