Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	-	COMP	LETED
		IL6008049	B. WING		09/2	9/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
				E BOULEVARD		
ROCK RI	VER HEALTH CARE		RD, IL 6110			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
S9999	Final Observations		S9999			Proceedings
			MANAGE CHILD			
	Statement of Licens	sure Violations:	in in the second			
	300.610a)					OCCUPATION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE
	300.1010h)		Angel Parket Barrell			
	300.1210b)		T-10-10-10-10-10-10-10-10-10-10-10-10-10-			
	300.1210d)6)					
	300.1220b)3)		v pour la company de la compan			
	300.3240a)					
	Section 300.610 Re	esident Care Policies				
		have written policies and		100		
		ng all services provided by the				
		policies and procedures shall				
		Resident Care Policy			1	
	Committee consisting	dvisory physician or the			o Longer	
		mmittee, and representatives				
		r services in the facility. The				
		y with the Act and this Part.				
		shall be followed in operating				
		be reviewed at least annually				
		documented by written, signed				
	and dated minutes	or the meeting.				
					The state of the s	
	Section 300.1010 M	ledical Care Policies			And an angle and the	
	,					
		notify the resident's physician				
		ry, or significant change in a that threatens the health,				
		a resident, including, but not				
		nce of incipient or manifest				
		a weight loss or gain of five				
		nin a period of 30 days. The				
	facility shall obtain a	and record the physician's plan				
		or treatment of such accident,				
	injury or change in c	condition at the time of			***************************************	I

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATE FORM 6899 ZUL911 If continuation sheet 1 of 33

STATEME	NT OF DEFICIENCIES	(V4) BBOV(BBB)(VIBB)					
	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		(X3) DATE SURVEY	
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		IL6008049	B. WING		09	/29/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE			
DOCK E	N/ED HEALTH CADE			DE BOULEVARD			
ROCK	IVER HEALTH CARE		RD, IL 611				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	al	PROVIDER'S PLAN OF CORREC	TION		
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1/10	THE STATE OF THE	SO IDENTIFY THIS INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
\$9999	Continued From pa						
03300		ge i	S9999				
	notification.		Sample of the sa				
	Section 300 1210 G	eneral Requirements for					
	Nursing and Person	al Care	TOTAL COLOR OF THE				
	b) The facility shall p	provide the necessary care					
	and services to attai	n or maintain the highest					
	practicable physical,	mental, and psychological				187	
	each resident's com	ident, in accordance with prehensive resident care	and the second				
	plan. Adequate and	properly supervised nursing	Surgicial designation of the surgicial surgici				
	care and personal ca	are shall be provided to each					
	resident to meet the	total nursing and personal					
	care needs of the re-	sident.					
	d) Pursuant to subso	ection (a) general survivo					
	care shall include at	ection (a), general nursing a minimum, the following					
	and shall be practice	d on a 24-hour.				TOTAL DE BERTHAM	
-	seven-day-a-week ba	asis:					
A MA NAVA	0) 411					77	
	6) All necessary prec	autions shall be taken to					
	assure that the resident by	ents' environment remains					
'	as iree or accident na nursing personnel sh	azards as possible. All all evaluate residents to see				Notice to the second se	
	that each resident red	ceives adequate supervision					
:	and assistance to pre	event accidents.					
TO THE SECOND SE	·	The state of the s					
	2 (1 222	Option to the state of the stat					
	Section 300.1220 Sup	pervision of Nursing					
	Services						
***************************************						THE PROPERTY OF THE PROPERTY O	
l t) The DON shall sun	ervise and oversee the				The state of the s	
r	nursing services of the	e facility, including:					
		_					
3	 Developing an up-t 	o-date resident care plan for					
e	each resident based o	on the resident's					
C	omprenensive asses	sment, individual needs					

Illinois Department of Public Health

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION :		E SURVEY PLETED
		IL6008049	B. WING		09/	29/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCK R	IVER HEALTH CARE		RIVERSIDI RD, IL 6110	E BOULEVARD 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	and goals to be according personal care are representing other sactivities, dietary, are ordered by the personal care in the preparation of the plan shall be in writing modified in keeping indicated by the resistant be reviewed at Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent of a facility shresident. (A, B) (Section 300.3240 A a) An owner, license agent agent of a facility shresident agent agent of a facility shresident agent	omplished, physician's orders, and nursing needs. Personnel, services such as nursing, and such other modalities as obysician, shall be involved in the resident care plan. The ing and shall be reviewed and with the care needed as ident's condition. The plan is least every three months. Buse and Neglect the administrator, employee or all not abuse or neglect a cition 2-107 of the Act) Is are not met as evidenced and in 1:1 supervision when she of suicide. The facility failed and shoe laces) from her id talked about using or had empts. These failures inpting suicide with her shoe around her neck on 6/22/14. Of five residents (R12) elated to suicide risk in the	S9999			

PRINTED: 11/06/2014

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6008049 B. WING _ 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD **ROCK RIVER HEALTH CARE** ROCKFORD, IL 61103 (X4) II PRÉF

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	·
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		
	ideations and attemptsAge 50 R12 reports ongoing suicide ideations with numerous attempts: cut self, strangle with shoe strings, and bag over head. R12 would likely benefit from continued groups to gain coping skills and symptoms management. The Pre-Admission Screening Mental Health Level II Notice of Determination dated 11/23/13 shows R12 requires special services: "Professional Observation (MD/RN) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Illness self management, and Community re-integration activities." R12 was admitted to a psychiatric Hospital from 4/9/14-4/29/14 for inpatient treatment due to the severity of her suicidal and self-destructive thoughts. The Medical History and Physical Examination form from the psychiatric Hospital on 4/9/14 states, "R12 is depressed and suicidal. R12 put a cord aroundr neck to kill herself and later changed her mind. R12 has a history of physical and sexual abuse at the age of 10. R12 has auditory and visual hallucinations R12 hears devil 's voiceR12 suffers fromPost Traumatic Stress Disorder The My Safety Crisis Plan sent with R12 on discharge from the psychiatric hospital on 4/29/14 shows R12's Triggers and Stressors include: "any kind of sexual abuse reference, slamming doors, raised voices, conflict, feeling ignored, feeling invisible, people coming up behind me, unpredicted changes." R12's warning signs include: sleeping too much, and withdrawing. Other plans on the My Crisis Plan Sheet included guidance on coping skills and People to call and Reminders. This sheet was marked as copy for reatient. This form was discovered in the thinned			
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llinois Department of Public Health STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO		
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ROCK RIVER HEALTH CARE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO		
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S9999 Continued From page 4	(X5) COMPLETE DATE	
STEEL STREET		
portion of R12's record, stored in the basement, not readily available to the resident or staff. On 9/22/14 at 4:00PM, E2 (Director of Nursing) said this should be incorporated into her care plan. On 6/12/14 the Social Services Notes by E3 (Social Service Director) states,"R12 shows signs and symptoms of depression. R12 tends to appear and feel depressed daily has had thoughts of suicide, has sleep disturbances, and lacks energy at timesR12 has had three psych hospitalizations for suicidal ideation since admission, currently stable." On 6/12/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows R12 has a score 10. A score of 6-15 is at moderate risk. The Risk Screening Assessment for Indicators of Aggressive, Harmful and/or Inappropriate Behaviors 6/12/14 shows R12 has a score of 6 (a score of 0-10 is at minimal/low risk). The Screening Assessment to Determine the Presentation of Abuse and/or Neglect Factors 6/12/14 shows R12 has a score of 4 (a score of 4 or more represents a high risk). The Psychiatric Consultation progress note dated 6/16/14 said, R12 with recent suicide ideation and plan in place. R12's plan is to place a plastic bag around her neck. The trigger is relieved by removing the pillow case bag from the pillow. There are significant symptoms of depression and mood changes. R12 needs more psychotherapy. On 6/20/14 26 (Psychiatrist) stated, "R12 reports chronic suicidal thought. R12 reports 2 days ago she had thoughts to wrap her panty hose. R12 reported last night she hid her Prazadone (Anti-psychotic medication) in her closet with the plan to save her meds and take them on Monday night. 15 minute checks at night		

PRINTED: 11/06/2014 FORM APPROVED 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 B. WING IL6008049 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD **ROCK RIVER HEALTH CARE** ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 The Nurse's Notes dated 6/20/14 said, R12 has been storing Trazadone in her closet. R12 said, she had a plan to take all her medications at once one night. Fifteen minute checks ordered and watch R12 take medications. On 6/20/14 the Social Service Notes by E3 states, "Z6 (Psychiatrist) called the facility and spoke with nurse stating that during visit R12 stated that she was not taking Trazadone. R12 was saving pills to hurt herself. A Room check was done and two pills were found. Z6(Psychiartist) placed R12 on 15minute checks." On 6/20/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows a score of 13. A score of 6-15 is at moderate risk. E3(SSD) wrote on the Screening Assessment, R12 was reassessed on this date related to making a suicide statement. E3 felt that resident was not a threat to herself. For 6/22/14 (Saturday) there was no documentation of 15 minute checks for R12. On 6/22/14 at 5:55 PM, An Incident and Accident Report states, "R12 wrapped shoe strings and call light around her neck and R12's face was turning blue. All ties and cords cut and removed. R12 kept pulse during whole process911 called, Director of Nursing on site, Medical Doctor notified, family called, sent to Emergency room per protocol." The Nurses Note dated 6/22/14 states, "Certified Nursing Assistant to answer R12's call light and then yelled out loudly multiple times "Help!!!" I

ran to R12's room and observed shoelaces and call light cord all tied around her neck and R12's

immediately used my medical scissors and cut all ties around her neck and also removed call light cord. R12's color returned to pink immediately and she let out a deep gasp.. I asked R12 why did

