STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146157	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Falls Rehab & Hlth Care C	430 Martin Road Rock Falls, IL 61071

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 0623 Level of Harm - Actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review the facility failed to provide residents the appropriate notice prior to transferring them to another facility for six of 25 residents (R1-R6) reviewed for discharges in the sample of 25. This failure resulted in psychosocial harm, confusion, crying, and scared feelings. The findings include: 1. R1's Admission Record dated November 4, 2024, shows she was admitted to the facility on [DATE], with diagnoses including need for assistance with personal care, muscle weakness, osteoarthritis, depression, bipolar disorder, anxiety disorder, Alzheimer's disease, and schizoaffective disorder. R1's Discharge Note shows she was discharged to another facility on November 5, 2024. On November 8, 2024, at 2:21 PM, V3 R1's power of attorney and sister said she was told by the facility on November 4, 2024, that she had 48 hours to find another place for R1 because the facility was closing. V3 said R1 was upset. V3 said R1 has been at the facility for about [AGE] years, That's her home. V3 said she has visited R1 at the new facility, and V1 is very unresponsive to us. She is confused and scared. She's not normally like this, the move has affected her. The people at the other facility were her family. This has been very hard for her. V3 said that R1 has cried at the new facility. V3 said she went to visit R1 and R1 asked V3 if R1 could go with V3 and V3 had to tell R1 no. V3 said that R1 then started to cry. V3 said that R1 was born mentally challenged and she has dementia. V3 said the facility called her on a Monday and said R1 had to be out of the facility by Wednesday. V3 said she went to the facility on Tuesday November 5, 2024 and the facility had thrown all of her (R1) belongings into garbage bags and boxes. V3 said the facility moved R1 without V3 being present. I wanted to be there for her. I knew the move would be hard for her. V3 said she was angry. V3 said she talked to the facility a while ago when other facilities were closing in another state and asked if V3 should start looking for another home for R1 so that the transition could be smooth and V3 said the facility told her no. 2. R2's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including anoxic brain damage, chronic respiratory failure, tracheostomy, dysphagia, autistic disorder, epilepsy, tracheostomy, and cerebral palsy. R2's Discharge Note shows she was discharged to another facility on November 6, 2024. (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: 146157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER: Rock Falls Rehab & Hlth Care C		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Martin Road Rock Falls, IL 61071	

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F 0623 Level of Harm - Actual harm Residents Affected - Some	On November 8, 2024, at 1:33 PM, V4 R2's mother said she was notified on Monday November 4, 2024, that the facility was closing and the residents had two to three days to find another place. It was very terrible. V4 said R2 was placed two hours away. V4 said the facility put R2 there because that was the only facility that could accommodate R2's needs. V4 said she is now even farther away from R2. V4 said she let the facility place R2 there because it was such an emergency. V4 said she is going to try and find R2 a place closer to V4. V4 said the facility was supposed to give her a 60 day notice, but they did not. 3. R3's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including morbid obesity, osteoporosis, need for assistance with personal care, vascular dementia, and insomnia. The list of discharges provided by the facility shows that R3 discharged from the facility on November 5, 2024. On November 6, 2024, at 3:30 PM, R3 said They gave me two days to get out of the facility. It made me feel bad. On November 8, 2024 at 1:14 PM, V5 R3's Power of Attorney/daughter said she works during the day and had a whole bunch of messages from the facility. V5 said the facility said the place was closing and they had to place V5's mother. V5 said this all started on Monday November 4, 2024. V5 said her sister went to the facility to check on their mother because she was worried about R3's belongings. V5 said the facility said R3 had to be out on November 5, 2024. V5 said she barely got a 24 hour notice. V5 said she went to go see her mother at the new facility on November 5, 2024 where R3 gave V5 the letter from the previous facility's attorney. V5 said R3 was very upset. V5 said she knew the people there for a long time, she doesn't know anyone at the new facility. I was very disappointed how they packed her stuff for the transfer, they threw all of her belongings in garbage bags. They had all the residents lined up at the old facility in the dining room like they were being shipped off.' 4. R4's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including muscle weakness, trisomy 21, autistic disorder, depression, down syndrome, adjustment disorder with depressed mood, morbid obesity, and congenital central alveolar hypoventilation syndrome. R4's Discharge Note shows she was discharged to another facility on November 5, 2024. On November 7, 2024 at 9:55 AM, V6 R4's Power of Attorney/mother said, [Facility] gave us three days to move [R4]. She doesn't belong here. She's not appropriate to be here. R4 was observed in a wheelchair with children's toys all around her. R4's Admission Record shows R4 is [AGE] years old. V6 said that R4 has the mental age of about a third grader. V6 said she is also sleeping in the facility because V6 lives too far away from the new facility. V6 said she wants R4 closer to home and is trying to find placement closer. 5. R5's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including dysphagia, cerebral edema, aphasia, difficulty walking, major depressive disorder, and need for assistance with personal care. R5's Discharge Note shows she discharged from the facility on November 4, 2024. (continued on next page)

