STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock River Health Care	707 West Riverside Boulevard Rockford, IL 61103

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(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 obtain accurate weights on a resident with a feeding tube (R14). The facility failed to weigh a resident (R14) as per the dietician's recommendations. The facility failed to notify the dietician of a resident's (R14) refusals of tube feedings. The facility failed to notify the dietician of missed or omitted tube feedings for R14. The facility failed to notify the dietician or nurse practitioner of R14's significant and continued weight loss in a timely manner. These failures contributed to R14 sustaining a significant weight loss. These failures apply to 1 of 7 residents (R14) reviewed for weight loss in the sample of 19.The findings include:R14's current care plan showed R14 had diagnoses including end stage renal disease requiring dialysis, oral cancer, and Type 2 Diabetes Mellitus. R14 had a gastrostomy tube (G-tube) in place to receive nutritional support. The plan showed R14 was Full Code. R14 was not on hospice.Physician notes for R14 dated 11/4/25 and 12/10/25 showed R14 was cognitively intact. R14's November 2025 Medication Administration Record (MAR) showed R14 received a continuous infusion of Nephro (enteral feeding solution) at 40 mls (milliters) per hour, twenty-four hours a day, from 11/1/25-11/9/25, for nutritional support. R14 was NPO (ate nothing by mouth) during this time. R14's progress note dated 11/9/25 showed R14 was hospitalized for pneumonia and altered mental status. A progress note dated 11/14/25 showed R14 was readmitted to the facility. R14's November 2025 MAR showed R14's tube feedings were changed from continuous feedings to bolus feedings every six hours, upon his readmission to the facility on [DATE]. R14 was allowed to eat foods upon his readmission.R14's Dietary Progress Note dated 11/24/25 showed R14 was seen and assessed by V4 Dietician. The note showed R14 was readmitted (on 11/14/25) on an oral diet with tube feedings to supplement nutritional intakes. Per hospital records, he passed his swallow evaluation and diet was upgraded. PO (oral) intakes have been variable. Tube feeding does provide approximately 88% of residents estimated caloric needs. Plan: continue to monitor. Weekly weights to monitor resident and new tube feeding order.R14's Weights and Vital Summary report, printed 12/9/25, showed R14 weighed 135 pounds (lbs) on 11/1/25. This report showed no documented weight was obtained on R14 upon his readmission to the facility on [DATE]. The report showed no documented weight was obtained on R14 for the week of 11/24/25. The report showed R14 was weighed in the facility on 12/5/25 with a recorded weight of 101.4 lbs. R14's weight decreased to 101 lbs on 12/8/25. This showed R14 sustained a significant weight loss of 25.2% from 11/1/25-12/8/25. On 12/8/25 at 9:40 AM, R14 was in bed. R14 appeared thin and pale. R14 was alert and oriented to person, place and time. R14 stated he is able to eat regular food and also gets bolus tube feedings via his G-tube four times a day. When asked about his bolus tube feedings, R14 stated, I'm not going to lie. Sometimes I don't get a tube feeding because I am too full and don't want it but this weekend, I didn't get my tube feedings like I was supposed to.R14's progress note dated 11/28/25 showed R14 refused one of his bolus tube feedings. The note showed no documentation that V4 Dietician was notified. R14's December 2025 MAR showed R14 did not receive his bolus tube feedings on 12/6/25 at 8 AM and 2 PM. The MAR showed no documentation of R14 refusing these feedings or that V4 Dietician was notified of these omitted/missed feedings. On 12/9/25 at 9:42 AM, V4 Dietician stated she works on a (continued on next page)

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	consulting basis for the facility which only requires her to be in the facility once a month. V4 stated she monitors residents for weight loss by monitoring their weight and oral intakes that are documented in the facility's electronic medical records. V4 stated residents should be weighed as per their physician order or by her recommendation. V4 stated residents are to be weighed upon admission and readmission to the facility to ensure we have an accurate weight. V4 stated R14 was readmitted to the facility on [DATE] with an order to eat orally and his tube feedings were decreased to bolus feedings, four times a day. V4 stated, I saw (R14) on 11/24/25. I requested to have him weighed once a week due to the changes in