Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6008007 B. WING 11/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 NORTH MAIN STREET RIVER BLUFF NURSING HOME ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY S 000 Initial Comments S 000 Complaint Investigation: 2219291/IL153567 \$9999 Final Observations S9999 Statement of Licensure Violation: 300.1010h) 300.1210b)2) 300.1210d)2)3)6) Section 300.1010 Medical Care Policies The facility shall notify the resident's h) physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal Attachment A care needs of the resident. Restorative measures Statement of Licensure Violations shall include, at a minimum, the following procedures: Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ **B. WING** IL6008007 11/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 NORTH MAIN STREET RIVER BLUFF NURSING HOME ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) \$9999 Continued From page 1 S9999 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: All treatments and procedures shall be administered as ordered by the physician. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on observation, interview, and record

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: B. WING IL6008007 11/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 NORTH MAIN STREET RIVER BLUFF NURSING HOME ROCKFORD, IL 61103

ROCKFORD, IL 61103								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE					
S9999	Continued From page 2	S9999	# a s					
# # #	review the facility failed to provide the necessary care and services for a resident with a dislocated shoulder for 1 of 3 residents (R1) reviewed for quality of care in the sample of 3. This failure resulted in resident (R1) waiting approximately 12 hours to be transferred to the hospital for acute intervention of a dislocated shoulder.							
N 64	The findings include:							
942 0. Det	On 11/22/22 at 11:21 AM, R1 was observed in a wheelchair at the dining room table with a sling on her right shoulder. R1's right arm was immobilized by the sling. R1 stated she went to the bathroom, washed her hands, and when she came out of the bathroom, she couldn't lift her arm. R1 stated the Certified Nursing Assistant (CNA) was in there with her and nothing							
7 (1) 10 (1)	happened. R1 stated she didn't fall or bump anything with her arm. R1 stated "Oh my God yeah was it painful, the pain was a 10. They told me I had to wait for the X-ray. I had to wait a long time. Why they didn't send me sooner is a good question. I had to wait for X-ray in all that pain. I couldn't lift my arm."							
#() 44	On 11/22/22 at 11:45 AM, V4 CNA stated R1 was in the hall in her wheelchair and told her "Oh my arm hurts." V4 stated R1 told her that her arm was out of the socket. V4 stated R1 was putting pressure on her right shoulder with her left hand to try to relieve the pain.							
2.	On 11/22/22 at 12:35 PM, V6 CNA stated she took R1 to the bathroom in the morning and nothing happened out of the ordinary. V6 stated after she wiped R1, pulled up R1's pants, assisted R1 to sit and then R1 washed her own hands in the sink. V6 stated 10-15 minutes after this, R1 was complaining that her arm hurt, and							

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AND PLAN OF CORRECTION (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
RIVER BLUFF NURSING HOME 4401 NORTH MAIN STREET									
ROCKFORD, IL 61103									
(X4) 1D PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
\$9999	Continued From pa	ge 3	S9999	9					
	she couldn't lift it. Vo and R1 was still wai saying she couldn't	6 stated she left at 2:00 PM ting for her X-ray and kept lift her arm.	i.		61	9			
	stated R1 came out couldn't move her a happened to her be V7 state she asked was told nothing ha stated she did an as squeeze with both h touched R1's right a stated she was unal any further assessman. V7 stated she (NP) and relayed he ordered and X-ray or called and ordered to V7 stated R1 acted move her arm and to she gave R1 her momedication and did afternoon. V7 stated X-ray still had not be arm by her side and	PM, V7 Registered Nurse into the hallway and said she rm. V7 stated R1 told her this fore when she lived at home. the CNA what happened and opened during care. V7 seessment and R1 could lands, but when she barely rm, she cried out "Ouch." V7 ole to do range of motion or nent on R1's right arm due to called the Nurse Practitioner of findings. V7 stated the NP of the shoulder. V7 stated she he X-ray to be done that day, normal unless R1 tried to then she had pain. V7 stated orning scheduled pain give R1 Tylenol later on in the law hen she left for the day the end done. V7 said R1 kept her was not moving it. V7 stated ming or looked like she was we sent her out."	± 10						
E. 3 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	received the call from shoulder dislocation her about R1's histo out, R1's pain with p was not able to do a R1's pain. V8 stated to determine if the sistated she didn't recitive X-ray during the resistance.	PM, V8 NP stated she in the nurse about R1's . V8 stated the nurse did tell ry of R1's shoulder popping alpation, and that the nurse further assessment due to d she ordered a STAT X-ray houlder was dislocated. V8 eive any results from the for her shift, the next NP on 8 stated if she would have	;**		e A ET				

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up portable X-ray for today."

At 4:00 PM, shows "X-ray of right shoulder taken, 2 views. Resident continues to complain of pain and inability to raise her harm. She is able to move her hand and fingers...Medication given for

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