STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014401	A. BUILDING: _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF EDWARDSVILLE	6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025

(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 2243505/IL146571	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1010h) 300.1210b) 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 300.1010 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: This requirement was not met as evidenced by: Based on interview and record review the facility failed to monitor a change of condition and respond timely for 1 of 3 residents (R2) reviewed for change of condition in the sample of 5. This failure caused a delay in treatment which resulted in R2 having multiple episodes of hypoxia before being sent to the hospital. Findings include: R2's Admission Record, not dated, lists Acute Respiratory Failure with Hypoxia as R2's Primary diagnosis. It also lists Chronic Obstructive Pulmonary Disease with Exacerbation and Chronic Pulmonary Edema as diagnosis. R2's Care Plan, dated 3/29/2022, documents	S9999		

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(R2) has actual/potential altered respiratory status. It also documents "Interventions Administer oxygen as ordered VIA O2 (oxygen) CONCENTRATOR: (Specify frequency below) PRN (as needed) At 2-5LPM (liters per minute) via Nasal cannula Humidification Needed, Monitor for changes in / development of signs & symptoms of breathing difficulty and report to nurse if noted: SOB (shortness of breath), Cough (productive or non-productive), Fever, Chills, Difficulty speaking, Bluish skin color, Changes in cognition. Notify nurse for any observed or reported breathing difficulty, excess secretions, or persistent coughing. 4-8-22 Resident will remove 02 at times, Encourage resident to leave 02 on. Provide resident / responsible party education PRN to include: Coughing / deep breathing, Fluid needs, Pursed-lip breathing, Need for rest, Compensatory strategies, Remind resident to breathe slowly and deeply when short of breath PRN, Report changes in respiratory status to physician."

R2's Minimum Data Set (MDS), dated 4/19/2022, documents R2 is moderately impaired cognitively.

R2's Monthly Summary, dated 4/17/2022, documents R2 is alert with confusion.

R2's Progress Notes, dated 4/30/2022 at 8:15 AM, document, "Health Status Note, Note Text: Resident hypoxic when staff got her sat up for breakfast with SpO2 (oxygen saturation) in 40-50%. Resident was refusing to go to hospital and code status is DNR (Do Not Resuscitate). Called MD (physician) and received orders to increase O2 flow to 4-5L (liters) via non rebreather and contact emergency contact for further info R/T (related to) transferring to acute care ED (emergency department) for further

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treatment. This RN (Registered Nurse) spoke with (V7, R2's family) and he was agreeable to increasing O2 via mask and re evaluation before sending (R2) to hospital. Resident immediately had improved SpO2 after increasing flow and application of non rebreather. current SpO2 @ 90%."

R2's Progress Notes, dated 4/30/2022 at 7:30 PM, document, "Health Status Note, Note Text: Call placed to 911 by this RN to transport Resident to hospital due to hypoxia, after speaking with her son to verify his agreement with decision. VS (vital signs) 99HR (heart rate) Resp (respirations) 16 on 5L O2 via mask SpO2 71% 97.5 145/71 Decision to transfer made after multiple episodes of hypoxia and s/s (signs/symptoms) of abnormal lung sounds. EMS (emergency medical services) transported Resident to (local hospital) ED."

On 5/12/2022 at 8:40 AM, V7, R2's Emergency Contact, stated that he was called at 7 PM on the day of her discharge to the hospital. V7 stated at that time he was notified that his mother was having shortness of breath and that she was delirious and she needed to go to the emergency room and be placed on a Bipap to help her breathing. V7 stated at 7 PM was the first time he was told that she was having problems. V7 stated that he was not aware of his mother having problems with her breathing and that her SPO2 level was 40% at all and that he was not notified until 7 PM at night. V7 stated that if he would have known that, he would have had her sent to the hospital. V7 stated that his mother was a DNR but she still would go to the hospital if something was wrong. V7 stated that his mother went to the hospital in March and this was the first time he was made aware of how serious it