his diet and tube feedings. R14's Weight and Vitals Report (printed 12/9/25) was reviewed with V4. V4 stated, I don't see that he was weighed when he got readmitted (on 11/14/25). I don't see a weight for the week of 11/24/25. No one from the facility called me to tell me about his weight on 12/5/25. I actually noticed his weight from 12/5/25 in the computer yesterday and had the facility reweigh him. I see his weight on 12/8/25 was even lower. If he had been weighed upon readmission (on 11/14/25) or the week of 11/24/25 after I saw him, this weight loss could have possibly been caught. I would have assessed him. I would have possibly increased his tube feedings and added fortified foods. When R4 was asked if the facility had notified her that R14 had refused and missed some of bolus tube feedings, R4 stated, No and they should have told me. That can decrease the amount of calories and nutrition he needs daily. On 12/10/25 at 8:11 AM, V5 Nurse Practitioner stated she had just seen and examined R14 that morning (12/10/25). V5 stated the facility did not call her to notify her of R14's weight loss until 12/9/25. V5 stated all resident weights are to be monitored as ordered. Facility staff are to notify her as soon as any resident excessive weight gains or losses are noted. On 12/10/25 at 9:32 AM, V3 Restorative Nurse presented this surveyor with a revised Weights and Vitals Summary report, dated 12/10/25, for R14. The report showed that V3 had crossed out R14's documented weights on 12/5/25, and 12/8/25. The report showed V3 had added the following weights for R14 of 99 lbs on 11/3/25, 95.1 lbs on 11/18/25, 96.8 lbs on 11/25/25, and 95 lbs on 12/1/25. V3 stated she crossed out R14's weights on 11/1/25, 12/5/25 and 12/8/25 because although our CNA's (certified nursing assistants) weighed him those days, we could not verify if the weights were accurate. When V3 was asked where she got R14's weights from that she recorded on 11/3, 11/18, 11/25, and 12/1/25, V4 stated, Those are not weights we got on (R14). I found those weights last night (12/9/25) when I was looking through his dialysis records. V3 stated the facility was unaware of R14's dialysis weights prior to 12/9/25. V3 stated she had never herself weighed R14. Based on the first (printed 12/9/25) and second (dated 12/10/25) Weights and Vitals Summary records for R14 that were provided to this surveyor by the facility, R14 weighed 106.3 lbs on 10/1/25 and 95 lbs on 12/1/25 which showed R14 sustained a significant weight loss of 10.6% from 10/1/25-12/1/25. The facility's Weight Assessment and Interventions policy dated January 2025 showed, Ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner. Weigh the resident upon admission and weekly for a total of four weeks. Do not use the hospital weight. Weights will be entered in the resident's medical record. The dietician will review the weight record to identify and address weight issues. Significant weight changes are defined as: 5% weight gain/loss in 30 days, 7.5% weight gain/loss in 90 days, and 10% weight gain/loss in 180 days.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review the facility failed to ensure a certified dietary manager was employed as food service director. This has the potential to effect all residents residing in the facility. The findings include:Centers for Medicare and Medicaid form 671 dated 12/8/25 shows there are 81 residents residing in the facility. On 12/8/25 at 9:31 AM, V13 (Food Service Director) said he is not licensed as a certified dietary manager. V13 said he took the courses at the local community college about 7 to 8 years ago and failed the exam on the first attempt. V13 has not retaken the exam since. V13 said he does initial and quarterly assessments of residents while the contract dietitian performs all assessments on high risk residents. Facility provided course certificates for V13 show that V13 completed courses in food nutrition therapy, food safety sanitation and human resource management, and management of food service operations. Per the Association of Nutrition and Foodservice Professionals, the there are no current certified dietary managers in the nation with the same last name as V13. Facility provided Job Description for Food Service Supervisor shows, . Qualifications: 1. A Bachelor of Science degree in Foods and Nutrition from an accredited college or university. 2. Graduation from a course in food service supervision which meets the established by the [National Association] or graduate of another course in food service supervision with ninety (90) or more hours in classroom instruction with on-the-job counseling by a dietitian.

