STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000848	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven on the River	**320 SOUTH 2ND STREET , GRAYVILLE, Illinois, 62844**

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S0000	Initial Comments Complaint Investigation 25511272 / 2674958	S0000		12/16/2025
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)1) 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 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.	S9999		12/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and 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 requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that includes post fall assessment and treatment, monitoring, reporting, and investigating, and failed to ensure a resident was properly assessed for injury and pain and to address resident complaints of pain post fall for 1 of 3 residents (R1) reviewed for quality of care in the sample of 6. This failure resulted in R1 falling and sustaining a hip and femur fracture without timely assessment and treatment after the fall. A reasonable person would experience feelings of discomfort and distress due to not receiving timely after fall care and severe pain and discomfort due to not receiving pain relief medication. This past non-compliance occurred between 11/14/25 and 11/16/25. Findings include:	S9999		

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S9999	Continued from page 2 R1's "Transfer/Discharge report, dated 12/2/25, documents an admission date of 12/3/2021 and a discharge date of 11/20/2025. R1's diagnosis report, dated 12/3/25, documents the following diagnoses in part, fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, muscle weakness (generalized), other abnormalities of gait and mobility, pain in right hip, unsteadiness on feet. R1's Minimum Data Set (MDS), dated 10/22/25, documents a Brief Interview for Mental Status (BIMS) of 9, indicating R1 is moderately cognitively impaired. Section GG-Functional Abilities documents R1 is dependent on staff for all transfers. R1's Care Plan documents R1 is at risk for falls, risk for injury from falls with an initiation date of 2/28/22. R1's Fall Risk Assessment, dated 9/25/25, documents R1 is at high risk for falls. R1's Order Recap Report, printed 12/2/25, documents R1 had an order for Ibuprofen Oral Tablet 600 milligrams (mg) give 600 mg by mouth every 8 hours as needed for pain started 8/24/23 and an order for Tylenol Extra Strength Tablet 500 mg give 2 tablets by mouth every 4 hours as needed for mild pain, take 1-2 tablets every 4-6 hours as needed for mild pain with a start state of 12/26/21. On 12/1/25 at 2:29pm, V12 (family member) stated V14 (family member) had visited R1 on 11/15/25 and said R1 was not wearing socks and she appeared to be in pain. V12 stated she went to visit R1 on 11/16/25 and noticed her leg did not look right and she was in pain. V12 stated one of the aides told her she had been in pain the day before and she had told the nurse about it. V12 stated she did not know the aide's name. V12 stated, "Staff were using a mechanical lift with her and her leg was so messed up, it was rotated, and her foot was flat on the recliner." V12 stated she told V8 (Registered Nurse/RN) something was not right with R1's leg; she stated V8 tapped her leg and said it looked a little swollen. V12 stated the hospital diagnosed R1 with a right hip fracture and a left leg fracture. V12 stated V2 (Director of Nursing/DON) called her and said a nurse admitted R1 had fallen and she didn't do anything about it. V12 stated V2 told her some staff stated they had reported R1 was in pain and the same nurse didn't do anything about it; he told her they got rid of the nurse.	S9999		

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S9999	Continued from page 3	S9999		

On 12/1/25 at 12:56pm, V2 (DON) stated there is an event that should be triggered in a resident's medical record when they have a fall or incident. V2 stated it will show up in the progress notes. V2 confirmed this was not done for R1's fall on 11/16/25.

On 12/1/25 at 2:54pm, V2 (Director of Nursing/DON) stated they realized there was an issue with R1 and quickly went into action to correct it.

On 12/2/25 at 11:31am, V8 (RN) stated she was the nurse that sent R1 out on 11/16/25. V8 stated she had noticed R1 had some increased edema more so in her left leg than in the right. V8 stated, "(R1) had edema, but it was a little more this day. She did not complain of pain; she did grimace a little when she touched it. (R1) was sent out because her daughter wanted her sent out." V8 stated she had pulses, and she had no complaint of pain prior to. V8 stated she had no knowledge of R1 falling until after she was sent to the hospital.

On 12/2/25 at 1:27pm, V9 (Certified Nursing Assistant/CNA) stated she was not working on R1's hallway on Friday, the day she fell. V9 stated one of the other CNA's told her she had to help V11 (Licensed Practical Nurse/LPN) put R1 back into bed after finding her on the floor. V9 stated the only nurse they worked with that following weekend was V11, and she reported to her two different nights that R1 was in pain. V9 stated she was not there the day R1 was sent out.

On 12/2/25 at 1:37pm, V10 (CNA) stated she was working the night that R1 fell. V10 stated she helped V11 (Licensed Practical Nurse/LPN) get R1 up after she fell; she stated she did not appear to be in pain. V10 stated V11 did not really assess R1, and she did not call her family or physician. V10 stated R1 did appear to be in pain later in the weekend, it was reported to V11, but to her knowledge V11 did not address it.