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S9999	Continued From page 4 was to have a low SPO2. V7 stated prior to that he was not aware of how serious it was. V7 stated that because of this he would have sent her to the hospital. V7 stated within the last 30 days of her life R2 was having increased confusion and erratic conversations. V7 stated that they were not aware if this was because of dementia, the uti (urinary tract infection) she had or the low SPO2 levels. V7 stated that his mother would not have been able to make that decision and if he was aware, he would have sent her to the hospital. V7 stated that he was not notified throughout the day of any problems with his mother's condition or breathing problems. V7 again stated that he was not made aware of his mother's breathing problems until 7pm when she was being sent to the hospital. On 5/12/2022 at 9:15 AM, V9, RN, stated that she was notified of R2's oxygen level being 40 by V10, Licensed Practical Nurse (LPN). V9 stated that she was going to send R2 out to the hospital. V9 stated that she called the Nurse Practitioner and told her that the resident oxygen level was ranging from 40% to 50%. V9 stated that R2 stated that she did not want to go to the hospital. V9 stated that she was informed by the NP that with R2's Oxygen levels being this low and her being hypoxic she would not be able to make the decision and to contact the family. V9 stated that she requested a nonrebreather mask. V9 stated that she called the son and told him about his mother's condition and orders received from the doctor and V7 agreed to monitor but stated that he wanted to be kept informed of her condition. V9 stated that she then applied the mask and R2's oxygen levels came up to high 80's, low 90's. V9 stated that for a good part of the day R2's oxygen levels stayed in the high 80's and R2 kept the mask on. V9 stated that as the day went	S9999		

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S9999	Continued From page 5 on R2's oxygen level dropped to low 70's. V9 stated that she then sent R2 to the hospital. V9 stated that upon EMTs (emergency medical technician's) arrival she was notified by the Technician that R2 appeared to be dying. V9 stated she told the technician that R2 required a higher level of care than what was being provided at this facility. On 5/12/2022 at 9:30 AM, V8, R2's Physician, stated that he was not notified of R2's change of condition. V8 stated that he came to visit residents and was told that by V9 that she had sent R2 to the hospital. V8 was not sure if it was later that day or the following day. On 5/12/2022 at 9:35 AM, V10, LPN, stated that she was not assigned to R2. V10 stated that she was aware that R2 takes off her mask so she went in her room. V10 stated that when she entered the room, R2 was gray and pale and her Oxygen level was super low. V10 stated that she notified the nurse and stayed with R2 until able to get Oxygen level up. V10 stated that then she left and V9 took over. V10 stated that R2 has a history of taking off her oxygen and her oxygen levels drop. On 5/12/2022 at 10:00 AM, V11, LPN, stated that she was the manager on duty on 4/30/2022 and in the building. V11 stated that she was notified by the agency nurse that R2 was sating low. V11 stated that she was unsure of the time but it was after breakfast but before lunch. V11 stated that she walked to the resident's room and the Resident was sitting up in the bed with head of bed elevated and oxygen on with a nasal cannula. V11 stated that the saturation level came up a little. V11 stated that she then left the room. V11 stated shortly after the nurse asked	S9999		

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her help to find a mask. V11 stated that she helped the nurse find the mask. V11 stated that she was called by the nurse and told she was sending the resident out. V11 stated that this was prior to 12:30 PM. V11 stated that she did not see the resident go to the hospital but assumed she did.

On 5/12/2022 at 12:50 AM, V2, Director of Nursing (DON), stated that she reviewed R2's progress notes and spoke with the nurse. V2 stated that V9 notified the physician and family and the decision was made for R2 to remain in the building. V2 stated that she was not in the building and did not speak with the son so she is not sure of what V7's understanding was. V2 stated that some families don't understand that if a resident has an acute situation that they can be sent out. V2 stated that 90% oxygen level after dropping to 40% to 50% was stable. V2 stated that per the documentation and conversation with the nurse later that day the nurse called the physician and the son. V2 stated that at that time, the son was ok with sending R2 to the hospital. V2 stated that she would expect the nurse to continue to monitor R2 and document. V2 stated that if they did it it would be documented. V2 stated that if there was any further episodes of hypoxia, dropping of O2 sat she would not consider R2 to be stable and would expect the nurse to notify the physician and get directions and update the family with each episode. V2 stated that V9 has (V8) documented as the doctor she spoke to but it would have been his nurse practitioner (V14).