facial color was beginning to turn blue. I

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
7.10.0.		IDENTIFICATION NOMBER:	A. BUILDING:		СОМ	COMPLETED	
	H 6000040			į			
		IL6008049	B. WING _		09/2	29/2014	
NAME OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE			
ROCK R	IVER HEALTH CARE			DE BOULEVARD			
	CULTUTOVOTA		RD, IL 611	03			
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				DEFICIENCY)			
S9999	Continued From page	ge 6	S9999				
	you decide to do this	s? R12 stated," I ' m done."					
	What are you don	e with? R12 stated, "Life"					
The state of the s	How long have you	been feeling this way? R12					
	states, "3 days" I as	ked her did you tell anyone					
	about how you were	feeling? R12 states," Yes,					
	my medication"	nly said, he would increase					
		Note dated 6/27/14 by					
	E3(SSD) states." R1	2 was readmitted on this					
770	date from Rockford	Memorial Hospital Behavioral					
	Health Unit To ens	ure R12's safety the following			:		
	actions have been p	ut in place. R12 will be on 15					
	minute checks for fir	st 24 hours on 6/28 and 6/29					
	R12 will be on 30 mi	nute checks. On 6/30R12					
****	Will be on 1 hour che	cks for 90 days. R12's call					
THE COLUMN	laces removed from	/edR12 also has had all shoesno plastic bagsall					
	precautions have her	en care plannedR12 will					
	be encouraged to att	end group in facility"					
	The 1 Hour Care She	eet for R12 from 6/30/14 -			Proposition		
!	9/16/14 shows no do	cumentation for 9 days, 7			D. Mary or visit of the control of t		
	Care Sheets are com	pleted hourly, and remaining					
	sheets are not docum	nented hourly.					
	On 9/18/14 at 11:00A	M, E22 (Medical Records)					
	said, triese are the or he was able to find.	nly hourly care sheet records					
		through June 2014 shows					
	R12 has a history of	suicide attempt as well as			Topologica		
	suicidal ideation. In th	ne past two years she has			3		
	nad more than 50 atte	empts with most recent			14 (1.00 m) 1 (1.00 m)	l	
(choking herself with s	shoe laces and call light cord					
a	around her neck on 6	/22/14. R12 has a			PERMITALA	i	
	nagnoses of Major D	epression recurrent and					
L	Sipolar Disorder. R12	2's Care plan states," In the			Andre Annum		
E	sveni inai KTZ exhibit	ts behavior of thoughts or			And the second s		
	ncemple to Harmself,	R12 is to placed on one to Medical Doctor to be notified					
r	esident will be monite	ored till discharged to				l	
h	ospital." R12's Care	Plan was not revised to				ļ	
ir	nclude removing plas	tic bags and shoelaces,	And the state of t				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION C:		SURVEY PLETED
		IL6008049	B. WING		09/:	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
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ROCK R	IVER HEALTH CARE		RD, IL 6110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	supervision checks, On 9/17/14 at 11:45 shoes with shoelace On 9/17/14 at 2:00 licans with trash bag. On 9/22/14 at 3:05 licans with trash bag. On 9/22/14 at 4:10 licans of the commate's bed. On 9/22/14 at 4:10 licans licans licans of the commate's bed. On 9/22/14 at 4:10 licans li	and attend group. AM, there were four pairs of es underneath R12's bed. PM, there were two garbage in R12's room. PM, a garbage bag was in d a garbage bag was near her PM, E19 (Housekeeping I took the bags out of her they weren't supposed to be hat on to my housekeepers." PM, E3 (SSD) stated, "R12 she has feelings or issues to gap in time where she had call lightI don't have now. They stopped in July." AM, R12 said, Groups have habout 2 months. I think the hen we had them. AM, E23(Licensed Practical ehaviors are managed well sy. Isolation increases her The Sheet dated through the shear of the policy and the policy titled Policy and the policy				
E	Behavior under section	on II describes what the			anomanono adina	

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6008049 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD **ROCK RIVER HEALTH CARE** ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 8 S9999 facility is to do when a resident threatens or attempts to self harm. Under Verbal Threat and plan, in the event a resident makes a negative statement (indicating) self harm and voices a plan: a) the resident will be immediately placed on one to one supervision, b) The nurse in charge will immediately contact the Administrator. Director of Nursing and the Social Service director, c) the nurse in charge will contact the physician for (an) order for a psych evaluation, d) If an order cannot be obtained from the physician, the resident will be sent out on petition with 911, and e) (the) responsible Party will be notified of the event and facility policy. B. Based on observation, interview and record review the facility failed to ensure residents safety by not revising approaches for a resident who had 12 falls in the past 9 months (1 fall resulting in a hip fracture), failed to conduct neurochecks after a resident fell twice and hit his head, failed to lock the treatment cart and failed to keep chemicals in locked storage. This applies to 2 of 3 residents (R5, R17) reviewed for safety in the sample of 19. The Findings Include: 1. R5's September 2014 Physician Order Sheets shows R5 has a diagnoses including Osteoporosis, Weakness and Hip Fracture. R5's History and Physical from a previous hospitalization on 4/2/14 states, R5 has a history of recurrent hip dislocations ...R5 reported that she was trying to get out of bed alone and fell. The Minimum Data Set assessment of 6/20/14 shows R5 transfers with a two person assist. On 9/16/14 at 1:20 PM, R5 stood up by herself attempting to transfer from her wheelchair to her

bed. R5 held on to her side table and bed for assistance. E10(Licensed Practical Nurse) was at

the bedside and did not assist R5 with her transfer. The chair alarm did not alarm.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008049	B. WING		09/	29/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCK R	IVER HEALTH CARE		RIVERSID RD, IL 6110	E BOULEVARD 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	wheelchair by herse alarm. On 9/16/14 at 1:05 F Nurse) said, R5 trans has a chair/bed alarm. R5's Care Plan date had a fall that results shows staff to assist transfer to/from whe R5's Care Plan was has had 8 falls since was not in the Care The Fall Risk Assess year documented sh score of 10 or more falls. 3. The February 201 showed R17 was adwith diagnoses to incomplete the fall risk assessed R17 as semaking and needing for transferring. R17 unsteady for balance required 1-2 staff for Living) except eating. The fall risk assessment of the fall risk assessment risk a	AM, R5 stood up from her lf. The chair alarm did not PM, E10 (Licensed Practical sfers with 1 staff assist and m. d through April 014 shows R5 ed in a hip replacement. It with all transfers. R5 is not to elchair or toilet without staff. last revised on 3/28/14. R5 ethen. The bed/chair alarm Plan. Sments dated July with no ows R5 has a score 12. A represents a high risk for 4 Physician's Order Sheet mitted to the facility on 2/5/14 clude: Dementia, Diabetes Renal Disease, Chronic ary Disease and Set (MDS) of 2/19/14 everely impaired for decision Ilimited assistance of 1 staff was assessed as being during transfers. R17 all ADL's (Activities of Daily ent completed 2/5/14 high risk for falls.	\$9999			
	ransterred self to/fro	om wheelchair without	***************************************			

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DA7	TE SURVEY
	ANDI	VOI SOMMESTICIT	IDENTIFICATION NUMBER:	A. BUILDIN	G:	CON	MPLETED
			IL6008049	B. WING _		09	/29/2014
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
	ROCK R	IVER HEALTH CARE			DE BOULEVARD		
ŀ	/VA) ID	SHIMMADV STA		RD, IL 611			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	S9999	Continued From page	ge 10	S9999			
	- till ar Till	supervision is remin request assist due to "On 2/21 at 10:30pm propels wheelchair a reminders to reques "On 3/12 (10:20pm), not to get out of bed assist." The care plan initiate cognitive/function or thought processes. 2/25/14 and showed deconditioning. App the resident's needs. falls and attempt to compose the pad alarm in bed, wheelchair, check fur and ensure it is on arroom. The nurse's notes on a larm like he had in the nurse's notes on a larm like he had in the head chair to recline e fell and hit the bace	ded by staff that he should by safety." n, "Resident alert to self. Self able to transfer self but needs it assist for safety." Resident needs reminders or up from chair without ed 2/25/14 showed R17 has Dementia related to impaired The falls care plan is dated R17 is at risk due to roaches include: Anticipate Review information on past letermine cause of falls. causes. Alter/remove any possible. evised on 3/7/14 to include: Arecliner and while in actioning with every transfer and active prior to leaving the sethe resident to have an the hospital). 3/4/14 (6:10am) describe, y staff transferring from and fell. Resident stated k of his head on the wall.	S9999			
	P 6 T p;	OA were not notified: :10am. he "Head Chart" for atients vital signs, pu onciousness after he	5:00pm document MD and of the fall that occurred at m is used to monitor upils, and level of ead injuries/unwitnessed sed sed injuries/unwitnessed sed sed injuries/unwitnessed sed sed sed sed sed sed sed sed se				

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If continuation sheet 12 of 33

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6008049	B. WING		09/:	29/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
POCK R	IVER HEALTH CARE	707 WEST	RIVERSIDI	E BOULEVARD		
NOOK III	VERTICALITY OAKE	ROCKFOI	RD, IL 6110	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S999 9	Continued From page	ge 11	S9999			
	the time of the incide. The head chart was of 21 times in a 72 h 6:40am, 6:55am, 10 and 2:10pm. E2's n completeing the ass documentation of vit 6:55am to 2:10pm. documentation of vit 2:10pm to 3/6/14 at Comments on the fabackwards, with just wheelchair. On 9/22 asked why R17's he incomplete. E2 stawhy there were gaps R17's nurse's note owheel chair all night, elevate edematous I min checks by staff a (9:20pm) Resident in the bed, attempted to wheelchair, resident resident stood, startenurse and CNA, but resident. He slipped bed. Assisted off floopost-Fall investigation	ent was 6:10am on 3/4/14. incomplete and only done 6 nour period: at 6:25am, i:10pm and on 3/5 at 6:10am ame was in the area as ressment but there was no tals shown on 3/4 from There was no tals/nerochecks on 3/5/14 at 6:10am (72 hour monitoring) all checklist described R17 fell resocks on, transferring self to 1/14 at 10:00am, E2 was ad chart form for 3/4/14 was ated, "I honestly don't know in the neurochecks." In 3/5/14 (8:00am), Sat in refused to sit in recliner and regs. No alarm present, 30 all night. In room in wheel chair next to reso stand without locking in stocking feet. When red to slide, which alerted staff could not get to and landed on butt next to or per 2 and into recliner. In report dated 3/5/14	39999			
Total Annual Control of Control o		ot attached to the resident.				
c F t	showed, Vital signs to Up in recliner at time complained of heada R17 blew nose and la issue. Alarm in plac (1st shift)- Resider refused dialysis said,	iche. PRN Tylenol given. arge amount of blood was in				

