Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6008114	B. WING		C 11/08	3/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		-
ROCK FA	ALLS REHAB & HLTH	CARE C 430 MART ROCK FA	ΓIN ROAD LLS, IL 610	71		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 2419151 /IL180635				
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations				
	Complaint Investiga	ation 2419151 /IL180635				
	300.610a) 300.1210b) 300.3300a) 300.3300y)					
	Section 300.610 R	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1210 ( Nursing and Persor	General Requirements for nal Care				
	care and services to practicable physical well-being of the re- each resident's com-	shall provide the necessary of attain or maintain the highest land, and psychological sident, in accordance with aprehensive resident care properly supervised nursing				

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

TITLE (X6) DATE

**Electronically Signed** 

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
	IL6008114		B. WING			C <b>08/2024</b>				
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
	430 MARTIN ROAD									
ROCK F	ALLS REHAB & HLTH	CARE C		LLS, IL 6107	71					
(X4) ID PREFIX TAG			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 pa	ge 1		S9999						
	care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures									
	Section 300.3300	Γransfer or Dischar	ge							
	a) A resident may be discharged from a facility after the resident gives the administrator, a physician, or a nurse of the facility written notice of their desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of their guardian or if the resident is a minor, their parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. (Section 2-111 of the Act)									
	y) The administ under the Act shall voluntarily closing a facility, or prior to closing such part with discharge of more to Such notice shall be the Office of State I to any resident who discharged, to the roto a member of the practicable. If the I revokes, or denies license, then notice the date specified by shall state the proportion of the shall address the proportion of the shall address the proportion of the shall address the proportion.	in facility or closing a cosing any part of a cosing any part of a cosing any part of a sill require the transfer and the cost of the part of the cost of the cost of the cost of the cost of the facility of the Department. The facility shall be given no look of the facility the Department. The facility shall support of the cost of the cost of the facility shall support of the facility shall support of the facility shall support of the cost of the cost of the cost of the facility shall support of the cost o	prior to iny part of a facility if fer or idents. rtment, to nbudsman, ad or rative, and rhere ds, ty's ater than Notice g and the ubmit a proval which							

Illinois Department of Public Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
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		IL6008114	B. WING		11/08/2024	
NAME OF I		CTDEET AD	DDECC CITY (	STATE ZID CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCK FA	ALLS REHAB & HLTH	CAREC	TIN ROAD	7.4		
		RUCK FA	LLS, IL 610	/1		
(X4) ID	-	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
S9999	Continued From pa		S9999			
09999	Continued From pa	ige z	39999			
		s. The approved plan shall be				
		ce. The facility shall offer to				
		in securing an alternative				
	•	Il advise the resident on				
		es. When the resident is				
		n alternate placement and is				
		ship, the Department shall be				
		for relocation assistance. A entirety shall not admit any				
		r after the date written notice is				
		epartment under the Act and				
		ty shall comply with all				
		regulations until the date of				
		nose related to transfer or				
		nts. The Department will				
		eam in the facility as provided				
		u) of this Section. (Section				
	3-423 of the Act					
	•	as not met as evidence by:				
		on, interview, and record				
	,	ailed to provide residents the				
		orior to transferring them to				
		six of 25 residents (R1-R6)				
		rges in the sample of 25. This				
	crying, and scared	sychosocial harm, confusion,				
	crying, and scared	reenings.				
	The findings include	e:				
		Record dated November 4,				
		as admitted to the facility on				
		ith diagnoses including need				
		personal care, muscle				
		thritis, depression, bipolar				
		sorder, Alzheimer's disease,				
and schizoaffective disorder.						