On 5/12/2022 at 11:05 AM, V14, Nurse Practitioner, stated that she was previously notified of R2 being confused and having episodes of removing oxygen tubing the weekend

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S9999	Continued From page 7 prior to hospitalization. V14 stated that she was made aware at that time that R2 removes her oxygen tubing and her sat drop and the facility reapplies and they come up. V14 stated that she was not notified of R2's change in condition. V14 stated that with R2 having an Oxygen level ranging from of 40% to 50% she would have sent R2 out to the hospital. V14 stated that she would have expected the nurse to notify her or the physician if R2 continued to have hypoxic episodes. On 5/12/2022 at 12:50 AM, V2 stated that as a result in V9 not notifying the physician of the additional hypoxic episode during the day, this caused a delay in treatment. The "Change in Condition" policy, dated 3/27/21, documents "Standard: It will be the standard of this facility to notify the physician, family, resident and/or responsible party/resident representative (as is applicable) of significant changes in condition and provide treatments according to the resident's wishes and physician's orders." Guidelines: "2. When a change is noted, gather pertinent data such as vital signs, weights and other clinical observations;" "7. Contact the primary physician to update him/her to the change in condition;" "11. Notify the family or responsible party/resident representative regarding the resident condition and change". (B) 2 of 2 300.610a) 300.1210b) 300.1210d)6)	S9999		

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S9999	Continued From page 8 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. Restorative measures shall include, at a minimum, the following procedures: 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999		

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S9999	Continued From page 9 that each resident receives adequate supervision and assistance to prevent accidents. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to prevent falls for 1 of 3 residents (R1) reviewed for falls in the sample of 5. This failure resulted in R1 falling, sustaining a fractured hip requiring hospitalization and surgical repair. Findings include: On 5/10/22 at 12:15PM, R1 was observed in her bed. R1 was tearful and stated she fell on 4/27/22 around 11AM. R1 stated she was sitting on the toilet, felt herself "going forward" and she fell forward. R1 stated she was weak the day of the fall due to having diarrhea. R1 stated she had been having diarrhea for about 2 weeks prior to the fall and they (R1 and V6, R1's family) had been telling V4, LPN, and V4 was telling her "it wasn't diarrhea, just loose stools." V6 confirmed she had told V4 that R1 had been complaining of diarrhea for the past two weeks (unsure of dates) and stated R1 was diagnosed with clostridium difficile while in the hospital. R1 states "she", later identified as V5, Certified Nurses Assistant (CNA), wasn't in the bathroom with her when she fell. R1 stated she told V4, Licensed Practical Nurse (LPN), that her hip was broken and she wanted to go to the hospital. R1 states V4 told her her hip wasn't broken and refused to send her to the hospital, but she was "eventually" sent. R1 stated V4 and V5 told her to get off the floor, but she couldn't so they got her up into the wheelchair and then put her in bed. R1 stated V5 did not evaluate her before getting her off of the floor and into her wheelchair after the fall. R1	S9999		

