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 11/04/2022

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 #2248472/IL152545	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	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
	IL6014401	A. BUILDING: _____ B. WING _____	C 11/04/2022

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
S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met evidenced by: Based on interview and record review, the facility failed to provide treatment in accordance with professional standards of care for a fall resulting in injury for 1 of 3 residents (R2) reviewed for quality of care in the sample of 3. This failure resulted in a delay in treatment of almost 12 hours for R2 after a fall in which she hit her head and sustained a nondisplaced periprosthetic right femoral fracture which required hospital admission for pain control. Findings include:	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 11/04/2022

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
S9999	Continued From page 2 R2's Minimum Data Set (MDS) dated 10/5/2022 documents R2 has moderately impaired cognitive skills for daily decision making. R2's MDS dated 8/19/2022 documents R2 requires limited assist for transfers, bed mobility and is occasionally incontinent of urine. R2's face sheet documents diagnoses include, ANXIETY, MAJOR DEPRESSIVE DISORDER, MUSCLE WEAKNESS, UNSTEADINESS ON FEET, OTHER ABNORMALITIES OF GAIT AND MOBILITY and COGNITIVE COMMUNICATION DEFICIT. R2's Care Plan, dated 8/23/22, documents R2 is at risk for abnormal bleeding related to use of anticoagulant. Interventions include report to the physician any signs/symptoms abnormal bleeding or hemorrhage. R2's 10/2022 Medication Administration Record (MAR), documents R2 takes Eliquis and Aspirin for anticoagulation. R2's Chart Note dated 10/19/2022 02:44 AM, documents: guest fell, no injury noted, daughter called waiting for call back, message left for gen med (general medicine) in folder. R2's Chart Note, dated 10/19/2022 10:07 AM, documents: Resident continues to complain of pain Tylenol not effective. Dr. notified. Vital sign monitoring continues from being observed on the floor. Neuro checks continue and remain WNL (within normal limits). Afebrile Resident has loss of appetite due to increased pain. Small hematoma noted behind right ear. Unable to move without yelling out. New order received to send to the hospital for evaluation and treatment. POA (Power of Attorney) notified and gave verbal	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 11/04/2022

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
S9999	Continued From page 3	S9999		

consent to send to hospital. (local) EMS (emergency medical services) notified of order for Resident pick up.

R2's Chart Note dated 10/19/2022 3:00 PM, documents: EMS arrived for Resident pick up and transport to (local hospital) ED (emergency department). EMS arrived to facility. Resident left facility accompanied by x2 EMTs (emergency medical technicians) via stretcher. POA in NH (nursing home) sitting with Resident prior to arrival of EMS transport.

On 10/27/2022 at 12:00 PM, V4, Licensed Practical Nurse (LPN), stated he received report from night shift nurse on 10/19/22 that R2 had a fall around 2-3am with no injuries and that the doctor and POA were aware. V4 stated he did walking rounds at the beginning of his shift and R2 was in bed. V4 stated around breakfast time the CNA (Certified Nursing Assistant) staff asked him to go to R2's room because they tried to raise the head of R2's bed to eat and she was in pain. V4 stated he entered R2's room and asked R2 what was going on. V4 stated R2 said she had fallen last night and she hurt all over. That her knee, head and shoulder hurt. V4 stated he gave R2 some acetaminophen for her pain and asked her to try and eat. V4 stated he did not do a physical assessment on her at that time. V4 stated around 10:00 am, he called V5, Nurse Practitioner (NP). V4 stated he told V5 that R2 had fallen last night and that she hit her head and was on blood thinners, that R2 was in pain unrelieved by acetaminophen and that her leg was turned outwards. V4 stated he received orders from V5 to send R2 to the hospital. V4 stated he called (local ambulance) transportation and they stated they were running behind. V4 said (local ambulance) transport asked him if this

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 11/04/2022

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
S9999	Continued From page 4 was an emergency and he stated no. V4 stated the (local ambulance) transport stated that they would be at the facility at 12:30-1:00pm for transport. V4 stated R2 did not transport to hospital until 3pm. V4 stated he did not make any additional calls to get R2 to the hospital earlier. V4 stated he felt as if R2 should have been transported to ER (Emergency Room) on night shift. V4 stated he did not notify NP of delay in transfer and he did not request any additional pain medication for R2 due to the acetaminophen not controlling the pain. On 10/27/2022 at 1:00 PM, V5, NP, stated she would expect the facility to transfer R2 immediately to the hospital due to her being on blood thinner and hitting her head during the fall. V5 stated she would have ordered something more for pain if she was aware of R2 not being transferred to ER until 3pm due to her pain not being relieved with acetaminophen. V5 stated she was not a made aware that R2 wasn't transferred to ER until 3pm. R2's hospital records for emergency room visit note dated 10/19/2022 documents per EMS that R2 received 4 milligram (mg) of morphine for pain and that R2's right lower extremity noted to be externally rotated and shortened. This document also documents R2 as having a nondisplaced periprosthetic right femoral fracture and was admitted to hospital for pain control. The Facility standards and guidelines document includes the following: contact the primary physician to update him/her to the change of condition, if the residents condition is considered to be life threatening and the resident requires immediate medical care notify the emergency medical system (911).	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 11/04/2022

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
S9999	Continued From page 5 (A)	S9999		