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(A1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DAT COM	E SURVEY IPLETED
			IL6008049	B. WING		09/	29/2014
-	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		=0/2017
	ROCK R	IVER HEALTH CARE			E BOULEVARD		
				RD, IL 6110	13		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	S9999	Continued From pag	ge 12	S9999			
		labs to be drawn for and Hemoglobin 5.6 resident to ER for extransfusion. Resider 3/10/14.	Alysis informed nurse that stat Hemoglobin. Results back Received orders to send ral and treatment with nt returned from hospital on				
	100-1-707-201-101-101-101-101-101-101-101-101-101	R17 is a fall risk occa transfers, decreased cues for redirection a Unable to perform at	y note dated 3/11/14 showed asional impulsive as to safety awareness, required and safety. Ambulation: this time due to decreased and activity tolerance.				
	in the first section of the section	heard falling on to the Client on back and waside. Bed/chair alarn CNA last seen reside with alarm attached. In the back of his hear the back of his cell phone. Clesident to his bed to notident report of the stad a bump on the bafty cent piece. The collection is the bafty cent piece.	npleted after R17				
	ai pi ch [T	nd was sent out and revious Director of N narge covering a call the procedure when	2 said [on 3/15/14] R17 fell suffered a hematoma. The ursing was the nurse in off when it happened. someone falls] an incident it is reassessed and vitals				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION DE LE CONSTRUCTION		E SURVEY PLETED
		IL6008049	B. WING		09/	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROCK R	IVER HEALTH CARE		r RIVERSID RD, IL 6110	E BOULEVARD 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S99 99		ge 13 irs, neurochecks are done	S9999			
		ation tool is filled out by the				
	scan of the head wa	sical of 3/15/14 showed, "CT is done which showed some odural hemorrhage." R17 was asive Care Unit (ICU).				
	details of the incider ambulance company	ort dated 4/7/14 described the ort, On 3/15/14 at 12:36am the oy received a call from the g that R17 had fallen. At				
	12:52am the ambula home and found R1 with a bump to the b	ance arrive at the nursing 7 sitting in a chair in his room ack of his head. He seemed arse stated that this was				
	normal and also he t stand and get on the given a CT scan of t	falls alot. R17 was able to hir cot. At the ER, R17 was he head which showed a	į			
77700	More CT's of the hea subdural hematoma	He was admitted to ICU. ad were done and showed his had worsened. His mental e after a few days and he				777707700000000000000000000000000000000
770700000	was seen by the pall the family opted to s	iative care team. On 4/1/14 end R17 to another facility.				
		7 expired on 4/7/15 at e of death was Subdural dary to a Fall.				
TA A	room on the 2nd floo	d 9/17/14 the soiled utility r was unlocked. The door's covered over by masking	The state of the s			
•	tape. The room cont containers such as d cleaner and floor clea	ained bulk cleaning supply isinfectant, toilet bowl aner. The containers posted	And the second s			
•		nful if Swallowed", "May and "Keep Out Of Reach Of 4 (Housekeeping				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		IL6008049	B. WING		09/3	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	1 00/2	.3/2014
DOCK B	IVED HEALTH CADE			E BOULEVARD		
ROCK R	IVER HEALTH CARE		RD, IL 6110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	ge 14	S9999			
	Supervisor) said the	lock was broken				
	,					
000 mm m m m m m m m m m m m m m m m m		(A)				
	300.610a)					
W	300.1210b) 300.1210d)5)				and the state of t	
	300.3240a)				O TOTOLOGICA ANALASA	
A CANADA					A PROPERTY OF THE PARTY OF THE	
	Section 300.610 Res					
	 a) The facility shall he procedures governing 	ave written policies and g all services provided by the				
	facility. The written p	olicies and procedures shall				
	be formulated by a R	Resident Care Policy				
	Committee consisting administrator, the ad-	g of at least the visory physician or the				
	medical advisory con	nmittee, and representatives	T T T T T T T T T T T T T T T T T T T			
	of nursing and other	services in the facility. The				
	The written policies s	with the Act and this Part.			and the state of t	
1	the facility and shall t	be reviewed at least annually			T COLOR	
	by this committee, do and dated minutes of	ocumented by written, signed				
•	aria datea minates of	rule meeting.			THE STATE OF THE S	
and the second s	Soction 200 4040 O -	and Decision 1.5				
	Nursing and Persona	eneral Requirements for all Care			THE REPORT OF THE PARTY OF THE	
	-				http://www.neidololol	
1	ו ו ו ו ו ו ו ו ו ו ו ו ו ו ו ו ו ו ו	ovide the necessary care or maintain the highest			AAC	
F	oracticable physical, i	mental, and psychological				
V	vell-being of the resid	dent, in accordance with	volencement a second			
F	each resident's comp plan. Adequate and p	rehensive resident care roperly supervised nursing	A PARTICULAR PROPERTY AND A PARTICULAR PROPE			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
IL6008049		B. WING		09/	29/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	IDRESS CITY	STATE, ZIP CODE		20/2014
				E BOULEVARD		
ROCK R	IVER HEALTH CARE		RD, IL 6110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
s999 9	Continued From page	ge 15	S9999			
	care and personal or resident to meet the care needs of the re	eare shall be provided to each total nursing and personal esident.	Wedge of Additional Communication Communicat			
A CONTRACTOR OF THE CONTRACTOR	d) Pursuant to subsecare shall include, a and shall be practice seven-day-a-week b					
TO COLOR OF THE PROPERTY OF TH	pressure sores, hea breakdown shall be seven-day-a-week be enters the facility with develop pressure so clinical condition der sores were unavoidate pressure sores shall services to promote	n to prevent and treat t rashes or other skin practiced on a 24-hour, easis so that a resident who chout pressure sores does not ores unless the individual's monstrates that the pressure able. A resident having receive treatment and healing, prevent infection, essure sores from developing.				
	agent of a facility sha	ouse and Neglect e, administrator, employee or all not abuse or neglect a tion 2-107 of the Act)				
	These Requirements by:	s are not met as evidenced				
1	review, the facility fainutritional status by recommended to see the contraction of the facility failure restound weight loss in the failure restound weight loss in	n, interview, and record led to maintain residents not identifying causes for a s in one month for a resident r nutrition through a feeding ulted in R7 experiencing a 20 one month and developing being solely tube fed.				

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This applies to 1 of 2 residents (R7) reviewed for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)	DATE SURVEY	
1 (A3) MOETIFIE CONSTRUCTION 1 (A3)	DATE SURVEY	
I AND FLAN OF COUNCILLINE I IDENTIFICATION NUMBER:	COMPLETED	
IL6008049 B. WING		
12000049	09/29/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCK RIVER HEALTH CARE 707 WEST RIVERSIDE BOULEVARD		
ROCKFORD, IL 61103		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFINE (EACH CORRECTIVE ACTION DEFINE)	(X5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE E DATE	
DEFICIENCY)		
S9999 Continued From page 16 S9999		
tube feeding in the sample of 19.		
The findings include:		
On 9/15/14 at 11:20 AM, R7 had Fibersource HN		
1.2 tube feeding being administered at 50ml		
(milliliters) per hour with a pump.		
R7's MDS dated 5/31/14 showed that she is		
totally dependent on staff for activities of daily		
living and that she is at risk for pressure ulcers.		
On 5/22/14, R7's Braden scale-for predicting		
pressure sore risk was 7 (severe risk).		
R7's care plan for tube feeding initiated on 6/4/14		
shows an intervention of: RD (registered dietitian) to evaluate quarterly and as needed (PRN).		
Monitor caloric intake, and estimate needs. Make		
recommendations for changes to tube feeding as		
needed.		
The facility's undated tube-feeding policy states, "		
The dietician will complete a comprehensive		
nutritional assessment determining the		
appropriateness of the tube feeding order. The		
dietitian may make a recommendation to the		
physician to consider changing the tube-feeding if		
indicated. The dietitian will reassess the tube-fed		
resident's needs on a monthly basis. The		
facility's undated nutritional assessment policy		
states, " A comprehensive nutritional assessment		
is completed by the appropriate health		
professional within 14 days of admission. This		
includes information on the resident's nutrition		
status and requirements. Nutrition needs are		
reassessed quarterly and annually unless there is		
a change of condition which pertains to the		
resident's nutritional status.		
R7's admission physician's order sheet dated		
5/22/14 shows an order for NPO (nothing by		
mouth) and an order for Isosource HN 1.2 at		
50ml per hour continuously. R7 has been on		
Isosource or Fibersource (calorie equivalents) at		
50ml/hour since admission. R7's complete		
metabolic panel done on 6/4/14 shows a glucose		

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008049	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/	29/2014
ROCK R	IVER HEALTH CARE	707 WES		E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	(blood protein) of 2. July weight that was weights list report w weight that was doc monthly weights and lbs. R7 had a 20 por R7's resident admisdated 5/22/14 showed ulcers. The facility's 7/29/14 showed a faright buttock measure open wound with 50 serous drainage. R3 reviewed and no die On 9/16/14 at 8:50 A	al 70-102) and an albumin 8 g/dL (normal 3.4-5.0). R7's documented on the facility's as 165 lbs. R7's August umented on the facility's divitals 2014 form was 145 and weight loss in 1 month. sion nursing assessment ed R7 had no pressure wound spreadsheet dated acility acquired wound to the ring 2.6 cm x 2.6 cm x .1 cm % granulation tissue and light 7's medical records were titian notes were found. M, E2 (director of I, "There has not been a	S9999	SEL GIEROT)		
	Section 300.4000 Ap	plicability of Subpart S			4000	
		2002, a licensed SNF or ICF persons with serious mental				