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		IL6008114	B. WING		11/0	8/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCK F	ALLS REHAB & HLTH	CARE C 430 MART				
		ROCK FA	LLS, IL 6107	71 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	R1's Discharge Note shows she was discharged to another facility on November 5, 2024.  On November 8, 2024, at 2:21 PM, V3 R1's power of attorney and sister said she was told by the facility on November 4, 2024, that she had 48 hours to find another place for R1 because the facility was closing. V3 said R1 was upset. V3 said R1 has been at the facility for about 12 years, "That's her home." V3 said she has visited R1 at the new facility, and V1 is "very unresponsive to us. She is confused and scared. She's not normally like this, the move has affected her. The people at the other facility were her family. This has been very hard for her." V3 said that R1 has cried at the new facility. V3 said she went to visit R1 and R1 asked V3 if R1 could go with V3 and V3 had to tell R1 no. V3 said that R1 then started to cry. V3 said that R1 was born mentally challenged and she has dementia. V3 said the facility called her on a Monday and said R1 had to be out of the facility by Wednesday. V3 said she went to the facility on Tuesday November 5, 2024 and the facility had "thrown all of her (R1) belongings into garbage bags and boxes." V3 said the facility moved R1 without V3 being present. "I wanted to be there for her. I knew the move would be hard for her." V3 said she was angry. V3 said she talked to the facility a while ago when other facilities were closing in another state and asked if V3 should start looking for another home for R1 so that the transition could be smooth and V3 said the facility told her no.  2. R2's Admission Record shows she was					
	diagnoses including	lity on October 1, 2020, with g anoxic brain damage, failure, tracheostomy, disorder, epilepsy,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6008114		B. WING		C 11/08/2024	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/0	0/2024
		430 MART	, ,	7777E, ZII OOBE		
ROCK FA	ALLS REHAB & HLTH	ROCK FA	LLS, IL 6107	71		
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	tracheostomy, and	cerebral palsy.				
		te shows she was discharged n November 6, 2024.				
	On November 8, 2024, at 1:33 PM, V4 R2's mother said she was notified on Monday November 4, 2024, that the facility was closing and the residents had two to three days to find another place. "It was very terrible." V4 said R2 was placed two hours away. V4 said the facility put R2 there because that was the only facility that could accommodate R2's needs. V4 said she is now even farther away from R2. V4 said she let the facility place R2 there because it was such an emergency. V4 said she is going to try and find R2 a place closer to V4. V4 said the facility was supposed to give her a 60 day notice, but they did not.					
	3. R3's Admission Record shows she was admitted to the facility on January 11, 2024, with diagnoses including morbid obesity, osteoporosis, need for assistance with personal care, vascular dementia, and insomnia.  The list of discharges provided by the facility shows that R3 discharged from the facility on November 5, 2024.  On November 6, 2024, at 3:30 PM, R3 said "They gave me two days to get out of the facility. It made me feel bad."  On November 8, 2024 at 1:14 PM, V5 R3's Power of Attorney/daughter said she works during the day and had a "whole bunch of messages from the facility." V5 said the facility said the place was closing and they had to place V5's mother. V5 said this all started on Monday November 4,					

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Illinois Department of Public Health

IIIINOIS D	epartment of Public	Health				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IL6008114		B. WING		C 11/08/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
10 101 1	TO VIBER OR GOLF EIER		TIN ROAD	37.11.2, 2.11 3322		
ROCK FA	ALLS REHAB & HLTH	I CARE C	LLS, IL 610	71		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 5	S9999			
	check on their moth about R3's belongir R3 had to be out or she barely got a 24 to go see her mothe November 5, 2024 from the previous fa was very upset. V5 there for a long time the new facility. I wa packed her stuff for her belongings in ga residents lined up a room like they were 4. R4's Admission F admitted to the faci with diagnoses inclutions 21, autistic syndrome, adjustme	sister went to the facility to her because she was worried higs. V5 said the facility said howember 5, 2024. V5 said hour notice. V5 said she went er at the new facility on where R3 gave V5 the letter acility's attorney. V5 said R3 said "she knew the people e, she doesn't know anyone at as very disappointed how they of the transfer, they threw all of arbage bags. They had all the at the old facility in the dining e being "shipped off."  Record shows she was lity on September 25, 2024, uding muscle weakness, disorder, depression, down ent disorder with depressed				
	alveolar hypoventila	•				
	0	te shows she was discharged n November 5, 2024.				
	On November 7, 2024 at 9:55 AM, V6 R4's Power of Attorney/mother said, "[Facility] gave us three days to move [R4]. She doesn't belong here. She's not appropriate to be here." R4 was observed in a wheelchair with children's toys all around her. R4's Admission Record shows R4 is 24 years old. V6 said that R4 has the mental age of about a third grader. V6 said she is also sleeping in the facility because V6 lives too far away from the new facility. V6 said she wants R4 closer to home and is trying to find placement closer.					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IL6008114		B. WING			C <b>08/2024</b>		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
ROCK F	ROCK FALLS REHAB & HLTH CARE C 430 MARTIN ROAD								
	T			LLS, IL 6107					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
S9999	Continued From pa	ge 6		S9999					
	5. R5's Admission F admitted to the faci diagnoses including aphasia, difficulty w disorder, and need care.	lity on January 24 g dysphagia, cere alking, major dep for assistance wi	, 2018, with bral edema, pressive th personal						
	R5's Discharge Not the facility on Novel		harged from						
	On November 8, 2024 at 4:02 PM, V7 R5's guardian/son said the facility called him on Monday November 4, 2024 and R5 was discharged to another facility that same night. V7 he did not really have time to look for a facility that he preferred. V7 said at the new facility, R5 had a roommate which he stated that R5 was not a huge fan of because R5 is an introvert. V7 said that R5 is still missing her tablet and some pictures. V7 said that R5 is upset about her missing pictures. "We could have had a little more heads up. I wanted to go and help her pack up so I made sure she had all of her belongings. I thought they were supposed to give us 60 days."								
	6. R6's Admission F admitted to the faci diagnoses including paranoid schizophre disorder, weakness	lity on April 14, 20 g congestive hear enia, major depre	024, with t failure, essive						
	R6's Discharge Not from the facility on I								
	On November 8, 20 of Attorney said she closing on Monday, the facility was mov Wednesday. V8 sai "I couldn't believe it	e was notified of to November 4, 2027 ing all the resident d they only gave	he facility 24. V8 said nts by						