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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 hand hygiene was performed after touching a garbage can lid and performing other tasks. This has the potential to effect all residents that receive food from the kitchen. The findings include: Centers for Medicare and Medicaid form 671, dated 12/8/25, shows there are 81 residents residing in the facility. Centers for Medicare and Medicaid form 802, dated 12/8/25, shows there are 2 residents that receive nutrition via a tube feed. On 12/8/25 at 11:55, V14 (Dietary Aide) was by the dish machine, grabbed the lid for the garbage can, and placed it onto the garbage can. V14 did not perform hand hygiene before going to another area in the kitchen. V14 then grabbed a clean and sanitized food service pan and walked it over to the storage rack and placed it with the rest of the clean and sanitized food service pans. V14 still had not performed hand hygiene. During this time, V14 would put V14's hands in the front pocket of V14's hooded sweatshirt and remove them to perform other tasks. V14 then was approached by a staff member by the entrance door to the kitchen who requested something from V14. V14 then opened the door to the cooler, grabbed an item, and handed it to the staff member without performing hand hygiene. When finished V14 returned V14's hands to the front pocket of V14's hooded sweatshirt and did not perform hand hygiene. V14 then grabbed three large plastic bags and opened them to get them ready to use to cover the tray carts during service. V14 still did not perform hand hygiene after this task and again placed V14's hands back into the front pocket of V14's hooded sweatshirt. On 12/9/25 at 9:50 AM, V13 (Food Service Director) said kitchen staff should wash their hands after touching the garbage can, lid, or handling garbage. V13 also said staff should wash hands when completing different tasks. Facility Handwashing policy for the kitchen dated 9/21/23 states, . 2. Employees are required to wash hands: . Before starting any task . Touching the hair, face or body . After taking out the garbage .Anytime the hands are soiled .

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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 the pureed pork was a smooth consistency. This applies to 4 of 4 residents (R38, R41, R40, R69) reviewed for pureed diets in the sample of 18. The findings include:Facility provided diet report dated 12/8/25 shows R38, R41, R49, and R69 all receive a pureed diet. On 12/8/25 at 11:45 AM, V15 (Cook) grabbed a pot from the stove that had seven servings of pork slices that were cooked in chicken broth. V15 started the puree process by adding all pork slices to a blender pitcher and added additional chicken broth to help puree. At 11:48 AM, V15 added a thickening powder to the puree pork. At 11:52 AM, V15 finished the pureed pork and transferred it to a food service pan. The consistency of the finished pureed pork appeared chunky and was not smooth. On 12/8/25 at 11:28 AM, V15 said the finished consistency for purees should be similar to pudding consistency and not too thick or too runny. On 12/8/25 at 1:00 PM, a facility provided test tray of the puree meal was tested by this surveyor and V13 (Food Service Director). The consistency of the puree pork was not smooth and required chewing. V13 said the puree pork could be a little thinner, cooked longer, or blended longer to be easier to swallow and was not an appropriate texture. Facility provided Pureed Food Preparation policy dated 9/26/23 states, . 3. Pureed food must be the consistency of pudding or mashed potatoes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Level 2 Preadmission Screening and Resident Review (PASRR) interview was completed as requested for a resident admitted with known mental illness. This applies to 1 of 7 residents (R4) reviewed for PASRRs in the sample of 19. The findings include: R4's Facesheet shows R4 was admitted to the facility on [DATE] with diagnoses including, but not limited to, schizoaffective disorder, dementia, major depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder. R4's PASRR report from 10/2/24 shows that R4 required a PASRR Level 2 evaluation to be completed. The facility was unable to show a PASRR Level 2 evaluation was completed. On 12/10/25 at 12:24 PM, V3 (Restorative Nurse) said the facility requested a Level 2 evaluation for R4 to be completed, but the evaluation was canceled when the evaluator went to R4's previous facility to conduct the evaluation. Facility provided Pre-admission Screening and Resident Review (PASRR) policy states, It is the policy of this facility to: . 2. Request full and complete PASRR materials (Level 1 and 2) from each referral source prior to or soon following admission.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Level 1 Preadmission Screening and Resident Review (PASRR) evaluation was resubmitted before expiration of the 60 day approval. This applies to 1 of 8 residents (R71) reviewed for PASRRs in the sample of 19. The findings include:R71's Facesheet shows R71 was admitted to the facility on [DATE] with a diagnosis of bipolar disorder. R71's PASRR Level 1 screening dated 1/24/24 shows R71 was allowed a 60 day stay or less in a nursing facility. This screen also states that a re-screening must be performed by or before the 60 day period. R71's next PASRR provided by the facility was a Level 2 evaluation done on 2/26/25; beyond the 60 days. On 12/10/25 at 9:40 AM, V8 (Social Services Director) said PASRR is done on admission and after a temporary one expires. Most of the time, the hospitals have been doing the 30 or 60 day temp assessments. If someone has a new mental illness diagnosis, PASRR needs to be requested to have the PASRR 2 started with the mental illness.

