Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012074	A. BUILDING: ______ B. WING ______	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ALTON	3490 HUMBERT ROAD ALTON, IL 62002

(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 #2245978/IL149574	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1	S9999		

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:

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 were NOT MET as evidenced by:

Based on interview and record review the facility failed to monitor a bruise for 1 of 3 residents (R3) reviewed for change in condition in the sample of 11. This failure resulted in R3 having decline in condition and increased pain due to an unidentified and untreated rib fracture.

Findings include:

R3's Care Plan, revision date 11/21/22, documents "Resident is at risk for falls. The resident has IMPAIRED COGNITION and IMPAIRED SAFETY AWARENESS, The resident has BALANCE OR WALKING IMPAIRMENTS, The resident has a HISTORY OF FALLS, The resident has URINARY INCONTINENCE which may create a wet floor and increase fall risk. It also documents Interventions: Increase staff

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S9999	Continued From page 2	S9999		

monitoring.

R3's Health Status Note, dated 7/10/2022 at 10:00 PM, documents "Note Text: This writer was made aware by CNA (Certified Nurse Aide) staff of resident on the floor at this time. resident observed on floor bleeding noted from laceration to forehead in his room by the door in right side lying position. Resident was lying on his rt (right) arm with pants down below knees. rt leg shortening noted. walker in front of bed. noted soda spilled in middle of bedroom floor. Resident was last observed laying in bed at 9:30pm. Resident alert and verbal stating get me up . This writer stayed by resident side and talking with resident entire time until paramedics arrived. resident denies pain at this time. paramedics arrived at (10:15 PM) turned resident over to supine position and then to sitting position. resident moves both arms WNL (within normal limits) at this time. noted swelling to nose and laceration. paramedics wrap kling around laceration to forehead. resident denied pain and stood up with assist of 2 paramedic and walked to stretcher was transferred to (local hospital) for further eval and treat. MD (physician) made aware, POA (power of attorney) (V4, R3's son) made aware no concerns voiced."

R3's Chest Xray from local hospital, dated 7/11/2022 at 12:40 AM, documents "Bones: No acute findings. Other: No significant findings."

R3's Health Status Note, dated 7/11/2022 at 06:02 AM, documents, "Note Text: resident returned from er (emergency room) @450 am to facility via ambulance. resident transferred into bed via ambulance from stretcher. resident is noted to have stitches to laceration above left eyebrow. resident has fx (fracture) of nose. nose

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S9999	Continued From page 3 has bruising and swelling. skin tear to hand. resident is to f/u (follow up) with pcp (primary care physician). resident has no c/o (complained of) pain or discomfort at current time. resident is resting in bed in room covered up with blankets. resident able to move all extremities wnl. 97.8 t (temperature), 132/77 b/p (blood pressure), 63 p (pulse), 18 r (respirations). family notified of return. poa stated son will be up in the am to see resident. physician notified medprocity (secure messaging) of return to facility. on call nurse notified of return to facility." R3's Health Status Note, dated 7/11/2022 at 1:14 PM, documents "Note Text: Resident remains on po (oral) antibiotics for UTI (urinary tract infection) and no sign of any adverse reaction noted. sutures to left eye brow to forehead intact and bruising or discoloration on the nose and the area to forehead and dressing to skin tears on right hand intact, resident's son was here aware of resident's status and he spoke with D.O.N (Director of Nursing) and administrator. resident encouraged po fluids and drank house supplements and water and peri care given per CNA." R3's Health Status Note, dated 7/12/2022 at 9:54 PM, documents "Note Text: Sutures to face CDI (clean, dry, intact) healing Tylenol given Refused to eat or drink at supper but did take meds (medications) and drink a shake at HS (bedtime) VS (vital signs) 97.9 72 20 142/76 SAT (oxygen saturation) 97% on R/A (room air) bruising noted to nose and eye and dressing to hand w/ (with) some bruising on index finger. Denies pain but moans when moved." R3's Health Status Note, dated 7/13/2022 at 2:24 AM, documents "Note Text: Resident remains on	S9999		

