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 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock River Health Care	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the safety of a dependent resident during community pass for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 10. This failure resulted in R1 leaving the facility on 2/3/26 with an unknown male, not returning to the facility, and being admitted to the acute care hospital on 2/5/26 with a diagnoses of fluid overload. The Immediate Jeopardy began on 2/3/26 when R1, a quadriplegic (paralyzed from the neck down) who is dependent for all cares and requires a mechanical lift for transfers left the facility with a friend. V1 (Administrator) was notified of the Immediate Jeopardy on 3/24/26 at 9:49 AM. The surveyor confirmed by observation, interview, and review that the Immediate Jeopardy was removed on 3/24/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:R1's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include spinal stenosis, seizures, chronic obstructive pulmonary disease, spondylosis with myelopathy, cervical disc displacement, acute kidney failure, personal history of mental and behavioral disorders, and retention of urine. R1's facility assessment dated [DATE] showed she had no cognitive impairment and is dependent on staff for all cares. R1's Community Survival Skills assessment dated [DATE] showed, 1. The resident is sufficiently alert, oriented, coherent, and knowledgeable allowing him/her to be considered for independent outside pass privileges. No. 2. The Resident is able to move/navigate/negotiate safely on community streets. No. 4. The resident appears able to refrain from self-harmful and/or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice harm reduction strategies. Cannot Determine. 7. The resident has the ability to adhere to pass privilege policies, e.g. getting permission to leave, signing out, respecting time parameters and curfews. Cannot determine. 9. The resident sufficiently follows rules addressing medication compliance, participation in his/her treatment plan, appropriate hygiene and grooming and treats others with respect. Cannot determine. Recommendations: . The resident does not appear to be capable of unsupervised outside pass privileges at this time.R1's Discharge Planning Review dated 1/16/26 showed, . Barriers to Discharge. The resident has extensive care needs secondary to physical disability. Physical and mental health problems increase the resident's vulnerability and would likely cause him/her to become undomiciled, suffer from a lack of proper hydration/food/clothing and/or become a victim or perpetrator of abuse/neglect in a less structured setting. Discharge Plan: . Nursing facility required to help the resident attain or maintain highest practical health status.R1's February 2026 Physician Order Sheet showed no order in place allowing R1 community access. The facility's sign out sheet located in the entrance of the facility included an undated sign out for R1 with the Signature of Party Accepting Responsibility being illegible. This form showed, Authorization must be signed by the resident, nearest relative or guardian when the resident is physically or mentally incompetent. R1's record showed no notes entered 2/3/26 that R1 was leaving the building to go out on pass, who she left with, or when she was going to be returning to the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	facility.R1's 2/4/26 eMAR (electronic Medication Administration Record) note entered at 10:01 PM showed, Resident went OOP (out on pass) 2/3/26 and has not returned. On 3/19/26 at 8:40 AM, R1 said, I was there about a month and a half. I left on February 3, because I was swelling up with a lot of water. I tried to inform the staff of what was going on. I had been back and forth to the hospital anyway. The doctor was there, and I tried to show him the swelling because it was getting worse. The head nurse who I had words with previously shrugged me off. I called a friend and asked him if he could come and get me and take me to the hospital because I feared for my own health. It was for sure the 3rd of February. I had a friend pick me up, it was about 6PM or 7PM. I had a wheelchair and I got on the bus. I stopped at my godmother's house because I honestly didn't want to go to the hospital, because the last 5 months I saw a hospital more than anything. At some point on the 4th, my friend made me go to the hospital. I was in the hospital I think from February 4th to the 20th. I had asked them about the doctor for the swelling and they ignored me. The head nurse, [V4] was arguing with me about my shoulder pain and said if I can feel pain in my shoulder then I wasn't actually a quadriplegic. They ignored me so I called someone to take me there. I don't remember who was there when I left, I know they said now that I signed out AMA (against medical advice) but that was a lie, then they said it was a ?verbal' sign out and that didn't happen either. After my hospitalization. I spoke with [V4] on the phone and she was very rude at that time as well. I had no conversation with the facility