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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. Based on interview and record review the facility failed to schedule a doctor's appointment for a resident. This failure applies to 1 of 19 residents (R7) reviewed for quality of care in the sample of 19.The findings include:R7's care plan dated 6/27/25 showed R7 was visually impaired related to his diagnosis of Type 2 Diabetes Mellitus with diabetic retinopathy. On 12/8/25 at 10:14 AM, R7 stated, My vision has really gone downhill the past six months. I saw an eye doctor here, but that doctor said I needed to see a specialist for cataracts or glaucoma. No one has made an appointment for me. A facility optometrist report dated 11/24/25 showed R7 was seen and examined in the facility by an in-house optometrist. The report showed R7 was diagnosed with bilateral cataracts with a note that showed facility staff were to make an appointment for R7 to see a glaucoma specialist. R7's physician order report printed 12/9/25 showed no scheduled appointment for R7 to see an optometrist specializing in the treatment of glaucoma. R7's progress notes dated 11/24/25-12/8/25 were reviewed and showed no documentation of staff scheduling this appointment for R7. On 12/9/25 at 10:09 AM, V8 Social Services Director stated she was not aware the facility's in-house optometrist had made a referral for R7 to see an optometrist specializing in glaucoma. On 12/9/25 at 10:01 AM, V7 Charge Nurse stated she is responsible for making outside appointments for residents as soon as she is notified of the request or referral. V7 stated if the facility's in-house optometrist or dentist refers a resident to a physician outside of the facility, they would make a referral through V8 Social Services Director. V8 then would notify V7 that an appointment needs to be made for a resident. V7 stated, I didn't get a referral from (V8 Social Services Director) for (R7) to see a glaucoma specialist. I don't know anything about it. On 12/10/25 at 10:13 AM, V1 Administrator stated the facility did not have a policy on scheduling outside appointments for residents.

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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 low air loss mattress settings were programmed to effectively off-load areas of pressure for residents with pressure injuries for 3 of 8 residents (R14, R11, R3) reviewed for pressure injuries in the sample of 19. The findings include:1.R14's Wound Evaluation report dated 12/3/25 showed R14 had a Stage 4 pressure injury to his coccyx. R14's revised care plan dated 8/4/25 showed a pressure reducing (low air loss) mattress was listed as one of R14's pressure relieving interventions for R14's coccyx pressure injury. The plan showed no documentation that R14 requested to have his pressure reducing mattress programmed for a specific setting. R14's weight record dated 12/8/25 showed R14 weighed 101 pounds (lbs). On 12/8/25 at 9:40 AM, R14 was in bed lying on a low air loss mattress. R14's mattress was programmed for a resident weighing 350 lbs. On 12/9/25 at 8:03 AM, R14 is in bed. R14's low air loss mattress remained programmed for a resident weighing 350 lbs.2.R11's Wound Evaluation report dated 12/3/25 showed R11 had a Stage 4 pressure injury to her medial right knee. R11's revised care plan dated 8/8/25 showed a pressure reducing (low air loss) mattress was listed as one of R11's pressure relieving interventions for R11's pressure injury. The plan showed no documentation that R11 requested to have her pressure reducing mattress programmed for a specific setting. R11's weight record dated 12/5/25 showed R11 weighed 81.4 lbs. On 12/8/25 at 9:25 AM, R11 was in bed lying on a low air loss mattress. R11's low air loss mattress was programmed for a resident weighing 400 lbs. On 12/9/25 at 8:00 AM, R11 was in bed. R11's low air loss mattress remained programmed for a resident weighing 400 lbs. 3.R3's Wound Evaluation Report dated 12/3/25 showed R3 had pressure injuries to his left ischium and coccyx area. R3's revised care plan revised on 4/30/24 showed a pressure reducing (low air loss) mattress was listed as one of R3's pressure relieving interventions for R3's pressure injuries. The plan showed no documentation that R3 requested to have his pressure reducing mattress programmed for a specific setting. R3's weight record dated 12/5/25 showed R3 weighed 205.3 lbs.On 12/8/25 at 8:51 AM, the low air loss mattress on R3's bed was programmed for a resident weighing 400lbs.On 12/9/25 at 8:51 AM, R3's low air loss mattress remained programmed for a resident weighing 400 lbs. On 12/9/25 at 9:15 AM, V6 Wound Care Nurse stated low air loss mattress should be programmed at the correct weight of the resident so the mattress can help heal or prevent pressure injuries. V6 stated, If the weight is set too high on the mattress, the mattress will not reduce pressure to the areas with wounds and can impede wound healing. The facility's Pressure Injury Prevention policy dated October 2025 showed, When using low air loss mattress, follow manufacturer's instructions related to use, setting, and care. The facility's low air loss mattress operator's manual (undated) showed, Operating Instructions. Determine the patient's weight and set the control knob to that weight setting on the control unit.