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S9999	Continued From page 4 PO antibiotics for UTI; no S/S (signs/symptoms) of any ASE (adverse side effects) noted. sutures to left eye brow to forehead intact and bruising or discoloration on the nose and the area to forehead and dressing to skin tears on right hand intact, fluids encouraged; peri care given per CNA" R3's Weekly Skin Check, dated 7/13/2022 at 9:11 AM, documents bruising to chest, 2 open areas to right hand, stitches to the left side of forehead, bruising to left side of eye and left side of nose. R3's Health Status Note, dated 7/13/2022 at 1:36 PM, documents "Note Text: Resident INC f/u for fall; no new or apparent injuries noted; sutures intact bruising noted above L (left) eyebrow and L hip; all treatments completed per scheduled tx (treatment) nurse, (V29). Res also on ABT (antibiotic) for UTI; no ase noted; fluids offered and accepted; appetite poor; res refused shower and bed bath; son made aware per (V24, Licensed Practical Nurse- LPN); will monitor R3's Health Status Note, dated 7/13/2022 2:15 PM Late Entry date 8/5/2022 at 2:15 PM , documents "Late Entry: Note Text: Bruising also present on left rib area from fall on 7/10/22" R3's Health Status Note, dated 7/13/2022 at 2:18 PM, documents "Note Text: Resident refused shower 4x's, This writer called his son (V4) and informed him of the refusal, (V4) said that is ok that he misses his shower today and for staff to wash him up when assisting him with toileting, and he will be up Saturday to make sure that he gets his shower, He also asked me to talk with the MD about getting a stronger pain medication, This writer spoke with the PA (V12, Physician's Assistant) and he said that he will assess the	S9999		

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S9999	Continued From page 5 resident and write an order," R3's Physician progress notes, dated 7/13/2022, documents Skin normal appearance, normal turgor, no rashes, 7/13 laceration on left side of forehead closed and appears to be healing well. There is significant amount of ecchymosis. It also documents I am seeing the patient acutely today for emergency room visit follow up and also because nursing is concerned that pain is uncontrolled. Patient suffered a fall on 07/10 resulting in a laceration to his forehead and bilateral epistaxis. Was sent to the emergency room where laceration was closed with nylon sutures. Work up in the emergency room showed displaced bilateral nasal bone fractures. Nursing staff reported that patient pain is uncontrolled. R3's Health Status Note, dated 7/14/2022 at 6:02 AM, documents "Note Text: Resident continues fall follow up. Resident is able to make needs known and voice no concerns at this time. Resident stitches remain intact. Resident continues ABT. Resident does not display any sign and symptoms of distress adverse reaction or fever. Resident noted to be laying in bed with eyes closed at this time." R3's Health Status Note, dated 7/14/2022 at 9:57 PM, documents "Note Text: Sutures to face CDI color pink skin W/D (warm/dry) ate poorly but drank shakes X 2 denies pain and continues ABT T-97.8 No ill effects." R3's Health Status Note, dated 7/15/2022 at 1:49 AM, documents "Note Note Text: Resident remains on PO antibiotics for UTI; no S/S of any ASE noted. sutures to left eyebrow to forehead intact and bruising or discoloration on the nose and the area to forehead and dressing to skin	S9999		

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S9999	Continued From page 6	S9999		

tears on right hand intact, fluids encouraged; peri care given per CNA"

R3's Health Status Note, dated 7/18/2022 at 1:37 PM, Documents "Note Text: resident tilt backwards in wheel chair. appeared at that resident was trying to position self in wheelchair. no new injuries or bruising related to this incident at this time. voiced c/o pain PRN (as needed) medication given. in bed resting at this time. resident refused lunch and returned to bed room. MD, DON and responsible party aware of incident. VS: 123/64 74 18 98.0"

R3's Discharge Summary, dated 7/18/2022 at 9:00 PM, documents "Note Text: Resident had previous fall last Monday. i.e. sutures, scattered bruising and discoloration of nose. Resident suffered another fall on day shift today, falling backwards out of wheelchair and hitting head. Nurse in room attempting to position resident at side of the bed to feed dinner as it has been reported resident has not eaten much since previous fall. Upon repositioning, feet flat on floor. Resident still unable to sit up straight, kept leaning back and wincing in pain. Resident's son arrived with food and assisted resident in eating, resident still refused but later had a few bites. Resident noted to be having a hard time chewing. Nurse started to assess resident's body and get vitals for Neurochecks. Huge bruise noted to left ribcage, notified doctor. (V20) gave orders for chest Xray. Son had questions about resident possibly needing CT's (computed tomography) and more labs ran r/t (related to) fall earlier in the day. Nurse agreed due to resident's continued decline, poor appetite and overall drastic change from baseline since first fall. Notified family that resident could be sent out at their request. Doctor notified of family's request to be evaluated in the

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S9999	Continued From page 7	S9999		

ER. Doctor said Ok. Resident transferred out to (local hospital)."

