Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Care Centre	2313 North Rockton Avenue 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 - Minimal harm or potential for actual harm Residents Affected - Few	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 a resident was supervised while being toileted to prevent an injury. This applies to 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 7. The findings include:R1's face sheet lists her diagnoses to include: Alzheimer's Disease and dementia. R1's unwitnessed incident report dated 2/18/26 shows, CNA (certified nursing assistant) informed writer that resident was on the floor in her bathroom. Nurse arrived observed resident sitting on buttocks with shirt on, brief down to the ankles, and with gripper socks on. The same report also shows, R1 is oriented to person only and other info shows, Resident stated to CNA I will like some privacy while using the restroom. On 2/25/26 at 1:11 PM, V6 Licensed Practical Nurse (LPN) stated, he admitted R1 when she came to the facility a day before. She was agitated about being at the facility but eventually calmed down. She would try to stand up by herself sometimes. She was a high fall risk. The night R1 fell he was doing medication pass when the CNA (V7) informed him R1 fell. He observed her on the floor in the bathroom across from the toilet on her buttocks with her back against the wall. R1 said, she didn't know how she fell and was tired. The CNA (V7) told V6 LPN she assisted R1 to the toilet and R1 asked for some privacy. R1's daughter was in the room at the time and told her it was ok she left because she was in the room with her. V7 CNA left the room. R1's daughter came out of the room and told V7 CNA she was leaving. When V7 CNA went back to the room she found her on the floor in the bathroom. V6 LPN stated, residents who are high risk for falls should not be left alone in the bathroom. On 2/25/26 at 1:39 PM, V7 CNA stated she was the CNA that cared for R1 the night she fell. It was the first time she had taken care of R1 since she was admitted . The last time she took R1 to the bathroom she asked for some privacy. The daughter was in the room and said it was ok she left. It was dinner time and the drinks came up from the kitchen. She was passing out drinks to residents when R1's daughter came to her and told her it was best she left now while her mom was in the bathroom otherwise she would want to leave with her. V7 CNA asked if she was still on the toilet and the R1's daughter told her she was. V7 CNA continued to pass drinks to a few more residents and then went to check on R1. When she got back to R1's room, R1 was already on the floor. The facility's IDPH (Illinois Department of Public Health) incident report form shows, R1 had a fall on 2/18/26 at 6:00 PM. On 2/18/26 the resident (R1) had a fall while attempting to self transfer in her bathroom. The resident pain, no injuries observed on assessment, Provider & POA (power of attorney) notified of fall & provider ordered resident to be sent to the ER (emergency room) for eval (evaluation). EMS (emergency medical system) arrived & resident sent to the ER without incident. Imaging in the ER revealed a left 4th finger fracture. Final Report: Upon staff interview & record review it was determined that the resident was in the bathroom sitting on the toilet with her daughter present in her room, resident daughter stated she would stay with resident while she was in the bathroom, resident daughter approached staff CNA down the hallway & she stated she was leaving 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

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NAME OF PROVIDER OR SUPPLIER Amberwood Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2313 North Rockton Avenue 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility & her mother was still on the toilet in the bathroom. The daughter also indicated she did not want her mother to see her leave. Staff CNA returned to the room to observed resident sitting on her buttocks on the bathroom floor.On 2/25/26 at 2:29 PM, V10 Restorative Nurse stated, R1 was a high risk for falls. When she first came she kept trying to get up. She was pleasantly confused. She told the staff to bring her out of the room and keep an eye on her. Residents who are high risk for falls should always be supervised while toileting. R1's Morse Fall Scale dated 2/16/26 shows, she was a high risk for falling due to history of falling, impaired gait and overestimates or forgets limits. R1's Minimum Data Set, dated [DATE] shows, she is not cognitively intact and requires substantial/maximal assistance with toileting. R1's care plan shows, she has impaired cognitive function or impaired thought processes r/t (related to) Alzheimer's/Dementia, ADL (activity of daily living) self-care performance deficit r/t confusion, impaired balance and is high risk for falls r/t confusion and gait/balance problems. The facility's falls and fall risk, managing policy revised March 2018 shows, Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.