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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 by the physician. There were 30 opportunities with 12 medication errors resulting in a 40% medication error rate. These failures apply to 2 of 3 residents (R23, R47) observed in the medication pass. The findings include:On 12/8/25 at 10:13 AM, V9 Registered Nurse prepared R47's morning medications. V9 dispensed a tablet of chewable aspirin 81mg in R47's medication cup. V9 administered the aspirin to R47.R47's Physician Orders dated 11/26/25 shows and order Aspirin Enteric Coated Tablet Delayed Release 81 mg. Give 1 tablet by mouth in the morning for heart health.On 12/09/2025 at 8:13 AM, V10 Licensed Practical Nurse prepared R23's morning medication including 11 oral tablets. R23 was in her room, in chair, with her breakfast on the overbed table. At 8:23 AM, V10 set R23's medication cup with 11 medications on R23's breakfast tray. At 8:30 AM, V10 administered R23's insulin (R23's medications remained on the breakfast tray). V10 left the room, signed off R23's medications in the computer as administered and then pushed the medication cart down the hall to the other side of the building without making sure R23 took her medications. At 8:35 AM, R23's medications were still on her breakfast tray. R23 said she needs to eat before taking her medications. On 12/8/25 at 2:35 PM, V2 Director of Nursing said if the resident's physician order is for enteric coated aspirin, chewable aspirin should not be given.On 12/09/2025 at 1:30 PM, V2 said a complete medication pass includes preparing the medications, bringing them to the resident, and watching the resident take the medications. V2 said medications should not be left at the bedside for residents to take on their own. R23's Physician Orders for December 2025, do not contain an order for R23 to self-administer her medications. The facility's Administering Medications Policy dated 3/24 shows Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, times and positive verifications of the resident's identity.

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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. Based on observation, interview and record review the facility failed to ensure residents medications were securely stored and inaccessible to residents for 2 of 19 residents (R43, R59) reviewed for medication storage in the sample of 19. The findings include: 1.R43's physician order report printed 12/9/25 showed R43 was prescribed Novolog insulin and Ozempic related to his diagnosis of Type 2 Diabetes Mellitus. The report showed no physician order to allow R43 to keep medications in his room or to allow R43 to self-administer his medications. On 12/8/25 at 10:11 AM, R43 was seated in his bed. On R43's bedside table was a Novolog insulin pen and a pen of Ozempic medication. Both pens had been opened and used, with medication missing from each pen. R43 stated he kept the medications by his bedside because sometimes my meds are given late here so I give them to myself. On 12/9/25 at 8:08 AM, R43's Novolog insulin and Ozempic pens remained on R43's bedside table. On 12/0/25 at 8:09 AM, V2 Director of Nursing stated residents cannot have any medications in their room and/or self-administer their medications unless they have a physician order to do so. The resident must also be assessed by facility staff to self-administer their medications. V2 stated, We have these things in place to make sure a resident is safe to self-administer their meds. On 12/9/25 at 12:26 PM, V1 Administrator stated the facility had not completed a medication self-administration assessment on R43. 2. R59's Physician Order Report printed on 12/9/25 showed R59 has an order for Breo Ellipta inhalation aerosol powder orders as 1 puff inhaled orally one time a day related to chronic obstructive pulmonary disease. With the instructions to rinse mouth with water and spit after use. The report had no order for R59 to store medications or self-administer medications. On 12/8/25 at 10:05 AM, R59 was sitting on the side of their bed. R59 has their Breo inhaler on the bedside table. R59 stated he had just finished with it. When R59 was asked if they needed to do something after taking the medication R59 stated they were not sure. R59's medical record showed no assessments related to self-administering medications On 12/9/25 at 12:45 PM 12 Licensed Practical Nurse (LPN) stated if a resident is going to self-administer medications they need to be assessed and have an order for it. R59's Care plan printed 12/9/25 showed no focus areas of R59 wanting or attempting to be able to self-administer medications. The facility's Administering Medications policy dated March 2024 showed, Medications may be self-administered by residents who have been assessed and determined to be safe and upon physician order. The facility's Self-Administration of Medications Procedure policy dated January 2025 showed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. Building B. Wing	12/10/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside storage of prescription or nonprescription drugs is not permitted unless a resident has been assessed and demonstrates the practice is safe.