R3's Thoracic and Lumbar spine CT, dated 8/19/2022 at 12:37 AM, Impressions: 1. Left posterior 12th rib fracture, moderately displaced. 2. Oblique fracture extending posteriorsuperior corner of L2 (2nd lumbar spine) to the mid anterior end plate with widening of up to 8mm (millimeters).

On 8/4/2022 at 11:05 AM, V24, LPN, stated that she was familiar with R3 and his care. V24 stated that prior to the fall R3 was independent with occasional incontinence and family provided disposables. V24 stated that after the fall R3 had increase confusion and was weak. V24 stated that R3 was diagnosed with a uti at the emergency room. V24 stated that R3 was weak. V24 stated that she was not aware of R3 complaining of pain but do know that he would moan. V24 stated that R3 would still try to transfer himself in a weaken state. V24 stated that she was only aware of bruising to R3's face. V24 stated that it was not reported to her of R3 having additional bruising to R3's body. V24 stated if this would have been reported to her it would have been monitored for further injury and pain. V24 stated the physician, and the Director of Nursing would have been notified as well.

On 8/4/2022 at 11:40 AM, V23, Registered Nurse (RN), stated that she was not notified of a bruise or discoloration on R3's side and was not monitoring a bruise to R3 rib area. V23 stated that she was only aware of the bruising and injury to R3's face. V23 stated that if notified of a bruise or would have been reported she would have assessed it, notified the doctor, V2 DON, and would have monitored it to make sure it didn't get

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S9999	Continued From page 8 bigger or worse. On 8/8/2022 at 9:00 AM, V12, Physician Assistant, stated that he was made aware from the mediprocity on 7/18/22. V12 stated that he was not the physician that responded as he was off. V12 stated that the nurse sent a picture of bruise. V12 stated that the bruise did not just show up and the bruise had to be there prior to the fall on 7/18/2022. V12 stated that due to the color and size of the bruise it was an older bruise. V12 stated that the bruise and the fractures to R3's ribs would have occurred on the first fall. V12 stated that he was notified of R3's pain being uncontrolled but was not notified until he reviewed the mediprosity from 7/18/2022 on the following morning. On 8/8/2022 at 3:20 PM, V15, CNA, stated that she was working when R3 returned from the hospital and R3 did not have any bruising to his left side and rib area. V15 stated that prior to R3's fall he was independent and after R3 fell he was dependent on staff for care. V15 stated that R3 was attempting to transfer himself out of bed when first returning but was unable to. V15 stated that she is not aware of him falling again but knows that initially he was trying to get out the bed. On 8/8/2022 at 3:30 PM, V16, CNA, stated that she took care of R3 after his fall. V16 stated that when caring for R3 he would yell out in pain when turning him during care. V16 stated that R3 was more confused and weaker. V16 stated that she does not remember any bruising to R3 body but does remember bruising to his face. V16 stated that prior to fall R3 was independent and after fall R3 was totally dependent. V16 stated that after the fall R3 was total care. V16 stated that she did	S9999		

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S9999	Continued From page 9	S9999		

not get R3 out of bed. V16 stated that there was no interventions put in place and that it was care as usual.

On 8/8/2022 at 4:00 PM, V27, CNA, stated that when returning from the hospital R3 was different. V27 stated that R3 was independent before going to the hospital and not wanting the staff to help. V27 stated that when R3 returned from the hospital he was total care. V27 stated that she was not aware of a bruise to R3's left rib area or R3's left side. V27 stated that if she would have seen the bruise she would have told the nurse and watch it to make sure he didn't get hurt more. V27 stated that R3 was more confused and at times didn't know who she was which was different for him. V27 stated that he was in a lot of pain, moaning and yelling when touched.

On 8/8/2022 at 4:20 PM, V25, LPN, stated that she was not monitoring a bruise to R3's left side. V25 stated that she did not see, nor did anyone report any bruising. V25 stated that if she would have been notified this is something that she would have monitored for additional injury.

