

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Rock River Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 707 West Riverside Boulevard Rockford, IL 61103	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488</p> <p>Based on interview and record review the facility failed to ensure a resident was free from physical abuse for 2 of 3 residents (R1, R2) reviewed for abuse in the sample of 6. This failure resulted in R1 being kicked in the genitals and R2 being pushed to the ground and sustaining a fracture of his left femur.</p> <p>The findings include:</p> <p>R1's face sheet showed he was admitted to the facility 4/23/2021 with diagnoses to include acute kidney failure, obstructive uropathy, benign prostatic hyperplasia, and major depressive disorder. R1's medical record showed he had an inguinal hernia repair 3/13/25 and could return to normal activity 3/17/25. R1's 2/17/25 assessment showed he has no cognitive impairment and exhibits no behaviors.</p> <p>On 3/22/25 at 10:12 AM, R1 was sitting in his room watching television. R1 was calm and pleasant. R1 declined to discuss the incident with the surveyor.</p> <p>R1's 3/20/25 Nursing Progress Note showed, Resident [R1] states [R2] kicked him, and he pushed him back and resident [R2] fell down. [R2] denied all treatment and said he was not hurt.</p> <p>R2's face sheet showed he was admitted to the facility 6/19/23 with diagnoses to include alcohol dependence, epilepsy, Wernicke's encephalopathy, and mood disorder.</p> <p>R2's facility assessment dated [DATE] showed he has severe cognitive impairment and exhibits hallucinations and delusions. R2's care plan initiated 3/14/24 showed, The resident requires psychotropic medication to help manage and alleviate: Agitation and aggressive behavior .</p> <p>R2's 3/22/25 Nursing Progress Note showed, Late entry on 3/20/25, I heard an altercation went to observe resident laying on the floor when resident tried to sit notice his left leg was awkwardly placed. 911 called and the DON (Director of Nursing), ED (Emergency Department) and brother, other resident stated that resident kicked him, and he pushed him back.</p> <p>R2's acute care hospital notes dated 3/20/25 showed, . CT (Diagnostic Scan) of the left hip showed: Displaced fracture of the proximal femoral shaft .</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 3/22/25 at 10:15 AM, V3 CNA (Certified Nursing Assistant) said, . [R2] gets confused and doesn't understand why he is here. [R2] is ambulatory and roams the halls . He gets aggressive with other residents but usually just verbally . If you don't intervene fast enough a fight could start because he won't back down from anybody .</p> <p>On 3/22/25 at 12:45 PM, V7 CNA (Certified Nursing Assistant) said, . My coworker was screaming my name to help, [R2] was on the floor in pain . I've never seen him yell at or be physical with other residents. He says a lot of things but never seen him be physical .</p> <p>On 3/22/25 at 12:24 PM, V6 CNA (Certified Nursing Assistant) said, [R2] was on the floor. I asked [R1] what happened, and he said [R2] kicked him in the balls, so he hit him . [R1] said he punched him .</p> <p>On 3/22/25 at 10:22 AM, V4 LPN (Licensed Practical Nurse) said, On that day [R2] was agitated . I tried to redirect him but towards the end of the day he starts sundowning (period of increased behaviors in the evening hours) . I heard yelling, usually when you got yelling, there is something going on, by the time I got out there I saw [R1] standing up and [R2] was on the floor. I asked what happened and [R1] said [R2] kicked him . [R2] said 'I did something I shouldn't of' . when he started trying to get up, he started yelling about his leg . I have never seen [R2] hit but he is verbally aggressive . I think since [R1] just had that hernia repair it was a reaction to get getting kicked. [R1] told me it was a reaction . When [R2] gets verbally aggressive you have to intervene as quickly as possible .</p> <p>The facility's policy with issue date of 01/24 showed, Abuse Prevention Program . Policy: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment .</p>		