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S9999	Continued From page 10 stated she did break her left hip and had to have surgery to repair it. R1 stated she fell around 11AM, her family was notified around 11:30AM and her family told the nurse to send her to the emergency room. R1 stated she is supposed to have help going to the bathroom, but "staff" tell her "you can do it." R1's Progress Note, dated 4/27/22 at 9:00AM, documents, Patient in wheelchair without pants on. Stated she didn't want to put them on due to frequent urges to use the bathroom for loose bowels. Informed nurse of patient's wishes. R1's Progress Note, dated 4/27/22 at 11:33AM, documents R1 attempted to transfer self to wheelchair, slid in feces and fell. Complains of pain to the left hip and leg, requesting to go to the emergency room. Unable to fully evaluate for injury. Resident non-compliant. R1's Nursing Risk Screen, dated 4/14/22, documents R1 is at risk for falls. R1's Fall Report, dated 4/27/22 at 10:59AM, documents while being toileted by staff, R1 was sitting on toilet, leaned forward attempting to get up, slipped in feces and fell onto the floor. Resident complaining of pain to the left hip and leg. Unable to fully evaluate resident for injury. Resident non-compliant. Staff was present when this occurred. Resident states she leaned forward on the toilet and fell. Injury to top of scalp, complaining of pain level of 6/10. Resident is alert, oriented to person, situation, place and time. R1's Hospital History and Physical, dated 4/27/22, documents patient complained of left hip pain. Patient states she was sitting on the toilet and fell forward. Patient states she has been having multiple episodes of diarrhea for the past couple of days, felt weak and when she leaned forward,	S9999		

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S9999	Continued From page 11 she fell onto her left side.R1 was diagnosed with an intertrochanteric fracture of the left femur. R1's Progress Note, dated 4/27/22 at 2:58PM, documents R1 was admitted to the hospital with a left hip fracture. R1's Emergency Medical Services (EMS) Report, dated 4/27/22, documents EMS received the call at 11:57AM, they were dispatched at 12:05PM and was at the scene at 12:27PM. The report documents the nurse (unidentified in report) stated patient fell off of the toilet with staff present and fell onto the left side. Found patient in bed, patient complained of left hip pain at 10/10. Left leg shortening and left leg rotated externally R1's Hospital Laboratory Report, dated 4/28/22, documents R1 was positive for clostridium difficile. R1's Hospitalist Progress Note, dated 5/6/22, documents R1 had a displaced intertrochanteric fracture of the left femur with surgical repair on 4/29/22 and entercolitis due to clostridium difficile. R1's MDS, dated 2/9/22, documents R1 is cognitively intact and requires an extensive assistance of 1 staff with toileting. R1's Care Plan, dated 5/18/21, documents R1 has the potential for loose stools with an intervention to monitor bowel movement status and to report changes in bowel status to resident's physician. On 5/10/22 at 10AM, V2, DON, stated if a resident has a change in condition, the nurses are to notify the physician, get orders for labs or anything that could help them pin point what's going on, make a note and let the family know.	S9999		