On 8/9/2022 at 1:15 PM, When asked how did V2, DON, know about the bruise, V2 stated that she was notified by V21, CNA, that R3 had the bruise.

On 8/9/2022 at 1:23 PM, V21, CNA, stated that she was aware of the dark bruise to R3's rib area. V21 stated that she doesn't know what day or what shift it was that she saw it. V21 stated that it was after the first fall but before the second fall. V21 stated that she has been a CNA for 20 years and knows that she reported it. V21 stated that she does not know what nurse she reported it to or when she reported it due to multiple days and

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S9999	Continued From page 10	S9999		

shifts she has worked. V21 stated that she did not notify V2.

On 8/9/2022 at 1:40 PM, V2 stated that V22, CNA, was the person that notified her of R3 having bruising on 8/5/2022. V2 stated the V22 did not report it because she assumed it was because of the fall. V2 stated that when R3 went to the hospital she discussed the bruise with V12, Physician Assistant. V2 stated that V12 told her that the bruising was old and had to be there prior to the fall on 8/18. V12 stated that the nursing staff were aware of the bruising and did not monitor it.

On 8/9/2022 at 1:47 PM, V22, CNA, stated that she was working the hall on a different set. V22 stated that she was asked to change R3. V22 stated that when checking R3, because he was dry she noticed a red area to R3's hip area. V22 stated that she did not see any purple or black discoloration or bruises to R3's rib areas. V22 stated that she did not lift R3's shirt up when she checked him because he was dry. V22 stated that she did see the bruises on R3's face and they were black and purple. V22 stated that she was notified of by V23, RN, of R3 having a fall. V22 stated that she did not report this to the nurse. V22 stated that she was unsure as to what day after the fall it was that this occurred. V22 stated that she was not assigned to R3's care after this.

On 8/9/2022 at 2:00 PM, V23 stated that she was not aware of a red area to R3's body and this was not reported to her. V23 stated that the only bruising or discoloration she was aware of was the bruising to R3's face.

On 8/9/2022 at 3:32 PM, V28 (LPN) stated that when R3 returned from the hospital she did not

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S9999	Continued From page 11	S9999		

see any bruising or discoloration to R3's side. V28 stated that R3 had covers pulled up over self. V28 stated that she was not notified of any bruising this is something she would have documented.

On 8/10/2022 at 1:53 PM, V20, Medical Director, stated that he was notified of R3's falls and injuries and bruising on 7/18/2022 at the time of the second fall. V20 stated that due to the information from the nurse that resident had a fall previously on the 10th and has been declining since Ist fall. V20 stated that he was notified of R3 not eating and bruising with picture sent per mediprosity. V20 stated that he originally requested an xray but was later notified of the family wish to send to the hospital. V20 stated that he has a physician assistant that is in the building and the facility may have notified him of the bruising. V20 stated that he would expect the facility to monitor the resident and report any changes to the him or (V12). V20 stated that with a rib fracture there is a hematoma that forms and this may show up later. V20 stated that if notified he would have ordered an x-ray. V20 stated that he is not sure how the treatment would have been but there would have logically been a change in care for the resident. V20 stated that the xray on 7/11/2022, from local hospital, documents no fracture. V20 stated that he wonders if there was another fall between 7/10 and 7/18. V20 stated that he can't say that his falls hastened R3's death as he does not know what the cause of death is at this time. V20 stated that the bruise should have been reported to the physician and monitored.

The facility's Change in Condition Standards and Guidelines, dated 3/27/2021, documents "It will be the standard of this facility to notify the

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	IL6012074	A. BUILDING: ____ B. WING ____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ALTON	3490 HUMBERT ROAD ALTON, IL 62002

(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 physician, family, resident, and/or responsible party/resident representative of significant changes of condition and providing treatment (s) according to the resident's wishes and physician's orders. Guidelines: 1 Observe resident during routine care and during monthly/quarterly/annual assessment periods to identify significant changes in physical or mental conditions, orientation, change in vital signs, weights, etc." The facility's Falls Standards and Guidelines, dated 3/27/2021, documents "Guidelines 4. Following a fall. Post event monitoring should occur to monitor vitals signs, change in function, change in condition, increased pain or changes in skin condition, increased pain or changes in skin condition, etc." (B)	S9999		