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F 0623 Level of Harm - Actual harm Residents Affected - Some	On November 8, 2024 at 4:02 PM, V7 R5's guardian/son said the facility called him on Monday November 4, 2024 and R5 was discharged to another facility that same night. V7 he did not really have time to look for a facility that he preferred. V7 said at the new facility, R5 had a roommate which he stated that R5 was not a huge fan of because R5 is an introvert. V7 said that R5 is still missing her tablet and some pictures. V7 said that R5 is upset about her missing pictures. We could have had a little more heads up. I wanted to go and help her pack up so I made sure she had all of her belongings. I thought they were supposed to give us 60 days. 6. R6's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including congestive heart failure, paranoid schizophrenia, major depressive disorder, weakness, and difficulty in walking. R6's Discharge Note shows she was discharged from the facility on November 4, 2024. On November 8, 2024 at 1:32 PM, V8 R6's Power of Attorney said she was notified of the facility closing on Monday, November 4, 2024. V8 said the facility was moving all the residents by Wednesday. V8 said they only gave her two days. I couldn't believe it! On November 6, 2024, at 12:51 PM V1 Administrator said, the facility building was bought out by another company because the previous company filed bankruptcy. V1 said in September 2024, families were beginning to ask her if the facility was closing and she told them she did not know. V1 said she was telling the families to be prepared. V1 said herself and the facility first became aware of the facility closing on Monday, November 4, 2024. V1 said the families of the residents were notified on November 4, 2024. V1 said the families were told the sooner the residents got out of the building, the better, due to the safety of the building. V1 said there was a rapid turn around for moving the residents out of the facility because it did not give them time to feel bad about the building closing. On November 6, 2024, at 2:06 PM, V9 LPN (Licensed Practical Nurse) said, Two people came in at about 10:30 AM and met with the administration of the building. Then at about 11:45 AM, during the lunch meal, they told us the facility will be closing in three days and we needed to get the residents out as soon as possible. They said everyone needed to be out by Wednesday. At 2:20 PM, V2 DON (Director of Nursing) said, The new owners came in and told us the building was closing and all the residents needed to be discharged by Wednesday, November 6, 2024. [The new company] gave us a list of where the residents needed to go. If the families requested a different facility, then staff had to clear it with the new company first. On November 6, 2024, at 12:20 PM, all residents were out of the facility with the exception of one hospice resident that was actively dying. There were some residents' belongings noted in the main dining room of the facility. Staff members were observed taking belongings in and out of the facility. The letter that was provided to the residents dated November 4, 2024 shows, We regret to inform you that [facility] has made the difficult decision to close due to unsustainable financial losses that prevents us from being able to deliver the high quality care you deserve .Our primary focus prior to closure is going to be your health and well-being, which includes ensuring you are transferred to a facility or other placement that meets your approval and needs .When you relocate to your new home, all of your personal belongings will be prepared for transfer in suitable containers to accompany you. (continued on next page)

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F 0623 Level of Harm - Actual harm Residents Affected - Some	The facility provided an undated list showing a total of 24 residents were discharged from 11/4/2024 through 11/6/2024. The list showed 1 resident remained in the facility. The facility's Transfer and Discharge policy revised October 2024, shows, It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances .The facility's transfer/discharge notice will be provided to the resident and the resident's representative. Generally, the notice must be provided at least 30 days prior to a facility initiated transfer or discharge of the resident.