. Illinois	Department of Public	Health				
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	IL6008049		B. WING		09/2	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROCK F	RIVER HEALTH CARE	707 WEST		E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S999 9	Continued From pa	ge 18	S9999			
	illness shall meet th Subpart S.	e requirements of this				
	serious mental illnes S shall also comply F, G, H, I, J, K, L, M In case of a conflict	ig services to persons with sign accordance with Subpart with Subparts A, B, C, D, E, I, N, O, P, and R of this Part. between those Subparts and estringent requirement				
	for Residents with S	Comprehensive Assessments erious Mental Illness s Subject to Subpart S			TO THE STATE OF TH	
	Team (IDT) for each of persons that repredisciplines, or service identifying an individe and that designs a partner IDT includes, at resident's guardian; Services Coordinate primary service prove LPN with responsibilithe individual; a psycactivity professional; professionals and cathe resident's needs guardian may also in with the IDT and participant in the resident of the reside	establish an Interdisciplinary resident. The IDT is a group essents those professions, se areas that are relevant to ual's strengths and needs, rogram to meet those needs. a minimum, the resident; the a Psychiatric Rehabilitation (PRSC); the resident's iders, including an RN or an lity for the medical needs of chiatrist; a social worker; an and other appropriate are givers as determined by . The resident or his or her livite other individuals to meet ticipate in the process of ent's strengths and needs.				
	performing a compre needed to suppleme	ntify the individual's needs by chensive assessment as nt any preliminary evaluation dmission to the facility. The				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	<u> </u>
		IL6008049	B. WING		09/29/2014	4
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROCK R	IVER HEALTH CARE			E BOULEVARD		
()(4) 15	CHAMAA DV CTA	TEMENT OF DEFICIENCIES	RD, IL 6110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMP	LETE
S9999	Continued From pa	ge 19	S9999			
	assessment shall be	e coordinated by a PRSC.				
	PRSD or PRSC sha statement for the ID findings regarding the limitations; indicates interests, expectation motivation for psych prioritizes needs for improved functioning independence. Section 300.4020 Fix with Serious Mental Subject to Subpart Statement review of assessments and tre PRSC shall inform the change in resign appropriate IDT mer	Reassessments for Residents Illness Residing in Facilities Be months, the PRSC shall the resident's progress, eatment plans. If needed, the ne appropriate IDT members ident's condition. The mber will reassess the e the resident's assessment,				
	for Residents with Sor Residing in Facilities k) The resident's trea and approve the resideveloped by the ID ² and approval shall be	adividualized Treatment Plan erious Mental Illness Subject to Subpart S ating psychiatrist shall review dent's treatment plan as T. The date of this review e entered on the resident's e signed by the attending				

PRINTED: 11/06/2014 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6008049 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD **ROCK RIVER HEALTH CARE** ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 20 S9999 Section 300.4040 General Requirements for Facilities Subject to Subpart S a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S: 4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness. symptom management, and substance abuse avoidance: Section 300.4080 Community Based Rehabilitation Programs for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S Community-based (off-site) rehabilitation programs shall be used as an adjunct to the facility program where their use will assist in community reintegration or in the development of relationships with the agency that will be providing services to the individuals after discharge. The facility shall develop and maintain working relationships and written agreements with community agencies that provide psychiatric rehabilitation services. Appropriate records shall be maintained for residents receiving psychiatric rehabilitation services from outside agencies. These records shall show the appropriateness of

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other pertinent observations.

the program for the individual, the ITP objectives addressed, the interventions being utilized, the

These Requirements are not met as evidenced

resident's response to the program, the responsible community agency staff, and any

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6008049	B. WING		09/2	29/2014
	PROVIDER OR SUPPLIER	707 WEST		STATE, ZIP CODE E BOULEVARD 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	facility failed to prov serious mental illnes Subpart S and comp This applies to 2 of reviewed for Subpart 11 residents (R29, F R43, R44, R45, R46 sample. The findings include On 9/16/14 at 10:45 Director - SSD) state Retardation, Develo Traumatic Brain Inju- diagnoses for Subpart The 13 residents (R R41, R42, R43, R44 are eligible for Subp During a confidentia person stated, "Noth S. There aren't any wasn't any documer yesterday." On 9/18/14 at 3:50p Administrator) state place for Subpart S. compliance. I have to long time. I know it von a survey that I he 300.3240a) then.	riew and Record Review the ride services to persons with a ss (SMI) in accordance with ply with all of the subparts. 13 residents (R5 & R12) rt S in the sample of 19 and R30, R39, R40, R41, R42, S, & R47) in the supplemental etc. From E3 (Social Service red, "Dementia, Mental right personal Disabilities and ries are disqualifying rart S (Serious Mental Illness). 5, R12, R29, R30, R39, R40, R45, R45, R46, & R47) on the list rart S services." If interview on 9/18/14, the ring is being done for Subpart groups being done and there right attention on these people until	\$9999			
POOLALA BARRANIA ANTARA	facility failed to have identifies the individu comprehensive asse	an interdisciplinary team that ual's needs by performing essments and structured h resident's interests and				

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STATEMENT OF DEFICIENCIES (VA) PROVIDED (STATEMENT OF DEFICIENCIES	Taxas =
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
IL6008049 B. WING	09/29/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/29/2014
ROCK RIVER HEALTH CARE 707 WEST RIVERSIDE BOULEVARD	
ROCKFORD, IL 61103	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED DEFICIENCY TAG CROS	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
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expectations regarding psychiatric rehabilitation. This applies to 1 resident (R43) that was reviewed for Comprehensive Assessments under Subpart S Guidelines in the supplemental sample. The findings include: The Department of Human Service (DHS) Assessment Summary for R43 dated 10/12/11 showed, "Schizoaffective Disorder and Personality Disorder, R43 rambling off topic at times. R43 is able to be redirected. R43 appears to have some religious preoccupation. History of delusions is noted. R43 requires prompts/cues from staff for med taking and cleaning. R43 will require ongoing psych services to maintain his current stability. R43 has been placed in a nursing facility in the past for the same issue and once stabilized he was able to return to community living." The DHS/Mental Health Level II Notice of Determination dated 3/20/13 for R43 showed the following special services are needed, "Professional observation (Medical Doctor/Registered Nurse) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of daily Living Training/Reinforcement, Mental Health Rehabilitation activities, Aggression/Anger Management, Illness Self Management, Incentive Program to improve participation in treatments and Community Re-integration activities." R43 did not have a structured assessment of his interests and expectations regarding psychiatric rehabilitation. R43 does not have an initial or annual assessment of his Level of Functioning/Skills. On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		IL6008049	B. WING		09/	29/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
ROCK R	IVER HEALTH CARE			E BOULEVARD			
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	on a survey that I he then." On 9/17/14 at 10:55 Director - SSD) stati interdisciplinary teal Comprehensive Assadmission (the initia There are not any row. The rehab I hasome of them. The Assessment is done annually or with a si	elped them with and it was out 5am, E3 (Social Services ted, "There isn't an m for Subpart S right now. sessments should be done at al one) and then annually. ehabilitation interventions right ave been doing is 1:1 with Level of Functioning e at admission and then ignificant change."					
	The facility failed to psychosocial, skills summary for resider reassessment is not This applies to 1 of Subpart S in the sar	13 residents (R5) reviewed for mple of 19 and 5 residents 5 & R46) in the supplemental					
	On 9/18/14 at 3:50pt Administrator) stated place for Subpart S. compliance. I have to long time. I know it von a survey that I he then." R5, R39, R40 & R43 Functioning/Skills As	m, E22 (Corporate d, "There isn't anything in The entire thing is out of been telling them that for a vas written here one year ago elped them with and it was out d, do not have Level of ssessments. chiatric Note/Evaluation for					

PRINTED: 11/06/2014 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6008049 B. WING 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD **ROCK RIVER HEALTH CARE** ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 24 S9999 Psychiatric Note/Evaluation for R5 was in August 2013. The last Psychosocial Assessment for R42 was dated 6/20/12. R43 does not have a Psychosocial Assessment and his Determination of Need Screening dated 10/7/11 showed he was admitted to the facility on 10/11/11. R39 does not have a Psychosocial Assessment and her Determination of Need Screening dated 3/7/13 showed she was admitted to the facility on 3/7/13. On 9/17/14 at 10:55am, E3 (Social Services Director - SSD) stated, "There isn't an interdisciplinary team for Subpart S right now. Comprehensive Assessments should be done at admission (the initial one) and then annually. The Level of Functioning Assessment is done at admission and then annually or with a significant change." On 9/24/14 at 8:55AM, E1 Administrator and E2 (Director of Nursing) verified that a psychiatrist has not seen residents in the building since November 2013. An agreement was signed with Z 7 on 7/31/14 but he has not been in the building since. They also confirmed that there has been no dietitian in the building between 2/11/4 and 9/23/14. There is an unsigned contract for a consultant dietitian dated 1/1/2014. D). Based on Record Review and Interview the facility failed to have the psychiatrist review, approve and sign the treatment plan for residents

resident's treatment plan.

that qualify for Subpart S. The facility failed to have the date of this approval entered on the

This applies to 2 of 13 residents (R5 & R12) reviewed for Subpart S in the sample of 19 and 9 residents (R30, R39, R40, R41, R42, R43, R44, R45, & R47) in the supplemental sample.

