STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.1210 d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These regulations were not met as evidenced by:

Based on observation, record review, and interview, the facility failed to assess for pressure ulcer risk, and failed to implement pressure relieving interventions for one of five residents (R10) reviewed for pressure ulcers in the sample of 30. These failures resulted in R10 developing three stage four pressure ulcers to the sacrum, left heel, and right heel.

Findings include:

The facility's Repositioning and Support Structures policy, dated 3-27-21, documents, "Repositioning is a common, effective interventions for preventing skin breakdown, promoting circulation, and providing pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Repositioning by facility staff should be congruent with the needs and level of function of the resident to maintain the highest practicable level of function while promoting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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	S9999		

preservation of skin integrity. Positioning the resident on an existing pressure injury should be avoided, when possible, since it puts additional pressure on tissue that already compromised and may impede healing."

The Electronic Medical Record documents R10 was admitted to the facility on 9/11/19 with no pressure ulcers or skin breakdown.

A Wound Assessment Details Report, dated 12/21/20, documents R10 developed a "facility-acquired pressure ulceration" to the right heel, measuring 2.5 cm (centimeters) x 2.5 cm x Unknown. A Wound Assessment Details Report, dated 12/22/20, documents R10 developed a "facility-acquired pressure ulceration" to the left heel, measuring 3.0 cm x 0.90 cm x Unknown.

R10's Minimum Data Set (MDS), dated 2/10/21, documents, "Always incontinent of bowel and bladder. Bed mobility (extensive assistance, two+ person physical assist). Active Diagnoses - Medically Complex Conditions, Stroke, Hemiplegia or Hemiparesis, Paraplegia, Other Abnormalities of Gait and Mobility. Skin Conditions - Resident has a pressure ulcer/injury. Resident is at risk of developing pressure ulcers/injuries. The resident has one or more unhealed pressure ulcers/injuries. One Stage three pressure ulcer (not present on admission). Two unstageable pressure ulcers (not present on admission) due to coverage of wound bed by slough and/or eschar. One unstageable pressure injury (not present on admission) presenting as deep tissue injury." On this same MDS, R10 is not marked for a turning/repositioning program.

R10's Care Plan, dated 2/10/21, documents, "Skin Integrity: (R10) has a potential for skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 integrity changes including the development of new or worsening pressure ulcers. Interventions include "Minimize pressure over boney prominence w/ repositioning when in bed. Extensive assist with two staff for turning/repositioning at routine intervals every shift when in bed. Self-Care &Mobility Deficits: R10 has had a Significant Change in Status (SCS) following Transient Ischemic Attack (TIA) w/ongoing residual effects. She now requires an increased amount of assistance for completion of all Activities of Daily Living (ADL) and mobility tasks. Worsening deficits are secondary to a recent TIA. New Risk Factors Include: Left Sided Flaccid Hemiplegia, decreased trunk strengths. Other Identified Risks Include: Limited Mobility, Limited Range of Motion (ROM) and Weakness." V18's (Wound Physician) Wound Evaluation &Management Summary, dated 5/3/21, documents "Stage four Pressure Wound of the left, lateral heel (over 123 days in duration) that measures 4 x 2.5 x 0.3 cm (centimeters). Stage four Pressure Wound of the right, lateral heel (over 123 days in duration) that measures 1.2 x 0.5 x not measurable cm. Full Thickness (stage four) Wound of the left, medial sacrum (at least 13 days in duration) that measures 2.7x1.5x0.3cm." The facility's Wound Quality System Review Tool, dated 5-4-21, and signed by V13 (Corporate Educational Nurse), documents R10 has not had a Braden assessment completed, and has not had weekly Registered Nurse assessment completed. On 5/04/21 at 1:00 PM, R10's left heel pressure ulcer was 4.0 x 2.5 x 0.3 cm (centimeters) with 75 percent of the wound covered in necrotic tissue	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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		

(black dead tissue). R10's right heel pressure ulcer was 1.2 cm x 0.5 cm and covered in yellow slough (dead tissue). R10's sacral pressure ulcer was not due for a dressing change and was not observed.

On 5/05/21 from 9:36 AM to 12:53 PM, R10 was laying on her back with direct pressure on the sacrum, in the middle of her bed. R10's left and right heels had padded boots and were lying directly on the bed without off-loading of pressure. V10, Licensed Practical Nurse (LPN), went into the resident's room at 11:31 AM, exited the room at 11:31 AM, and did not reposition the resident. At 11:57 AM, V7, Certified Nursing Assistant (CNA), entered the resident's room and exited at 11:58 AM, without repositioning the resident. At 12:18 PM, V7 (CNA) took a tray of food into the resident's room. At 12:24 PM, V10 (LPN) took a tray of food into the resident. At 12:53 PM, the resident was still on her back in the middle of the bed. R10 was observed continually from 9:36 AM, to 12:53 PM, and the resident was not turned or repositioned during this time and remained lying on her back.

