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 12/30/2025

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 First Revisit to Complaint Investigation 25511272 / 2674958	S0000		01/07/2026
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1) 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. c) Each direct care-giving staff shall review and be	S9999		01/07/2026

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

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S9999	Continued from page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received pain medication in a timely manner for 2 of 3 (R2 and R3) residents reviewed for pain management in the sample of 4. This failure resulted in R2 going 12 days without a pain medication patch and R3 going 16 days without prescribed pain medication. R2 and R3 both had complaints of pain that was interfering with their activities of daily living. Findings include: 1. R2's "Admission Record" documents an admission date to the facility of 10/29/2020. Diagnoses listed include Parkinson's Disease, chronic obstructive pulmonary disease, generalized anxiety disorder, chronic pain syndrome, other intervertebral disc degeneration, secondary kyphosis, fibromyalgia, and osteoarthritis. R2's Minimum Data Set (MDS), dated 10/27/2025, documents a Brief Interview for Mental Status (BIMS) of 10, indicating R2 is moderately cognitively impaired. R2's care plan documents a focus area of chronic pain related to intervertebral disc disease lumbar, kyphosis, thoracic spine pain, fibromyalgia, osteoporosis, scoliosis and osteoporosis with an initial date of 12/28/2021. Interventions listed include "give medications as ordered. Monitor for side effects and effectiveness." R2's "Order Summary Report", with a print date of 12/26/2026, documents R2 has an order for "Fentanyl Patch 72 hour 25 Micrograms (MCG)/hour, apply one patch transdermally every 72 hours for pain with an order date of 06/24/2025.	S9999		

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S9999	Continued from page 2 R2's "Medication Administration Record", with a date range of 12/1/2025 – 12/31/2025, documents on 12/18/2025 and 12/21/2025, a number "9" in the column for Fentanyl Patch. The chart code on the last page of the administration record documents that "9" means to see progress note. R2's progress notes have no documentation on 12/18/2025 and 12/21/2025. On 12/26/2025 at 11:21 A.M., R2 stated her pain is "killing her". R2 stated she is supposed to have a pain patch, but the facility can't get it. R2 stated she has been without it for weeks. R2 stated she does not have one on right now. R2 stated her pain is so awful it makes her feel miserable. R2 stated her pain is so bad "it is off the scale and I cannot give a number to it." R2 stated they are giving her Tylenol, but that is not helping. R2 stated she has had back surgeries before and needs her pain under control. R2 stated she only ate toast for breakfast because her pain was so bad. R2 stated no staff ask her what her pain level is. 2. R3's "Admission Record" documents an admission date to the facility of 11/23/2022. The diagnoses listed include chronic respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, gout, chronic kidney disease, and neuromuscular dysfunction of the bladder. R3's Minimum Data Set (MDS), dated 10/24/2025, documents a Brief Interview for Mental Status (BIMS) of 15, indicating R3 is cognitively intact. R3's care plan documents a focus area of pain. Interventions listed include "Administer medications per physician order and monitor for effectiveness." R3's "Order Summary Report", with a print date of 12/26/2025, documents an order for "hydrocodone tablet 7.5-325 Milligram (MG), give 1 tablet by mouth two times a day for pain", with a start date of 08/25/2025. R3's "Mediation Administration Record", with a date range of 12/01/2025 – 12/31/2025, documents on 12/16/2025 -12/26/2025 a "9" in the column for hydrocodone. The chart code on the last page of the administration record documents that "9" means to see progress note. R3's "Progress Note" documented: 12/16/2025 primary care physician alerted of need of prescription.	S9999		

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S9999	Continued from page 3 12/17/2025 awaiting delivery of hydrocodone. 12/17/2025 medical doctor notified that resident is out of this medication and we are awaiting a new prescription. 12/18/2025 awaiting delivery of hydrocodone. 12/20/2025 awaiting delivery of hydrocodone. 12/21/2025 awaiting delivery of hydrocodone. 12/24/2025 awaiting prescription for hydrocodone. 12/26/2025 awaiting delivery of hydrocodone. On 12/26/2025 at 12:06 P.M., R3 stated she has not had her pain medication. R3 stated she has been without it for at least two weeks. R3 stated she has no idea what the problem is. R3 stated her pain is an 8 out of 10, and it is unbearable. R3 stated she is learning to tolerate it. R3 stated she has to ask for Tylenol, but it does not help. R3 stated the facility has a new doctor and she keeps getting excuses from them about why they do not have her pain medication. R3 stated it is not acceptable for the facility to not have her pain medications. R3 stated she needs her pain medications to make her comfortable. R3 stated it's like no one at the facility cares about the residents. R3 stated there is no reason that they do not have her medications. R3 stated when she takes her pain medications it makes her pain go down to a 4-5 and that is tolerable. On 12/26/2025 at 11:30 A.M., V3 (Registered Nurse) stated R2 has been out of her pain patch for at least a couple weeks. V3 stated the facility is needing a script and has not received one from the doctor. V3 stated they have been using Tylenol. V2 stated she has attempted to contact the doctor without any success. On 12/26/2025 at 12:15 P.M., V3 stated R3 has been without her pain medication for weeks. V3 stated she is waiting on a script for the physician. V3 stated she has contacted the physician, and the office is aware that they are needing scripts. On 12/26/2025 at 12:46 P.M., V2 (Director of Nursing) stated a fax was sent to R2 and R3's doctor on 12/12/2025. V2 stated he is not sure why the doctor never completed the script. V2 stated he will have to investigate why they have no medication. On 12/26/2025 at 12:52 P.M., V4 (Licensed Practical	S9999		