Illinois Department of Public Health

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	Director - SSD) state R12, R29,R30, R39 R45, R46, & R47) of Subpart S services. During a confidential person stated, "Not S. There aren't any wasn't any docume yesterday." On 9/18/14 at 3:50 Administrator) state place for Subpart S compliance. I have long time. I know it on a survey that I he then." There weren't any tresidents with a ser qualify for Subpart S reviewed, approved On 9/24/14 at 8:55 A (Director of Nursing has not seen reside November 2013. Ar Z 7 on 7/31/14 but his since. R12's Care Plan data history of a suicidal idea has had more than recent attempt of chand call light cord at occurred on 6/22/14 major depression, re R12 returned from the suicidal form.	:45am E3 (Social Service ted, "The 13 residents (R5, 9, R40, R41, R42, R43, R44, on the list are eligible for " al interview on 9/18/14, the hing is being done for Subpart groups being done and there ntation on these people until				

PRINTED: 11/06/2014 FORM APPROVED 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 IL6008049 B. WING 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCK RIVER HEALTH CARE ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 26 S9999 first 24 hours; 30 minute checks until 6/30/14 then followed by hourly checks for the next 90 days; no call light for 90 days. R12 will be using a whistle. No shoes with laces or laces for the next 90 days and no trash bags in the room for 90 days. A Re evaluation will be done to determine stability and safety in 90 days from 6/27/14." 2. The Care Plan dated 4/30/14 for R5 showed, "R5 is at risk for abuse and at risk for abusive type behavior related to a diagnosis of Depressive Disorder. R5 has the potential to be verbally aggressive related to mental/emotional illness, ineffective coping skills and poor impulse control. " The Care Plan Meeting notes dated 7/2/14 for R5 showed her power of attorney was asking for groups to help with R5's behaviors of anxiety as part of her treatment. 3. R47's Care Plan dated 12/26/13 showed, "R47 has a history of violence and aggressive behavior towards others. R47 has a history of alcohol and drug use. R47 has a self harm which occurred in his teen years. R47 has a criminal history and is considered an identified offender by Illinois Department of Public Health (IDPH). R47 has a long criminal history involving drug possession and unlawful possession of a firearm as well as domestic battery. Currently R47 is on probation until 2015 for the most current arrest of unlawful possession of a firearm. R47's symptoms and problems are manifested drug and alcohol use, manipulation, confabulation, poor impulse control and poor anger/frustration control. R47 has a diagnosis of a serious mental illness, Bipolar I

Ilinois Department of Public Health STATE FORM

disorder."

4. R30's Care Plan dated 3/18/14 showed, "R30's symptoms an problems are manifested by manipulation, confabulation, poor impulse control, poor anger and frustration control. R30 has a diagnosis of a serious mental illness - Bipolar Disorder. R30 has deficits in the following areas:

Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING);	СОМ	PLETED
		IL6008049	B. WING		004	00/0044
		12000049			1 09/	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
700K D	N/CD LICALTH CADE	707 WES	T RIVERSID	E BOULEVARD		
ROCK R	IVER HEALTH CARE	ROCKFO	RD, IL 6110	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(VE)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
				DEFICIENCY)		
S9999	Continued From pa	ae 28	S9999			
	•					
	Schizophrenia and	Bipolar Disorder.				
OVI ALABAM			and the same of th			
40000	C\					000.000
		view and Record Review the				
		ide psychiatric rehabilitation				
		d programs to residents with a	***************************************			
THE PARTY OF THE P		ss (SMI) in accordance with	- Barana			***************************************
	Subpart S.		distance statistics			
	This applies to 2 of	13 residents (R5 & R12)	THE PROPERTY OF THE PROPERTY O			
		rt S in the sample of 19 and				
		R30, R39, R40, R41, R42,				
1		6, & R47) in the supplemental				
ANY Assistance	sample.	b, a rai / in the supplemental				
-	The findings include	,•				
A second		am E3 (Social Service				
		ed, "The 13 residents (R5,				
		9, R40, R41, R42, R43, R44,				
1		n the list are eligible for				
	Subpart S services.					
		Human Service (DHS)				
		ary Information dated 3/11/13				
		nizoaffective Disorder, and				
and the state of t		ive Disorder. R5 is pleasant				
19.000 to another than	and cooperative. R5	seems somewhat guarded in				
	her answers at times	s. R5 denies any current				To the second
	psych symptoms an	d none were obvious at this				2
TOTAL A MAR	time. R5 admits to v	oices in her past but denies				
		pressed interest in returning				
		en therapy is completed.				
		ised living arrangement. R5				
1	to benefit from conti					
		ould benefit from ongoing				
	skills training/educat					1
		uation and Follow Up form				
	dated 11/7/13 for R2					-
		phrenia and Paranoia. The				
		on and Follow Up form dated				
	11/18/13 for R30 sho	owed a Diagnosis of Bipolar	-			

Illinois Department of Public Health

Affective Disorder.

- Illinois L	Department of Public	<u>Health</u>				
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 5:		E SURVEY PLETED
		IL6008049	B. WING		09/	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY	STATE, ZIP CODE		
				E BOULEVARD		
ROCK R	IVER HEALTH CARE		RD, IL 6110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S999 9	Continued From page	ge 29	S9999			
	The OBRA-I Initial S	Screen dated 6/30/05 for R39				
3	showed Diagnoses	including Depressed Mood,				77.0
	Suicidal Ideation, Au	uditory Hallucinations and				and the state of t
	Anxiety. The Pre-ad	mission Screen (PAS) Mental				
		Notice of Determination				
	dated 11/23/13 for F	R39 showed the following				
		t are needed: "Instrumental /ing training/reinforcement,				
	Illness Self Manager	ment, Incentive Program to	: [
	improve/participation	in treatments and	ı			
THA	Community re-integr	ration activities."				
		al Psychiatric Evaluation for				
		owed, "Anxiety, Mania,				
	Behavioral Changes	, Change in Personality and				
		MH dated 3/13/13 for R41				
		special services that are				
		alth Rehabilitation Activities,				NO COLUMN TO THE PARTY OF THE P
		ment and Community				
	re-integration activiti	es. nt Summary dated 1/24/13				A THE PROPERTY OF THE PROPERTY
	for R42 showed Diag	gnoses including Major				
		, recurrent, severe without				
	psychotic features. T	The PAS/MH Level II Notice				
		ed 1/24/13 for R42 showed				
		services that are needed:				0.000
	"Mental Health Reha	bilitation Activities, Incentive				
A	Program to improve	participation in treatments				
1	and Community re-in	itegration activities."				
	I ne DHS Assessme	nt Summary for R43 dated				
	10/12/11 showed Dia Schizoaffective Disor					
	Disorder. The PAS/M					
		3/20/13 for R43 showed the				1
	ollowing special serv					
,	Instrumental Activitie	es of Daily Living	ļ			
	raining/reinforcemen					
		es, Aggression/Anger	- Annual Control			
N	Management, Illness	Self Management, Incentive				
F	Program to improve p	participation in treatments				110
a	and Community Re-in	ntegration activities."	***************************************			

· Illinois L	Department of Public	Health				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S:	COM	PLETED
		IL6008049	B. WING		00/	20/204.4
 		12000040			1 09/2	29/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
POCK B	IVER HEALTH CARE	707 WES1	RIVERSID	E BOULEVARD		
ROOKIK	TVERTILATITI CARE	ROCKFOI	RD, IL 6110	03		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				,		
S9999	Continued From pa	ge 30	S9999			
	The Psychiatric Eva	aluation and Follow Up form				700000
		4 showed Diagnoses including				
	Bipolar Disorder, Do	epression, Mania and				
	Personality Disorde	r.				
	The DHS Assessme	ent Summary for R46 dated				
VI obsessed		agnosis of Schizoaffective	1			
	Disorder. The PAS/	MH Level II Notice of	ı			
	Determination dated	d 8/16/12 for R46 showed the	1			
	following special se	rvices that are needed: "				
	Instrumental Activiti	es of Daily Living				
	training/reinforceme	ent, Incentive Program to				
		n in treatments, and				
	Community re-integration activities."					
THE STATE OF THE S	The DHS Assessment Summary Information					
	dated 6/12/13 for R4	47 showed Diagnoses				
The state of the s	including Major Dep	ressive Disorder with				
		sychotic features. The				
1000	PAS/MH Level II No	tice of Determination dated				
	6/12/13 for R47 sho	wed the following special				
WYPO JAKO		eded: "Instrumental Activities				- And the second of the second
		ng/reinforcement, Mental				
		n Activities, Aggression/Anger				
	Management, Illnes	s Self Management, Incentive				
		/participation in treatments,				
	Community re-integ					
	Substance use/abus					
	On 9/18/14 at 3:50p					
		d, "There isn't anything in				
		The entire thing is out of	i			
		peen telling them that for a			7	
		vas written here 1 year ago				1
		lped them with and it was out			a de la companya de l	
	then."	50				
		am, E3 stated, "We don't			- 14 C	
		rehabilitation groups. There				İ
		ation interventions in place.				Į
		e been doing is some 1:1				Ì
	with residents. The L					I
		ubpart S) residents is done	-			l
	ınıtıally at admission	and can be updated once on				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	I OF CURRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COME	PLETED	
		IL6008049	B. WING		09/2	29/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
DOCK P	IVER HEALTH CARE	707 WES1	RIVERSID	E BOULEVARD			
KOCK K	TV ER TILALITI CARE	ROCKFOR	RD, IL 6110	13			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
	significant change in level of functioning a As far as the Subpa people that would at stated the 5 people would benefit from persons if they were During a confidential person stated, Noth S. There aren't any wasn't any documer yesterday. E3 is not 1. The DHS Assess dated 6/12/13 for R4 including Major Depirecurrent, severe ps PAS/MH Level II Not 6/12/13 for R47 show	en the next annual or ninimum data set is done the assessment form is redone. It S groups, there were only 5 Ittend them anyway." E3 Ithat attended previous groups beychiatric rehabilitation provided. If interview on 9/18/14, the ning is being done for Subpart groups being done and there notation on these people until doing 1:1's with residents." Inde: Ind: Inde: Ind: Ind: Ind: Ind: Ind: Ind: Ind: Ind	S9999				
	management. 2. The PAS/MH Level dated 1/24/13 for R4 re-integration activition resident. 3. The PAS/MH Level dated 3/20/13 for R4 special services are Re-integration activities. The PAS/MH Level dated 8/16/12 for R4 special services that re-integration activities. On 9/17/14 at 10:55a person that goes out	es and Substance use/abuse el II Notice of Determination 2 showed community es are needed for this el II Notice of Determination 3 showed the following needed, "Community ies." el II Notice of Determination 6 showed the following are needed: "Community					