On 5/05/21 at 11:55 AM, V7 (CNA) stated, "I have not provided care for (R10) today. (R10) cannot reposition herself and should be repositioned every two hours."

On 5/05/21 at 12:16 PM, V10 (LPN) stated, "(V8/CNA) and (V9/CNA) are the staff assigned to care for (R10) today. (R10) cannot reposition herself and should be repositioned every two hours."

On 5/05/21 at 1:07 PM, V8 (CNA) stated, "(R10) needs assistance with moving in bed. I have not re-positioned (R10), so I am not sure when it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 done. It should have been done every two hours." On 5/05/21 at 1:14 PM, V9 (CNA) stated, "I don't know when (R10) was re-positioned. I have not done it since 6:00 AM. It should have been done before lunch." V9 was asked what time her shift started. "We (V8 and V9) started working at 6:00 AM this morning." On 5/06/21 at12:05 PM, V2 (Director of Nursing) and V13 (Corporate Educational Nurse) both stated "routine intervals q shift" means turn every two hours and as needed. On 5/06/21 at 1:30 PM, V13 stated, "We (the facility) do not have a policy on wound prevention. (R10) should have been re-positioned at least every two hours, or more. We (the facility) do not have current medical records to determine whether a wound risk assessment has been done. The pressure ulcers to the right and left heel were caused by pressure and were facility acquired." (B) 2 of 2 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 6 Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 7	S9999		

emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These regulations were not met as evidenced by:

Based on observation, record review and interview, the facility failed to notify the physician of significant weight loss, implement interventions to prevent further weight loss, monitor resident weight and implement nutritional supplements as instructed by the Registered Dietitian, for one of five residents (R17) reviewed for nutrition, in a sample of 30. These failures resulted in R17 experiencing a significant weight loss of 8.56% in one month on 11/13/21, and an additional significant weight loss of 15.23% in three months on 4/21/21.

Findings include:

The facility policy, titled "Weighing/Weight Loss Protocol (revised 3/05/21)", documents, "It will be the practice of this facility to implement the following systems regarding weight documentation. Guidelines: New admits and readmissions will be weight upon admission, monthly and/or as ordered by the physician. 1. Staff will be responsible for obtaining weights for these admits and will have this information available for morning stand-up meeting. 2. Off-hour admissions will need to be weighed by a member of the nursing staff on the off-hour shift to obtain initial weight if possible; obtaining weight the following day for late night admissions may be acceptable for resident comfort. 3. The (Registered Dietitian) is to review all admission weight for possible interventions. 4. Consistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 8 weight loss noted during the admission weight process will be brought to the attention of the (Medical Doctor) & responsible party. 5. Weight refusals, not consistent with the resident's known preferences or expressed desires, should be documented by the attending nurse in the resident/patient's chart with notification to (Medical Doctor) and responsible party. 6. Monthly weights will be completed by the nursing department. 7. Weekly and daily weights may be obtained per Registered Dietitian or Physician orders in order to monitor clinical status of a resident requiring closer monitoring and intervention." On 5/04/21 at 12:30 PM, R17 was sitting in a high back reclining chair, being fed lunch by staff. R17 was eating a pureed diet and was totally dependent on staff for eating. The Electronic Medical Record documents R17 was admitted on 3/14/19, and has the diagnosis of Dementia with behavioral disturbances. R17's Plan of Care, dated 11/27/20, documents R17 as at risk for altered nutritional status due to cognitive/psychiatric changes, requires feeding and hydration assistance, mechanically altered diet, and instructs staff to report any unplanned/unexpected weight loss to the physician. R17's electronic medical record documents R17's weight on 11/03/20 as 132 pounds. R17's weight on 11/13/20 was documented to be 120.7 pounds, which is a significant decrease of 8.56%. There is no documented evidence that the Physician or Registered Dietitian was notified at that time of R17's significant weight loss, and no diet changes were implemented. According to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 9	S9999		

the physician's orders, R17 remained on a mechanical soft diet and was receiving the house nutritional supplement three times per day (originally ordered 10/28/20).

