STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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
S 000	Initial Comments Complaint Investigation: 2211104/IL143384	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.686f)1) 300.686f)2) 300.686f)3)A)B)C)D)E)F)G)H)I) 300.686f)4) 300.686f)5) 300.686f)6)A)B) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications f) Protocol for Securing Informed Consent for Psychotropic Medication 1) Except in the case of an emergency as described in subsection (e), no resident shall be administered psychotropic medication prior to a discussion between the resident or the resident's surrogate decision maker, or both, and the resident's physician or a physician the resident was referred to, a registered pharmacist who is not a dispensing pharmacist for the facility where the resident lives, or a licensed nurse about the most common possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. (Section 2-106.1(b) of the Act) 2) Prior to initiating any detailed discussion designed to secure informed consent, a licensed health care professional shall inform the resident or the resident's surrogate decision maker that	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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 1 the resident's physician has prescribed a psychotropic medication for the resident, and that informed consent is required from the resident or the resident's surrogate decision maker before the resident may be given the medication. 3) The discussion shall include information about: A) The name of the medication; B) The condition or symptoms that the medication is intended to treat, and how the medication is expected to treat those symptoms; C) How the medication is intended to affect those symptoms; D) Other common effects or side effects of the medication, and any reasons (e.g., age, health status, other medications) that the resident is more or less likely to experience side effects; E) Dosage information, including how much medication would be administered, how often, and the method of administration (e.g., orally or by injection; with, before, or after food); F) Any tests and related procedures that are required for the safe and effective administration of the medication; G) Any food or activities the resident should avoid while taking the medication; H) Any possible alternatives to taking the medication that could accomplish the same purpose; and I) Any possible consequences to the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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 2 resident of not taking the medication. 4) Pursuant to Section 2-105 of the Act, the discussion designed to secure informed consent shall be private, between the resident or the resident's surrogate decision maker and the resident's physician, or a physician the resident was referred to, or a registered pharmacist who is not a dispensing pharmacist for the facility where the resident lives, or a licensed nurse. 5) In addition to the oral discussion, the resident or his or her surrogate decision maker shall be given the information in subsection (f)(3) in writing. The information shall be in plain language, understandable to the resident or his or her surrogate decision maker. If the written information is in a language not understood by the resident or his or her surrogate decision maker, the facility, in compliance with the Language Assistance Services Act and the Language Assistance Services Code, shall provide, at no cost to the resident or the resident's surrogate decision maker, an interpreter capable of communicating with the resident or his or her surrogate decision maker and the authorized prescribing professional conducting the discussion. The authorized prescribing professional shall guide the resident through the written information. The written information shall include a place for the resident or his or her surrogate decision maker to give, or to refuse to give, informed consent. The written information shall be placed in the resident's record. Informed consent is not secured until the resident or surrogate decision maker has given written informed consent. If the resident has dementia and the facility is unable to contact the resident's surrogate decision maker, the facility shall not administer psychotropic medication to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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 3 the resident except in an emergency as provided by subsection (e). 6) Informed consent shall be sought first from a resident, then from a surrogate decision maker, in the following order or priority: A) The resident's guardian of the person if one has been named by a court of competent jurisdiction. B) In the absence of a court-ordered guardian, informed consent shall be sought from a health care agent under the Illinois Power of Attorney Act [755 ILCS 45] who has authority to give consent. This requirement is not evidenced by: Based on Interview and Record Review the facility failed to obtain consent for the increase in dosage of a psychotropic medication for 1 of 3 residents (R1) reviewed for psychotropic medication in the sample of ten. The findings include: R1's Physician Order Sheet for October 2021 showed on 10/8/21 her dose of Citalopram (Celexa) was increased to 20 mg by mouth daily. On 2/10/22 at 8:21 AM V9 RN (Registered Nurse/Unit Coordinator) stated he did not know anything about the increase in R1's Celexa. V9 stated they have to get consent for any increases in psychotropic medication. On 2/10/22 at 10:32 AM, V10 RN (Registered Nurse/Unit Coordinator) stated there should have been a signed consent for a change in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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 4	S9999		

psychotropic medication. V10 stated family is notified of medication changes and it should be documented in the computer.

On 2/10/22 at 1:22 PM, V14 LPN (Licensed Practical Nurse) stated she did not know where the consent for R1's Celexa went. V14 stated she usually writes a paper up and gets a verbal consent on the phone. The consent is given to the secretary who mails it out. V14 stated she did not write a note that she called R1's family about the Celexa.

The Resident Admission Record for R1 dated 6/8/2021 showed medical diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, Generalized Anxiety Disorder, Hypertensive Heart Disease with Heart Failure, Angina Pectoris, Peripheral Vascular Disease, venous insufficiency, Systemic Lupus Erythematosus, low back pain and Osteoporosis. The Resident Admission Record for R1 dated 6/8/2021 showed V15 (R1's sister) was listed as R1's power of attorney.

The MDS (Minimum Data Set) dated 8/19/21 for R1 showed moderate cognitive impairment.

The facility's Psychotropic Medications policy (4/12/2021) showed, "Psychotropic Medications: Consent: provide the resident/resident representative with information on the medication, indication, dose, side effects, adverse consequences, and goal of treatment. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET 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 5 medication and resident choice. The resident and/or responsible party will be notified regarding dose changes." (C)	S9999		