Ilinois Department of Public Health

09/29/2014

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING:

> B. WING ___ IL6008049

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD

ROCK RIVER HEALTH CARE 707 WEST RIVERSIDE BOULEVARD 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 32 based programs coming to the facility for Subpart S residents. " On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago on a survey that I helped them with and it was out then."				
	(B)				

Illinois Department of Public Health STATE FORM

F 323 A

1. Corrective Action Taken for Residents Affected By Deficient Practice

In addition to the steps outlined on pages 8-9 of the Statement of Deficiencies, the facility has taken the following steps for R12:

- a. All facility staff including nursing, social services, housekeeping, maintenance, and office staff have been inserviced on the facility policy for Handling Self Harm Behavior with an emphasis on the need for proactive intervention and the promotion of physical and psychosocial wellbeing.
- b. The care plan for R 12 has been reviewed and revised as needed to incorporate as needed the My Safety Crisis Plan that came with R 12 when she was discharged from the hospital. The resident has been reassessed as part of this care plan review. The care plan has been revised to include R 12's triggers, stressors, warning signs, guidance on coping skills, people to call, interventions and approaches. Nursing staff who care for R 12were inserviced on the resident's revised care plan and on the need to follow the care plan. The DON, Care Plan Coordinator and medical records staff were inserviced on the need to include the crises planning information from the hospital or the resident's doctor in the resident's care plan and further on the need to ensure that nursing staff are fully inserviced on the care plan.
- c. All plastic bags and shoe laces have been removed from the resident's room. Nursing, housekeeping and maintenance staff have been inserviced on the need to ensure that these items are not allowed in the resident's room and on their obligation to immediately report and remove the presence of any of these items.
- d. Nursing staff have been inserviced on the steps that are required to be taken whenever R 12 threatens or attempts self-harm as set forth in the facility Self Harm Behavior policy and on the need to follow those steps.
- e. The results of the Psychiatric consultation for R 12 have been reviewed and incorporated as needed into the resident's care plan. Nursing staff have been inserviced on the revised care plan.
- f. Pursuant to the recommendation of the Psychiatrist, the resident is

receiving ongoing psychotherapy treatments.

Timbrose

- g. Nursing staff who administer medication to the resident have been inserviced on the requirement that they must observe the resident as she takes medication to ensure that the medication is swallowed and is not kept for later use. This approach and intervention has been included in the resident's care plan. Nursing staff were inserviced on the revised care plan as well as the resident's stated goal of keeping Trazadone pills to take in bulk for a suicide attempt.
- h. Nursing staff have been inserviced on the requirement that where periodic checks are required to monitor resident safety, those checks must occur and be documented.
- i. The DON and nursing staffhave been inserviced on the requirement in the Handling Self Harm Behavior policy for a reassessment of a resident on return from a psych evaluation to the facility with the care plan to be revised as needed. That has been completed for R 12.
- j. R 12 is no longer a resident at the facility.
- 2. Identification of Other Residents Having The Potential To Be Affected By Same Deficient Practice

The facility has identified five residents who are considered high risk for suicide or self-harm.

Each of these residents has been assessed for suicide risk. In addition, the facility has confirmed that the following steps have been taken for each of these residents:

- a. Each resident has been reassessed and a full care plan review has taken place. As part of the care plan review, the facility has confirmed that any crises planning information or psychiatric orders are incorporated in the care plan and are being followed. Care plans have been revised to include information on triggers, stressors, warning signs, guidance of coping skills, people to call, interventions and approaches.
- b. Nursing staff have been inserviced on the revised care plans and on the need to follow those care plans including the steps to be taken whenever a resident threatens or attempts self-harm or exhibits warning signs.
- c. The facility has confirmed that any recommendations for ongoing psychotherapy are being followed.
- d. Nursing staff who administer medication have been inserviced on the need to ensure that residents who are at risk of suicide are observed to verify that medication is taken and swallowed.
- e. Nursing staff have been inserviced on the need to follow and document safety checks.

- f. The facility has verified that each of these residents have been reassessed as required following readmission after a psych evaluation.
- g. Each resident who has been identified as being at risk for self-harm will be reassessed on a quarterly basis or more often as needed.
- h. Nursing staff have been inserviced on how to identify warning signs and possible triggers for self-harm or suicide.

3. Measures Taken To Assure That Deficiency Does Not Reoccur

Inservices on the facility Self Harm pty will be given monthly for three months and thereafter on a quarterly basis or more often as needed. The DON will on an ongoing as needed basis monitor the care and documentation of each resident at risk for self-harm to verify that each such resident has been assessed, that the care plan reflects the resident's current condition, approaches and interventions, that nursing staff are following each such resident's care plan, that reassessments are taking place as required upon readmission from the hospital or following a psych evaluation, that nursing staff are reporting and documenting changes in each resident's behavior with proper follow up occurring as required, and that all steps to ensure each resident's safety are being followed as required by each resident's care plan. The DON and QA Committee will document that this ongoing monitoring is occurring and that resident care is being provided as required by facility policy.

4. Quality Assurance

Inservices on the facility Self Harm policy will be given monthly for three months and thereafter on a quarterly basis or more often as needed. The DON will on an ongoing as needed basis monitor the care and documentation of each resident at risk for self-harm to verify that each such resident has been assessed, that the care plan reflects the resident's current condition, approaches and interventions, that nursing staff are following each such resident's care plan, that reassessments are taking place as required upon readmission from the hospital or following a psych evaluation, that nursing staff are reporting and documenting changes in each resident's behavior with proper follow up occurring as required, and that all steps to ensure each resident's safety are being followed as required by each resident's care plan. The DON and QA Committee will document that this ongoing monitoring is occurring and that resident care is being provided as required by facility policy.

В.

1. Corrective Action Taken For Residents Affected By Deficient Practice

R 5 has been reassessed for falls. The resident's care plan has been revised to include additional interventions and approaches for fall prevention in light of the resident's assessment. The resident's bed alarm has been checked and is properly working. Nursing staff have been inserviced on R 5's revised care plan and fall prevention program as well as how to properly use a bed alarm.

The noted treatment cart on the second floor is locked when not in use or when it is not in direct view of a nurse. Nursing staff have been inserviced on the need to keep treatment carts

locked when not in use or when not in direct view of a nurse.

R 17 is no longer are sident at the facility.

Imposed

The soiled utility room on the second floor is locked and the masking tape has been removed from the lock mechanism. Nursing staff, housekeeping, and maintenance have been inserviced on the requirement that the soiled utility room must be kept locked when not in use by a staff member because of the presence of items that are potentially harmful to residents.

2. Identification of Other Residents Having The Potential To Be Affected By Same Deficient Practice

The facility has reviewed each resident who is at risk of falls to verify that each resident has been properly assessed for fall prevention with a care plan that includes appropriate approaches and interventions to prevent further falls. The facility has inserviced nursing staff on the need to ensure that bed and chair alarms are in place and are properly functioning. All bed and chair alarms have been tested and are in working order. The facility has verified that for all falls that have occurred within the last three months, each resident's doctor and POA were notified of the fall and that documentation of the notification is in the resident's chart. The facility has reviewed head charts for each instance of head injury for the last three months to verify that the head charts were properly completed and that the required checks on the resident's condition and vitals were taken and documented. The facility has inspected each medication cart and the doors to the soiled utility room to verify that they are locked when not inuse.

3. Measures Taken To Ensure Deficiency Does Not Reoccur

Nursing staff have been inserviced on the requirement that for each fall, an investigation of the fall must be conducted and documented and that the fall must be reported in writing to the DON. The DON and Care Plan Coordinator have been inserviced on the need to reassess each resident following a fall and to review and revise the care plan as needed for fall prevention intervention and approaches. Nursing staff will be inserviced on the revised care plans. Nursing staff have been inserviced on the proper use of and the need to test bed and chair alarms. The DON, Administrator, Charge Nurses and QA Committee will during regular rounds ensure that the doors to the soiled utility room are locked when not in use and that medication carts are locked when not in use or in direct view of a nurse. Nursing staff have been inserviced on the proper steps to follow after a head injury including the need to complete head charts and document post fall checks on the resident and vitals taken from the resident.

4. Quality Assurance

Nursing staff have been inserviced on the requirement that for each fall, an investigation of the fall must be conducted and documented and that the fall must be reported in writing to the DON. The DON and Care Plan Coordinator have been inserviced on the need to reassess each resident following a fall and to review and revise the care plan as needed for fall prevention intervention and approaches. Nursing staff will be inserviced on the revised care plans. Nursing staff have been inserviced on the proper use of and the need to test bed and chair alarms. The DON, Administrator, Charge Nurses and

QA Committee will doing regular rounds ensure that the doors to the soiled utility room are locked when not in use and that medication earts are locked when not in use or in direct view of a nurse. Nursing staff have been inserviced on the proper steps to follow after a head injury including the need to complete head charts and document post fall checks on the resident and vitals taken from the resident

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDING IDENTIFIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145818	B. WING			С
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 707 WEST RIVERSIDE BOULE ROCKFORD, IL 61103	ZIP CODE	9/29/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-s	FO	00		
	Annual Licensure a	nd Certification.				THE STATE OF THE S
	Licensure Survey fo	r Subpart S: SMI	7000			
	Complaint Investigat F323 cited	tion #1414215/IL#72177 -				
F 323 SS=J	An extended survey 483.25(h) FREE OF HAZARDS/SUPERV	ACCIDENT	F 32	3		70-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
70	as is possible; and ea	as free of accident hazards				
r	by: A. Based on observa eview the facility faile R12) with a history of	is not met as evidenced ation, interview, and record d to supervise a resident recent suicide attempts by				
fa e to a ro	ailed to place R12 on expressed thoughts of premove items she pattempt (trash bags, and the porm which R12 had to sed in previous attem	aute checks as ordered and 1:1 supervision when she is suicide. The facility failed alanned to use in a suicide and shoe laces) from her alked about using or had apts. These failures				
la As wa	esuited in R12 attemp ces and call cord aro s a result of this failur as identified.	oting suicide with her shoe und her neck on 6/22/14. The an Immediate Jeopardy				
		dy began on 6/12/2014	A TOTAL CONTRACTOR			
RATORY DIF	RECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNAT	TURE	TITLE	(X)	8) DATE