The electronic medical record documents on 12/14/20, R17's weight as 119.0 pounds. Nursing Progress notes document R17 was hospitalized from 1/09/21 to 1/14/21, and R17's weight upon return to the facility was 125.4 pounds.

Nutritional Progress Notes, dated 2/2/21, document "(R17) is alert and orientated, she feeds self with tray set up and encouragement to eat, she make her needs known, expresses her likes and dislikes of food, she does have chewing difficulty, not in any need of adaptive equipment, she eats in her room due to COVID guidelines, she has no skin issues, her (oral) intake is fair 25-50% of most meals, weight is 125 pounds, height 60 inches, BMI 24 will continue monitor."

A consultation by V6 (Registered Dietitian) on 2/21/21 for R17, documents "Interventions: 1.) Recommend continuing a Mechanical Soft Diet with Thin Liquids (texture per Speech Language Pathologist; diet appropriate with chewing difficulties and to encourage (oral) intake. Resident may benefit from a (no added salt/low concentrated sweets diet if (oral) intake improves). Recommend fluids per Medical Doctor (Congestive Heart Failure with Diuretics) 2.) Recommend 120 cc Med Pass (three times per day) to replace house nutritional supplement/high calorie. Recommend a daily MVI to assist with nutrient intakes (poor oral intake) 3.) Recommend daily weights to monitor for weight loss/gain (Congestive Heart Failure)." This is the only Consultation from the Registered Dietitian that could be located in the Electronic Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 10 Records during the last nine months of R17's admission. There is no documented evidence at that time, by review of all weight monitoring records and Medication/Treatment Administration records for February, March and April of 2021, that the facility implemented daily weight monitoring or changed R17's nutritional supplement to Med Pass 120 cc three times per day, as recommended by V6. Nursing Progress Notes document R17 was hospitalized from 2/27/21 to 3/01/21. There is no documented weight recorded upon R17's return to the facility. On 3/02/21, R17's Plan of Care was changed to the following: "R17 has specific nutritional needs. Resident has DIFFICULTY CHEWING - Mechanically altered diet in place. WEIGHT FLUCTUATIONS are expected related to (Congestive Heart Failure) with Diuretics. Goal: Resident will not experience an UNPLANNED WEIGHT LOSS of 5% or more in a month or a loss of 10% in 180 days. Interventions: Provide diet and serve as ordered; monitor meal intake; Provide supplements as ordered; monitor intake; REPORT unplanned/unexpected weight loss to physician; Resident receives a SPECIALIZED DIET - Mechanical Soft Diet. The TYPE or the CONSISTENCY of the food is ordered to be modified (check with nurse or check orders prior to offering additional foods)." On 3/23/21, the Physician's Order Sheet documents R17's diet was changed to pureed, with regular liquids, and the supplement of Boost Plus was added three times per day, per the recommendation of Speech Therapy.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 11	S9999		

R17's next documented weight was not recorded until 4/21/21, in which R17 weighed 107.4 pounds. Documentation indicates staff re-weighed R17 later in the day on 4/21/21 to verify her weight, and she was 106.3 pounds, which is a calculated decrease of 15.23%, from R17's previous weight of 125.4 on 1/23/21. As of 5/06/21, there is no documented evidence that the facility notified the physician or Registered Dietitian of R17's weight on 4/21/21 or that any dietary interventions have been implemented.

On 5/05/21, R17's weight was documented as 105.8 pounds.

On 5/06/21 at 11:05 AM, V4 (Dietary Manager) stated the Registered Dietitian comes to the facility on a weekly basis and is to be reviewing resident weights. The Registered Dietitian will notify V4 of any significant weight changes a resident might have and all dietary recommendations. According to V4, all ordered weights are to be documented in the Vital Sign section of the Electronic Medical Record and orders for Nutritional Supplements are entered in by nursing staff to be documented in the Medication/Treatment Administration Record.

05/06/21 at 9:52 AM, V2 (Director of Nursing) stated the Registered Dietitian is to be conducting quarterly nutritional assessments, at a minimum, and with a significant change in resident weight. V2 stated R17's Plan of Care should have been updated with each significant weight change and new interventions implemented to prevent further weight loss.

On 5/06/21 at 9:58 AM, V13 (Corporate Educational Nurse) stated the Registered Dietitian comes to the facility on a weekly basis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 12 and it is unknown as to why both of R17's significant changes in weight were not addressed by the Registered Dietitian at the time it occurred. V13 concluded the documented evidence reviewed was all the facility had available, and there were no indication daily weights were ever obtained, as ordered by V6 on 2/21/21. (B)	S9999		