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S9999	Continued from page 4 Nurse) stated she is aware there are residents who do not have their pain medications. V4 stated she has attempted to contact the doctor's office to get scripts for pain medications and have been unsuccessful. On 12/26/2025 at 2:41 P.M., V6 (Registered Nurse) stated, "If the electronic medical record does not indicate I gave the medication, it is because the facility did not have the correct medication. There is a problem getting scripts from the physician." V6 stated she has attempted to get scripts for R2 and R3 and was unsuccessful. V6 stated, "They have sent faxes to the physician's office for the doctor to sign to get the script and have heard nothing back. There is a lack of communication at the facility. There has been issues for a long-time getting residents the correct medication." V6 stated that she would offer Tylenol or other medications to R2 and R3 while waiting for the physician to get a script. On 12/30/2025 at 8:41 A.M., V2 stated, "I think the issues started when the new company took over. The fax line was switched from a phone line to a digital line. The digital line is adding a four-digit code at the beginning of the fax number causing issues with the fax being transmitted. Before this issue was discovered, the facility was getting a fax receipt that stated ok on it after the fax was sent. The staff would then receive a second fax confirmation a while later that would say no answer." V2 stated the nurses were not following up with the second fax. V2 stated, "Pharmacy came to the facility yesterday to look at the line to make sure it was not a pharmacy issue. IT is supposed to come look at it. The nurses have been educated on following up to ensure faxes are completed. The fax machine was reset and is currently operating correctly." V2 stated the nurses should have followed up and it is his expectation that the nurses do follow up. V2 stated residents should not go without their medications. V2 stated the pharmacy is now sending a list weekly that shows who needs a script and who has refills. V2 stated this should help prevent the problem from reoccurring. On 12/30/2025 at 9:30 A.M., R2 stated she has her pain patch now. R2 stated she still doesn't know why she had to go so long without it. R2 stated she is very thankful that she has the pain patch because her pain is now under control, and she feels much better. On 12/30/2025 at 9:35 A.M., R3 stated she has received her pain medications on 12/27/2025. R3 stated her pain is under control now.	S9999		

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S9999	Continued from page 5 On 12/30/2025 at 9:57 A.M., V5 (Medical Doctor) stated he spoke with V2 on 12/26/2025 and was not aware R2 had been without her Fentanyl patch since 12/15/2025 and R3 had been without her pain medication since 12/11/2025. V5 stated when he spoke with V2, V2 explained to him that there is a fax issue. V5 stated he instructed V2 that he would like a 5-7 day notice any time a resident needs a prescription for a medication. V5 stated that window of time will help prevent a resident from running out of medication. V5 stated he feels the facility needs to implement a double check system to ensure the faxes are getting to the pharmacy. V5 stated he asked the facility to track the residents who need prescriptions to ensure this issue does not reoccur. V5 stated his expectation is for the residents to not run out of pain medication and the facility should have followed up. V5 stated once he receives the request from the facility his goal is to complete it within 1-2 hours. V5 stated once the facility reached out to his office, they process the request as soon as possible. On 12/30/2025 at 12:02 P.M., V1 (Administrator) stated it is his expectation that the residents have the medications that they are prescribed. V1 stated it is also his expectation if a resident needs a prescription, the staff should get it as soon as possible to prevent any issues with the resident running out of medications. Facility Policy titled “Medication and Treatment Order Policy”, dated February 2014, documented “interruptions in the delivery schedule, when known, will be communicated to the prescribing physician.” Facility policy titled “Controlled Substance Prescriptions”, with a date of 10/25/2014, documented under section titled “Procedures: C. The prescriber and/or nurse are contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available.” “F. Refill Requests: 2) If only one refill remains or only a partial fill quantity remains, the pharmacy will simultaneously dispense the remaining refill, contact the facility to verify continuation of the medication is necessary, and, if necessary proactively seek out a new, complete prescription from the prescriber for suture use. If a new prescription is not obtained by the pharmacy before the medication would be “due” again, the facility is notified. In this situation the facility may be asked to contact the prescriber for a new prescription prior to the medication running out.” (B)	S9999		

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