On 12/2/25 at 11:08am and 12/3/25 at 9:37am; attempts to contact V11 (LPN) were made but unsuccessful.

On 12/2/25 at 2:19pm, V2 (DON) stated they held a meeting on 11/16/25 with himself, V1; and V13 (RN, Minimum Data Set (MDS)/Care plan coordinator) to investigate and develop a plan of correction. V2 stated they interviewed all staff and residents and educated all the staff; and V11 (LPN) was terminated.

On 12/2/25 at 2:40pm, V1 (Administrator) stated V2

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S9999	Continued from page 4 (DON) jumped into action as soon as they found out that all the events that had taken place with R1. V1 stated as soon as he found out everything that went on with R1, he terminated V11 (LPN). V1 stated all staff and residents were interviewed, and staff were educated immediately. Facility document titled “Fall Scene investigation” for R1 documents the date of fall as 11/14/25. This documents states under “Fall Summary” R1 was found on the floor (unwitnessed). This document states under “fall location” the fall occurred in resident room. This document states that the resident was attempting to self-transfer. There is no documentation in R1’s progress notes of a fall or post fall evaluation occurring on 11/14/25. R1’s progress notes; dated 11/16/2025 at 2:15pm; documents ...” Residents daughter requests her mother to be transferred to (local emergency room) to have left hip evaluated. Resident has edema to ble (bilateral lower extremities) and has had bil (bilateral) knee replacements in the past, she is non-weight bearing. Resident does not c/o (complain of) pain or ask for medications, she will grimace when foot is pulled. non emergent EMS (Emergency Medical Services) notified to transport, report called to er (emergency room)” ... R1’s medical record from the local hospital documents in the Emergency Room Provider notes; dated 11/16/25 at 3:41pm, “Patient is a 85-year-old female who presents to the ED (emergency Department) via EMS (Emergency Medical Services) from a local nursing facility complaining of left knee pain for the last 3 days. Patient has a history of dementia and does not recall any accident or injury to the knee. Per EMS, nursing faculty has no record of any injury to the knee. R1’s Medication Administration Record for November of 2025 documents R1 did not receive the as needed Tylenol Extra Strength 500 mg tablet or the as need Ibuprofen Oral Tablet 600 mg pain medications between the dates of 11/14-11/16/25. R1’s MAR documents R1 had pain assessments done day and night shift on 11/14/25 and 11/15/25 with a pain level of 0. On 11/16/25 during the morning shift, R1’s pain level was documented as a 2 on a 1-10 scale. R1’s Progress Notes from 11/14/25-11/15/25 did not document any reference to R1 being in pain. R1’s medical record from the local hospital documents	S9999		

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S9999	Continued from page 5 an x-ray result of R1's left knee, dated 11/16/25 at 4:55pm, showing a fracture of the distal femur. R1's medical record from the local hospital documents in the Emergency Room Provider notes, dated 11/16/25 at 3:41pm, "Patient is a 85-year-old female who presents to the ED (emergency Department) via EMS (Emergency Medical Services) from a local nursing facility complaining of left knee pain for the last 3 days. Patient has a history of dementia and does not recall any accident or injury to the knee. Per EMS, nursing faculty has no record of any injury to the knee." R1's medical record from the local hospital documents an x-ray result of R1's left knee, dated 11/16/25 at 4:55pm, showing a fracture of the distal femur. R1's medical record from the local hospital documents an x-ray result of R1's right hip, dated 11/16/25 at 4:57pm, to include: 1. sub capital fracture of the right femoral neck with proximal migration of the shaft, chronic in appearance however new since 2023. 2. Age-indeterminate fractures of the superior and inferior right pubic ramus. Facility Policy titled "Fall Guideline", with a revision date of 8/2024, documents under the section "Purpose" "To consistently identify and evaluate residents who fall and to treat or refer for treatment appropriately, and under the section titled "Post fall", "Staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. Documentation of falls should include information to assist in determining the cause of the fall...For an individual who has fallen, staff will attempt to define probable causes within 24 hours of the fall." Prior to the survey date, the facility took the following actions to correct the deficient practice: A QAPI (Quality Assurance and Performance Improvement) meeting was held on 11/16/25. In attendance - V1 (Administrator), V2 (DON) and V13 (MDS/Care plan coordinator). The QAPI ad hoc form notes the following: 1. Immediate corrective action: Resident received medical attention. MD (Medical Doctor) notified, DON (Director of Nursing) and POA (Power of Attorney) notified.	S9999		

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S9999	Continued from page 6 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents residing in the facility have the potential to be affected. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: All residents and staff interviewed to identify unreported falls. 4. Plan to monitor performance to ensure solutions are sustained: DON or designee will interview three residents and three staff members weekly for any unreported falls. Administrator will report quarterly findings to the QA (quality assurance) committee. An in-service was completed with all employees regarding documenting and reporting falls. (A)	S9999		