regarding leaving AMA. the facility declined for me to come back after my hospital stay. R1's Acute Care Hospital Documents showed she was admitted to the acute care hospital on 2/5/26 at 6:53 PM. These same documents showed, . Reason for Visit; Chief Complaint: Edema; Visit Diagnoses: Social Discord, Fluid Overload, Chronic pain due to trauma, Post-traumatic quadriplegia, spasticity.On 3/17/26 at 2:24 PM, V4 LPN (Licensed Practical Nurse) said she was working the day R1 left the facility. V4 said, Earlier that day she kept saying she was getting ready to leave and that her boyfriend was coming to get her. The day went on and we didn't think he was actually coming, then around about after dinner, he came, and she was telling me that she was getting ready to go but she was coming back. She didn't say what they were doing, she was going to go with him and have a little outing. We helped her put her coat on. I'm like, ?are you sure, are you aware of her condition, she is paralyzed from the neck down'. He knew it and was okay with it. He got her ready and they left. I believe they got on the bus. She got wheeled onto the bus.That was probably around 6ish. She said she was coming back. Our visiting hours/curfew is 8 pm. She said she was coming back. That was a Saturday. He signed her out . She just never came back. I haven't heard anything about where she is at. I was surprised she didn't come back because she emphasized that she was coming back. She can't do anything herself. She was her own POA (Power of Attorney), but I would think it would be her daughter that would be her contact. She made decisions for herself. Her daughter was here practically every day. That was the first day her boyfriend had been here. He just got out of jail or prison; I don't know which one. On 3/19/26 at 12:40 PM, V4 said, She didn't say what time she was coming back. They typically just know the curfew here is 8 PM. They like them to be back by 8 PM. I didn't discuss it with her that day because she already knew. I didn't send any medications with her when she left. On 3/19/26 at 1:23 PM, V6 CNA (Certified Nursing Assistant) said she worked 10PM to 6 AM the day [R1] left on pass. V6 said, [R1] needed total care. She was not able to move from her neck down. She was a 2-hour check at first, then she became an hourly check. We would go in the room and check on her every hour instead of every 2 hours making sure that she didn't need anything and that she was sleeping. She was on a 2 hour turn schedule . She was someone who would be up to her chair, put her at the nursing station, and take her into the dining room. I came in that day and said where is [R1]? They said some guy came in here and they put her up in her chair and they said they asked her multiple times if she was sure she wanted to go out because it was cold out there. They said they asked multiple times about if she wanted to go and some guy got her. They were concerned, so they were watching where he was taking her, and they said he pushed her across the street to the bus stop. They said they were concerned because ?who is taking care of her?'. They said they asked (continued on next page)

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 03/24/2026
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	if she was going to okay or if she was going to be safe? She kept saying yes. Mentally she was mind body and soul. Physically she can't move anything. They said she was supposed to have been back by 8pm that night because pass hours are 8-8. She never came back so I said, so what are we doing, I heard someone say that she called and said she would be back by midnight. I heard someone else say if she isn't back by midnight, she supposed to be admitted back into the hospital. On 3/19/26 at 2:15 PM, V5 CNA (Certified Nursing Assistant) said, I was here when [R1] left. The only thing I did for her is help her put on her coat. Some man came in here and got her. She had a catheter. Some kind of man, her ex-boyfriend I think she said they were going to go eat and would be back. She asked for help getting her coat on, he got one side, I got one side, and I said, ?well, have a good night'. No name was given. I asked her, ?how are you going out to eat?' and she said we are going on the city bus and I said, ?well just be careful'. I never saw her again. I kept asking her, ?you sure he is taking you on the bus?', because I really don't know her. They said they had free bus passes. I didn't know anything about her. The man called, she came out, I put her coat on, and she said ?bye'.On 3/19/26 at 2:51 PM, V8 LPN (Licensed Practical Nurse) said, I was not there when she left, I came later for my 7 PM - 7 AM shift. When I got there, I was told she had an agreement with the Administrator to be back by 12AM. I thought that was odd, because the buses stop running at midnight and Ubers won't assist a quadriplegic. I waited and waited, and she did not show up. I let [V10 Nurse Practitioner] know, [V2 Director of Nursing] and I informed [V1 Administrator] as well. After the next day (2/4/26), [V1] did say at that point [R1] would have to be seen at the emergency room before