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IIIInois L	epartment of Public	Health					
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		11 6000444	B. WING		C		
		IL6008114	B. W. C		11/0	8/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		430 MAR	IN ROAD				
ROCK F	ALLS REHAB & HLTH	CARE C	LLS, IL 6107	74			
	Г	ROCK FA	LLS, IL 610				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE	
IAG			IAG	DEFICIENCY)			
S9999	Continued From pa	ge 7	S9999				
	On November 6 20	)24 at 12:51 DM \/1					
		024, at 12:51 PM V1					
		the facility building was bought					
		pany because the previous					
		ruptcy. V1 said in September					
		beginning to ask her if the					
	,	and she told them she did not					
		was telling the families to be					
		nerself and the facility first					
		ne facility closing on Monday,					
	,	V1 said the families of the					
	residents were notif	fied on November 4, 2024. V1					
	said the families we	ere told the "sooner the					
	residents got out of	the building, the better, due to					
	the safety of the bu	ilding." V1 said there was a					
	rapid turn around fo	or moving the residents out of					
	the facility because	"it did not give them time to					
	feel bad about the b	•					
		3 3					
	On November 6, 20	024, at 2:06 PM, V9 LPN					
		Nurse) said, "Two people					
		0:30 AM and met with the					
		e building. Then at about					
		e lunch meal, they told us the					
		ig in three days and we					
		esidents out as soon as					
		everyone needed to be out by					
		20 PM, V2 DON (Director of					
		new owners came in and told					
		closing and all the residents					
	needed to be discharged by Wednesday, November 6, 2024. [The new company] gave us a list of where the residents needed to go. If the						
		•					
		a different facility, then staff					
	nad to clear it with t	he new company first."					
	0 11 1 2 2	004 440 00 DM "					
		024, at 12:20 PM, all residents					
		lity with the exception of one					
		at was actively dying. There					
	were some residents' belongings noted in the						

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AND DIANIOE CORRECTION I IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		IL6008114	B. WING		11/08/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ROCK FA	ALLS REHAB & HLTH	CARE C 430 MART	_	7.4		
0/4) ID	CLIMMA DV CTA		LLS, IL 6107		DNI .	()(5)
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
		f the facility. Staff members ng belongings in and out of the				
	The letter that was provided to the residents dated November 4, 2024 shows, "We regret to inform you that [facility] has made the difficult decision to close due to unsustainable financial losses that prevents us from being able to deliver the high quality care you deserveOur primary focus prior to closure is going to be your health and well-being, which includes ensuring you are transferred to a facility or other placement that meets your approval and needsWhen you relocate to your new home, all of your personal belongings will be prepared for transfer in suitable containers to accompany you."					
	total of 24 residents were discharged from 11/4/2024 through 11/6/2024. The list showed 1 resident remained in the facility.  The facility's Transfer and Discharge policy revised October 2024, shows, "It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstancesThe facility's transfer/discharge notice will be provided to the resident and the resident's representative. Generally, the notice must be provided at least 30 days prior to a facility initiated transfer or discharge of the resident."					
		(B)				

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