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S9999	Continued From page 12 On 5/12/22 at 9:40AM, V8, R1's Physician, stated any infection can cause weakness which can contribute to falls and he was not notified of R1 complaining of diarrhea for two weeks prior to the fall. On 5/10/22 at 12:50PM, V4, LPN, stated she was called to R1's room by V5, CNA, R1 was on the floor in the bathroom. V4 stated R1 is on lactulose and was having loose stools and there was feces all over the floor in front of the toilet. V4 stated R1 was complaining of loose stools "one time" on the day she fell, they weren't liquid but loose." V4 stated, R1 takes lactulose and she (R1) gets "upset, always saying she has diarrhea, I try to explain to her (R1) that it's not diarrhea, just loose stools." V4 stated V8, R1's Physician, was here "one day", unsure of date, and explained to R1 that if it's not liquid stool, just loose, he (V8) wasn't worried about it." V4 stated R1's left leg was caught between the riser and the toilet, "I told her to calm down cause she was upset, she (R1) kept saying get me up, so we (V4 and V5) got her up in the wheelchair and then into bed, she (R1) was screaming, not calming down. I did not assess her while she was on the floor. I tried to assess her after she was in the bed and she started complaining of her left hip and leg hurting, saying I want to go to the hospital so I sent her to the hospital. ." V4 stated R1 was complaining of loose stools "one time on the day she fell, they weren't liquid but they were loose." V4 stated she was not aware of R1 complaining of being weak due to having diarrhea. V4 stated R1 is stand by assist or a 1 assist with toileting and "therapy wanted us to have her do what she could for herself, so we would encourage her." V4 stated V5, CNA, was in the bathroom with R1 when she fell.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014401	A. BUILDING: _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 On 5/10/22 at 1:05PM, V5, CNA, stated when R1 fell, she had a bowel movement on the floor. V5 stated it could have been she (R1) "was weak and fell forward or was trying to get up." V5 stated she (R1) "would normally use her call light but she didn't ask that day, I think it was because she was having watery diarrhea." V5 stated this was the first day she had watery diarrhea that she was aware of. V5 stated R1's stool wasn't "hard" normally but it was the consistency of pudding. V5 stated R1 wanted to go out to the hospital that morning before she fell because of the diarrhea, and she (V5) reported it to V4, LPN. On 5/10/22 at 1:05PM, V5, CNA, stated when R1 fell, she had a bowel movement on the floor, the wheelchair wasn't in the bathroom and R1 was trying to get off of the toilet. V5 stated she was in R1's room and not the bathroom, putting "stuff down, V5 stated, I told her (R1) to sit down on the toilet, I wasn't in the bathroom when she fell, my back was turned and it could have been she was weak and fell forward or was trying to get up." V5 stated R1 was moving around on the floor and she (V5) and V4, LPN, got R1 off of the floor and after they got R1 into the bed, R1 was requesting to go to the hospital. V5 stated R1 told her, she leaned forward and fell. V5 stated R1 was doing her "regular grunting" after the fall, but didn't complain of pain until she was in bed. V5 stated R1 required supervision with toileting. On 5/10/22 at 1:15PM, V2, Director of Nurses (DON), stated R1 was having loose stools on the day she fell. V2 stated if a resident is alert, oriented and requested to go to the hospital, she would call the physician and let them know but she "wouldn't argue with them, it's their right." On 5/10/22 at 1:15PM, V2, Director of Nurses (DON), stated when R1 fell, V5, CNA, was getting	S9999		

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S9999	Continued From page 14 wipes out of the sink outside of R1's bathroom but in R1's room, R1 got up off the toilet and fell. V2 stated R1 got her foot caught on the toilet riser because "she was impatient and didn't want to wait for the CNA." V2 stated R1 was a 1 assist with toileting and was at low risk for falls. V2 stated if a resident is a 1 assist, "we wouldn't leave them in the bathroom alone but the girl just walked away to grab the wipes." V2 stated V5, CNA, helped R1 to the bathroom and R1 was having loose stools on the day she fell. V2 stated after a fall, she would expect the nurse to assess the resident, get vital signs and if signs of injury, they aren't to move them and they are to call the ambulance. V2 stated the assessment should include assessing for bruising, swelling, pain and range of motion, if able. The Mayo Clinic defines clostridium difficile as a bacteria that causes an infection in the large intestine, symptoms can range from diarrhea to life-threatening damage to the colon and it most commonly affects older adults in long term care facilities. The "Change in Condition" policy, dated 3/27/21, documents "Standard: It will be the standard of this facility to notify the physician, family, resident and/or responsible party/resident representative (as is applicable) of significant changes in condition and provide treatments according to the resident's wishes and physician's orders." Guidelines: "2. When a change is noted, gather pertinent data such as vital signs, weights and other clinical observations;" "7. Contact the primary physician to update him/her to the change in condition;" "11. Notify the family or responsible party/resident representative regarding the resident condition and change".	S9999		

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S9999	Continued From page 15 The "Fall Prevention" policy, dated 3/27/21, documents Standard: "It will be the standard of this facility to complete and initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls." Guidelines: "As part of the initial assessment, the facility will help identify individuals with a history of falls or risk factors for subsequent falling." (A)	S9999		