we could take her back if she showed up that day and I believe he said she was going to be AMA because she didn't return for 2 days. [R1] had a foley catheter, she was quadriplegic, it didn't seem like she could have the proper assistance, like a person to take care of her and help her get around. I was told that she had got on the city bus across the street which was not too good of an idea. The city bus is wheelchair accessible but it's difficult for someone in a high back wheelchair. I just didn't think it was a good idea because she can't move at all. She had no trunk control. She couldn't move her arms, had no movement from neck down. [V1] said basically, just wait to see if she shows back up and if she doesn't before the end of my shift let him know. I informed the 7AM nurse that she didn't return. When I got back (for the 7PM - 7 AM shift from 2/4/26 - 2/5/26), they said if she comes back now, she has to go to the ER. They didn't say she discharged AMA, they said her daughter even called the facility looking for her. On 3/17/26 2:08 PM, V3 (Charge Nurse) said, I was not here when she went out on pass. She went out on pass during the weekend. It would have been, I would assume the weekend prior to so either the 31st or the 1st or the 2nd, something along those lines. I know I talked to her on the 4th. whatever day she left so probably Sunday. [V4 LPN] was here. We tried to contact her, her situation was a little different. I don't know if all of it was true, but she told different people different stories. She recently became a quadriplegic because her and her boyfriend got into an altercation within the last year and apparently, she was not a force to be reckoned with. She said she lived on the second floor, and she fell down the stairs. She claims he pushed her. So, whether or not he was in jail because he pushed her or if it was another reason or if he was in jail at all, I don't know. The boyfriend, if I remember correctly, came to pick her up. Was it the boyfriend just out of jail? I don't know. She spent a lot of time on her phone speaking to a lot of different fellas. From what [V4] said when he came, he embraced her and she was like this is my boyfriend. She was at the nursing station. So, she went out on pass with him. I don't know their dynamics or whatnot; she was a complete quad (paralyzed from the neck down). He knew what care she needed because there was a conversation between the nurse and him. She is going to require complete care and he stated he was well aware of what her care needs were. She never came back after that. She called that following Wednesday and said she wasn't coming back.On 3/19/26 at 2:33 PM, V3 said, Ultimately, we like the residents back before 8 PM. If they are not going to make it before 8 PM, they should call and let someone know that they are running late and when they will be back. Anyone can go out on a pass, as long as someone comes and signs them out. They can go with whoever, as long as a responsible (continued on next page)

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 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock River Health Care	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	person takes them and is responsible for their care. There is not a doctor's order for leaving. Anyone can come get any resident and take them out. they have the right to make bad choices. If the resident doesn't return, there is usually a point of contact, if we cannot get ahold of that person, we would contact the next of kin or the POA. The floor nurse is the one who would make those contacts and they would document that they called. The evening nurse that was here should have made those contacts. She was here for a short period of time, I barely remember her for real. I don't know if she had a phone number in her chart. Sometimes they could find her contact information or someone in her family from the admission paperwork uploaded in her chart. If she didn't come with a telephone number, and there is no number listed for her, we would have eventually asked her for a phone number. If they couldn't get ahold of [R1] then they would contact [V1] and let [V2 (Director of Nursing] know and ultimately, they would need to contact the non-emergency police number and let them know a patient did not return from their visit. If they contact the non-emergency line it should have been documented in her chart. The floor nurse would make that call as well. What they do, I don't know. It would be an FYI (for your information) [R1] didn't come back, this is what she was wearing, this is her last contact, maybe do a well check. On 3/17/26 at 2:00 PM, V1 (Administrator) said R1's boyfriend that just got out of jail took her out of the facility. V1 stated, R1's sister had called the facility a couple days later looking for R1 and was surprised she was not there. V1 said R1's boyfriend must have picked her up physically and put her in his car. V1 said he thinks V3 (Charge Nurse) told him it was R1's boyfriend. On 3/19/26 at 2:45 PM, V1 (Administrator) said, They should have called the non-emergency line for law enforcement and tried to get ahold of a family