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ler safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 gram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/06/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 145818 B. WING 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROCK RIVER HEALTH CARE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 1 F 323 when R12 expressed suicidal thoughts. On 9/22/14 at 2:30PM, E1 (Administrator) was informed of the Immediate Jeopardy. The immediacy was removed on 9/22/14 at 6:15PM. when all residents at risk for suicide were reassessed and the policy regarding residents at risk for suicide was revised and was presented to staff. The facility remains out of compliance at a level 2 as staff on all shifts had not been in-serviced on the new policy and procedure. This applies to one of five residents (R12) reviewed for safety related to suicide risk in the sample of 19. The findings include: R12's Pre-Admission Screening (PAS) Assessment Summary Information on 11/23/13 shows R12 has a diagnoses including Bipolar. The PAS states, "R12 with long history of suicidal ideations and attempts...Age 50 R12 reports ongoing suicide ideations with numerous attempts: cut self, strangle with shoe strings, and bag over head. R12 would likely benefit from continued groups to gain coping skills and symptoms management. The Pre-Admission Screening Mental Health Level II Notice of Determination dated 11/23/13 shows R12 requires special services: "Professional Observation (MD/RN) for

medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living

Rehabilitation activities, Illness self management,

training/reinforcement, Mental Health

and Community re-integration activities."
R12 was admitted to a psychiatric Hospital from 4/9/14-4/29/14 for inpatient treatment due to the severity of her suicidal and self-destructive thoughts. The Medical History and Physical Examination form from the psychiatric Hospital on 4/9/14 states, "R12 is depressed and suicidal.

AND PLA	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC	CTION	(X3) DA	TE SURVEY MPLETED	
		145818					C	
NAME	OF PROVIDER OR SUPPLIER	143018	B. WING			09	/29/2014	
	RIVER HEALTH CARE				ESS, CITY, STATE, ZIP CODE VERSIDE BOULEVARD			
KOCK				ROCKFORD,				
(X4) II	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PR	OVIDER'S PLAN OF CORRECTION	.1	i	
PREFI TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH	H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	RE	(X5) COMPLETIC DATE	N
F 32	Continued From page	ge 2	5 0					
			F 3	23				
	later changed her m	ind her neck to kill herself and ind. R12 has a history of						
	physical and sexual	abuse at the age of 10. R12						
	has auditory and vis	ual hallucinations R12						
	hears devil 's voice.	.R12 suffers fromPost						
	Traumatic Stress Dis	sorder."		III DOOD				
	The My Safety Crisis	Plan sent with R1 on						
	discharge from the p	sychiatric hospital on 4/29/14						
	snows R12's Trigge	ers and Stressors include:				The state of the s		
	any kind of sexual a	buse reference, slamming						
	doors, raised voices.	conflict, being feeling						-
	Ignored, feeling invis	ible, people coming up		And the second s				1
	signs includes also ai	ted changes. "R12's warning						
	Over little things anti-	ng too much, getting angry				-		
	over little things, eating	ng too much, and						
	trails reading playing	I like to do:"Walking nature g games on kindle, bingo						1
	and devotionals."	g games on kindle, bingo						
	The Screening Asses	sment for Evaluating						
	Self-Harm/Suicide Ris	sk dated 3/14/14 shows R12				And distances		
	nas a score of 14(a se	core of 6-15 represents a						
	moderate risk). The 3	1/14/14 Risk Screening						1
	Assessment for Indica	ators of Aggressive Harmful						
	and/or inappropriate E	Behaviors shows R12 has a				-		
	score 8. (a score of 0.	-10 shows a minimal/low						
į	the Presentation of the	Assessment to Determine						
	trie Presentation of Ab	ouse and/or Neglect Factors						
Print Officeasses	or more represents his	as a score of 5 (a score of 4		***************************************				
	On 6/12/14 the Social	Services Notes by Es						
	(Social Service Director	or) states,"R12 shows				-		
	signs and symptoms of	of depression. R12 tends to				To the second se		
W. A	appear and feel depres	ssed daily has had						
	thoughts of suicide, ha	is sleep disturbances, and		7 (1)				
	lacks energy at times .	R12 has had three nsuch		-		***************************************		
	nospitalizations for suic	cidal ideation since				7		
	admission, currently sta	able."		:		1000		
	On 6/12/14 the Screen	ing Assessment for						į
	Evaluating Self-Harm/S	Suicide Risk shows R12						

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	ATE SURVEY OMPLETED
		145818	B. WING		09	C 9/29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 707 WEST RIVERSIDE BOULEV ROCKFORD, IL 61103	ZIP CODE	7.20,2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
i i i i i i i i i i i i i i i i i i i	risk. The Risk Scree Indicators of Aggres Inappropriate Behave a score of 6 (a score risk). The Screening the Presentation of 6/12/14 shows R12 or more represents. The Psychiatric Core 6/16/14 said, R12 we plan in place. R12's around her neck. The removing the pillow There are significant and mood changes. psychotherapy. On 6/20/14 Z6 (Psychotherapy. On Save her medight. 15 minute check. R12 then in the Nurse's Notes doesn storing Trazadoshe had a plan to take the pla	core of 6-15 is at moderate ening Assessment for sive, Harmful and/or viors 6/12/14 shows R12 has e of 0-10 is at minimal/low assessment to Determine Abuse and/or Neglect Factors has a score of 4 (a score of 4 a high risk). Isultation progress note dated ith recent suicide ideation and plan is to place a plastic bag the trigger is relieved by case bag from the pillow. It symptoms of depression R12 needs more chiatrist) stated, "R12 reports 2 days ago wrap her panty hose around hid her panty hose. R12 he hid her Trazadone cation) in her closet with the dis and take them on Monday cks at nightand increase ated 6/20/14 said, R12 has one in her closet. R12 said, the all her medications at once nute checks ordered and ications. If Service Notes by E3 rist) called the facility and thing that during visit R12 not taking Trazadone. R12 int herself. A Room check its were found.	F3			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA CO	TE SURVEY MPLETED
		145818	B. WING		C 09/29/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 707 WEST RIVERSIDE BOULEVAN ROCKFORD, IL 61103	CODE	129/20 14
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
in the second of	Evaluating Self-Harrof 13. A score of 6-1 E3(SSD) wrote on the R12 was reassessed making a suicide state was not a threat to he For 6/22/14 (Saturda documentation of 15 On 6/22/14 at 5:55 FR Report states, "R12 call light around her turning blue. All ties R12 kept pulse during called, Director of Nunotified, family called per protocol." The Nurses Note dain Nursing Assistant to then yelled out loudly ran to R12's room ar call light cord all tied facial color was beging immediately used my ties around her neck cord. R12's color returned she let out a deer you decide to do this would be states, "3 days" I ask about how you were the doctor and he only medication" The Social Services I sate from Rockford Mealth UnitTo ensured.	eening Assessment for m/Suicide Risk shows a score 5 is at moderate risk. The Screening Assessment, and on this date related to attement. E3 felt that resident the serself. The analysis of the service	F 32	23		

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DA CO	TE SURVEY
		145818	B. WING_		00	C 9/29/2014
7 4 40-5	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	R12 will be on 30 m will be on 1 hour che light has been remo laces removed from precautions have be be encouraged to at The 1 Hour Care Sh 9/16/14 shows no do Care Sheets are cor sheets are not docur On 9/18/14 at 11:00/said, these are the ohe was able to find. The Care Plan dated R12 has a history of suicidal ideation. In thad more than 50 attachoking herself with around her neck on 6 diagnoses of Major Espolar Disorder. R1 event that R12 exhibitatempts to harmself one, psychiatrist and resident will be monitated that the suicidal ideation checks, and 9/17/14 at 11:45 As a hoes with shoelaces on 9/17/14 at 2:00 Plans with trash bags on 9/22/14 at 3:05 Plans with trash bags on 9/22/14 at 3:05 Plans with trash bags on 9/22/14 at 4:10 Plans with trash with	rst 24 hours on 6/28 and 6/29 inute checks. On 6/30R12 ecks for 90 days. R12's call vedR12 also has had all shoesno plastic bagsall een care plannedR12 will tend group in facility" eet for R12 from 6/30/14 - cumentation for 9 days. 7 inpleted hourly, and remaining mented hourly. AM, E22 (Medical Records) inly hourly care sheet records through June 2014 shows suicide attempt as well as the past two years she has rempts with most recent shoe laces and call light cord 6/22/14. R12 has a pepression recurrent and 2's Care plan states," In the fits behavior of thoughts or R12 is to placed on one to Medical Doctor to be notified ored till discharged to Plan was not revised to stic bags and shoelaces, and attend group. AM, there were four pairs of underneath R12's bed. M, there were two garbage	F 32	3		

	IDENTIFICATION NUMBER		ING	CO	COMPLETED	
		145818	B. WING		05	C 9/29/2014
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103			32072014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	On 9/17/14 at 2:00 comes to me wherThere has been doesn't come and meetings with R12 aware what should bags, shoe laces, a groups running right On 9/18/14 at 9:00 not been offered for groups helped me On 9/18/14 at 9:25 Nurse) said, R12's when she is kept bound the endingers. The Physician Order September 2014 stringers. The Physician Order September 2014 stringers. The resident at risk signs and triggers. Their knowledge to that would cause that would be would b	that on to my housekeepers." PM, E3 (SSD) stated, "R12 as he has feelings or issues no gap in time where she see meI do one to one as neededAll staff are not be in her room garbage and call lightI don't have now. They stopped in July." AM, R12 said, Groups have r about 2 months. I think the when we had them. AM, E23(Licensed Practical behaviors are managed well usy. Isolation increases her er Sheet dated through nows R12 has diagnosis and Depression. It is and Depression. It is not the remove the immediacy: on taken for Residents in behaviors: will be assessed for warning The staff will use the best of remove or prevent any triggers are resident to decide to harm ill be done suing the new sment. The facility has five the beconsidered high risk. It is had the Suicide Risk	F3			