member. On 3/20/26 at 9:12 AM, V10 NP (Nurse Practitioner) said, I don't know exactly what their protocol is for pass. I'm not even sure exactly what happened with [R1]. I just know she left with someone, and she left against medical advice anyways. I kind of always leave the pass privileges up to [the physician] and the social services department. I haven't written any passes unless they were there for rehabilitation, and they were going for a few hours. It's hard in these facilities that have psychiatric patients because there is a rights issue too. She is alert and oriented and her own person and doesn't have a POA (Power of Attorney) as well, that is another thing because she is decisional. Her physical deficits make it harder. I would hope they would know who she was going out with. A lot of times they want passes and I tell them social services are the ones who would do that, they know the backgrounds of these people better than I would. I don't recall if they notified me of her not returning, I know they told me she went AMA. Whoever took her would have to be able to toilet her, feed her, transfer her, all of that stuff to be able to take her out.The facility's policy and procedure reviewed 12/25 showed, Community Pass Policy. Purpose: To define the facility's and the resident's responsibilities when a resident leave the facility with community pass. Procedure: . 2. Decisions regarding pass privileges, including independent privileges or being accompanied by a responsible individual, are determined by physician's orders and social services assessments.The Immediate Jeopardy that began on 2/3/26 was removed on 3/24/26 when the facility took the following actions to remove the immediacy.ABATEMENT PLAN DATE OF EVENT 2.3.2026 ABATEMENT PLAN 3.24.2026Re-education on Systems: The facility failed to ensure the safety of a dependent resident during community pass. The facility failed to notify law enforcement regarding R1s failure to return to the facility. The facility failed to complete an audit of residents with pass privileges for appropriateness related to resident care needs while out on pass. The facility failed to provide education to staff regarding ensuring contact information is available for residents prior to going out on pass. The facility failed to educate staff regarding ensuring residents are aware of expectations for return to the facility. R1 no longer resides in the facility.All staff will be re- educated by end of day 3.24.2026. The Administrator /DON have completed the education. To ensure the safety of a dependent resident during community passTo notify law enforcement regarding residents' failure to return to the facility at the designated time. To complete an audit of residents with pass privileges for appropriateness related to resident care needs while out on pass.To ensure contact information is available for residents prior to going (continued on next page)

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 03/24/2026
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	out on pass. To ensure residents are aware of expectations for return to the facility. New hires will be educated prior to starting on the floor. On the spot education is being completed. Staff not present in the facility have been re-educated via phone prior to the beginning of the next shift worked and will sign education sheets. Social Services/DON have completed an audit of residents with pass privileges for appropriateness related to resident care needs while out on pass. This included an audit of contact information. Completed 3.24.26. A QAPI audit tool is being completed for two months: To ensure the safety of a dependent resident during community pass for care needs. The community survival skills assessment will be audited weekly. 5 residents will be audited weekly by the Administrator or designee. To notify law enforcement regarding residents' failure to return to the facility at the designated time. An audit of 5 residents each weekly that sign out on pass will be audited to ensure that they have returned at the designated time or the police have been called. This will be audited for two months by the Administrator or designee. To ensuring contact information is available for residents prior to going out on pass. A weekly audit of 5 residents a weekly will be completed to ensure contact information is available. This audit will be completed Administrator or designee. To ensure residents are aware of expectations for return to the facility via a resident handout and resident council meeting. A weekly audit of 5 residents is being completed by the Administrator or designee for 2 months. Audits are completed by the Administrator or designee and an analysis presented through QAPI quarterly A root cause analysis was conducted to identify barriers and further education needed. Completed 3.24.2026 An Ad Hoc QAPI was completed 3.24.2026 to review systems and the analysis of the root cause analysisAll audits will be analyzed and reviewed in quarterly QAPI. This is overseen by the medical director and administrator. The QAPI Committee will determine if the audits will continue at that time.