STATEMEN' AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) D.	ATE SURVEY
		445040				С
		145818	B. WING			9/29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103)DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
	an as needed basis in-serviced on how signs and possible Nursing, Social Serimplement this tool that were admitted passessed using this date. 3. Measures taker from reoccurring: The Suicide Risk as admission by the sonursing staff will the determine possible. These assessments the Director of Nursing representative. The assess any 15 minuthrough Friday. At the Director of Nursing, Services rep will be the proper action cathe A. Quality Assurant The Social Service roursing, and adminimonthly for the next risk assessment too suicide precautions time an initial in-serviced. This of the policy and probehavior, Asta care for safety and the initialert staff that the resuicide. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced. B. Based on observing the side of the serviced on observing the side of the serviced on observing the side of the serviced on observing the side of the side of the serviced on observing the side of the s	i. Nursing staff will be to identify different warning triggers. The Director of vice and administrator will effective 9/22/14. All residents previous to this date will be tool within 30 days from this in to prevent deficient conduct essessment will be done upon icial service department. The in use this assessment to triggers for each resident. Is will be assessed weekly by ing and social service. Director of Nursing will also the check forms every Monday in time of any occurrence the administrator and Social notified immediately so that in be taken beginning 9/22/14.	F3	323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY
		145818	B. WING			C 09/29/2014	
	PROVIDER OR SUPPLIER			70	REET ADDRESS, CITY, STATE, ZIP CODE 17 WEST RIVERSIDE BOULEVARD OCKFORD, IL 61103	1 03/	29/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	by not revising appropriate falls in the past 9 hip fracture), failed the resident fell twice the treatment cart at locked storage. This (R5, R17) reviewed The Findings Include 1. R5's September is shows R5 has a diag Osteoporosis, Weak History and Physical hospitalization on 4/3 of recurrent hip disloushe was trying to get The Minimum Data Shows R5 transfers on 9/16/14 at 1:20 Pattempting to transfer bed. R5 held on to he assistance. E10(Lice the bedside and did intransfer. The chair al On 9/17/14 at 9:41 A wheelchair by herself alarm. On 9/16/14 at 1:05 Phurse) said, R5 transhas a chair/bed alarm. On 9/16/14 at 1:05 Phurse) said, R5 transhas a chair/bed alarm. R5's Care Plan dated had a fall that resulte shows staff to assist transfer to/from wheelenshas a chair bed alarm. R5's Care Plan was land a fall since was not in the Care Phe Fall Risk Assessive ar documented shows a continual since was not in the Care Phe Fall Risk Assessive ar documented shows a continual since was not in the Care Phe Fall Risk Assessive ar documented shows a continual since was not in the Care Phe Fall Risk Assessive ar documented shows a continual since was not in the Care Phe Fall Risk Assessive ar documented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual since was not in the Care Phersell Risk Assessive and coumented shows a continual	oaches for a resident who had months (1 fall resulting in a to conduct neurochecks after and hit his head, failed to lock and failed to keep chemicals in applies to 2 of 3 residents for safety in the sample of 19. e: 2014 Physician Order Sheets gnoses including these and Hip Fracture. R5's from a previous 2/14 states, R5 has a history locationsR5 reported that the out of bed alone and fell. Set assessment of 6/20/14 with a two person assist. PM, R5 stood up by herself for from her wheelchair to her er side table and bed for ensed Practical Nurse) was at mot assist R5 with her farm did not alarm. M, R5 stood up from her farm did not alarm. M, R5 stood up from her farm did not alarm. M, R5 stood up from her farm did not alarm. It with all transfers. R5 is not to elchair or toilet without staff. ast revised on 3/28/14. R5 then. The bed/chair alarm	F3	323			

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		145818	B. WING		05	C 9/29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	ODE	123/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	treatment carts on and unsupervised. Iocated at the end of from the nurse's swere not in direct violated at the end of the treatment cart ointments, ointment fingernail clippers, regauze, and wound of 9/18/2014 at 8:3 Practical Nurse-LPf cart) should be lock use ". An allegation of abured the meter feet away helpir The facility's policy (No Date) shows, the	t 11:30 AM, one of the two the second floor was unlocked The treatment cart was of long hall around the corner tation. The treatment carts iew from the nurse 's station. contained prescription ts for skin/perineal care, trazors, iodine, dressings,	F 3.	23		
S V N	showed R17 was ad with diagnoses to inc	4 Physician's Order Sheet Imitted to the facility on 2/5/14 Clude: Dementia, Diabetes Renal Disease, Chronic ary Disease and			i	
a	issessed R17 as se naking and needing	Set (MDS) of 2/19/14 verely impaired for decision plimited assistance of 1 staff was assessed as being				

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	NG	(^3) bA	MPLETED
		145818	B. WING		05	C 9/29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	ODE	720/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	required 1-2 staff for Living) except eating. The fall risk assessing showed R17 was at R17's nurse's notes. "On 2/12/14 at 10:19. Transferred self to/fis supervision is reminarequest assist due to "On 2/21 at 10:30 purpopels wheelchair areminders to request "On 3/12 (10:20 purpopels wheelchair areminders to request "On 3/12 (10:20 purpopels wheelchair areminders to request "On 3/12 (10:20 purpopels wheelchair and showed deconditioning. Appetration of thought processes. 2/25/14 and showed deconditioning. Appetration of the resident's needs falls and attempt to a Record possible rooppotential causes if possible rooppoten	r all ADL's (Activities of Daily g. ment completed 2/5/14 high risk for falls. document the following: pm, "Resident alert to self. rom wheelchair without ded by staff that he should be safety." n, "Resident alert to self. Self able to transfer self but needs to assist for safety." Resident needs reminders or up from chair without ad 2/25/14 showed R17 has Dementia related to impaired The falls care plan is dated R17 is at risk due to roaches include: Anticipate. Review information on past determine cause of falls. It causes. Alter/remove any possible. Evised on 3/7/14 to include: Articipate and while in notioning with every transfer and active prior to leaving the pow R17 had no alarm in place is the resident to have an	F 32			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION	(X3) DA	TE SURVEY
		445040	2 14/14/2				С
		145818	B. WING			09	/29/2014
	PROVIDER OR SUPPLIER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD COCKFORD, IL 61103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F v e n (!	R17 was witnessed wheel chair to reclin he fell and hit the bath The nurse's notes at POA were not notified 6:10am. The "Head Chart" for patients vital signs, proconciousness after health falls for 72 hours. R1 the time of the incided The head chart was of 21 times in a 72 health falls for 72 hours. R1 the time of the incided The head chart was of 21 times in a 72 health falls for 72 hours. R1 the time of the incided The head chart was of 21 times in a 72 health fall for 72 hours. R1 the time of the incided The head chart was of 21 times in a 72 health fall fall fall fall fall fall fall fal	by staff transferring from the rand fell. Resident stated ack of his head on the wall. It 5:00pm document MD and ad of the fall that occurred at the properties of the fall that occurred at the fall that occurred at the properties of the fall that occurred at the fall that occurre	F3	323			
n	urse and CNA, but s	taff could not get to and landed on butt next to					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NI MARED		TIPLE CONSTRUCTION	(X3) E	(X3) DATE SURVEY COMPLETED	
		145818	B. WING			C 0 9/29/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 707 WEST RIVERSIDE BOULEVAL ROCKFORD, IL 61103	CODE	1912912014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	Post-Fall investigations howed alarm was in the nurse's note for showed, Vital signs. Up in recliner at time complained of heads. R17 blew nose and tissue. Alarm in place (1st shift)- Reside refused dialysis said Tylenol for headacher refused dialysis. Dialabs to be drawn for and Hemoglobin 5.6 resident to ER for extransfusion. Resident to ER for extransfusion. Resident alarm attached cues for redirection at the complete of the performant endurance, strength R17's nurse's note 3/10/14 at 52/11/14 at 52/11	oor per 2 and into recliner. on report dated 3/5/14 not attached to the resident. R17 on 3/6/14 (3rd shift) taken. Alert with confusion. es during the night, ache. PRN Tylenol given. large amount of blood was in	F 3	23			

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	(X3) DATE SURVEY COMPLETED C 09/29/2014	
		145818			09		
NAME OF PROVIDER OR SUPPLIER ROCK RIVER HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP 707 WEST RIVERSIDE BOULEVAI ROCKFORD, IL 61103	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	had a bump on the fifty cent piece. The 3/15 to alert staff be subdural hematomat neurocheck sheet of complained of hittin. On 9/24/14 at 10 am and was sent out ar previous Director of charge covering a complained of the procedure where port is done, residuare taken for 72 hou and the fall investigation. The Coroner's Report and possible subdural hematomation and found R1 with a bump to the beconfused and get on the given a CT scan of the heat was a CT scan of the subdural hematomation and status did not change status did not change and to alert the subdural hematomatical status did not change and to alert the subdural hematomatical status did not change and to alert the subdural hematomatical status did not change and to alert the subdural hematomatical status did not change and the subdural hematomatical status d	ne same date documented R17 back of his head the size of a e chair alarm did not sound on efore R17 fell and sustained a a. There was no initial completed after R17	F 3	.23			

PRINTED: 11/06/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING C 145818 B. WING 09/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCK RIVER HEALTH CARE ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 Continued From page 14 F 323 the family opted to send R17 to another facility. He remained on comfort care and his condition did not improve. R17 expired on 4/7/15 at 12:50am. The cause of death was Subdural Hemorrhage, secondary to a Fall. 4. On 9/15, 9/16, and 9/17/14 the soiled utility room on the 2nd floor was unlocked. The door's lock mechanism was covered over by masking tape. The room contained bulk cleaning supply containers such as disinfectant, toilet bowl cleaner and floor cleaner. The containers posted warning labels, "Harmful if Swallowed", "May Cause Eye Irritation" and "Keep Out Of Reach Of Children." On 9/18/14 (Housekeeping Supervisor) said the lock was broken