PRINTED: 11/28/2023
FORM APPROVED

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 ______	R-C 10/19/2023

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 First revisit to ComplaitSurve: 2347660/IL164379	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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 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	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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and assistance to prevent accidents.

These Requirements were not et as evidenced by:

Based on observation, interview and record review the facility failed to implement fall interventions to prevent falls for 1 of 3 residents (R3) reviewed for falls in the sample of 4. This failure resulted in R3 rolling out of bed and receiving a displaced right maxilla/maxillary sinus fracture and acute fracture of right inferior orbital floor.

Findings include:

R3's Admission Record, with print date of 10/19/23, documented that R3 had the following diagnoses prior to her fall on 10/9/23: Parkinson's Disease with dyskinesia, muscle weakness, unsteadiness on feet, and fracture of left femur.

R3's Fall incident report date 10/9/2023 at 6:15AM documents R3 was found prone on the floor with right side of face to the floor and arms tucked underneath her. The report documents R3's bed was in the low position. The report documents R3 was lying in bed facing wall at about 5:20AM. The report documents resident stated she does not know how she got on the floor. The report documents that R3 stated she had a tramadol at bedtime and thinks medication makes hard for her to remember. The report documents immediate action taken, R3 rolled on back for further assessment. The report documents R3's right eye was swollen shut and bleeding. The report documents R3's upper lip was swollen. The report documents R3 denies headache. The report documents R3's face cleansed with wound cleanser and 911 called.

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R3's fall incident report documents hematoma to face and R3 alert and orientated to place and person.

R3's Health Status Note, dated 10/9/2023 at 07:22AM documents "Resident found prone on floor next to bed with R (right) side of face on floor. Resident rolled on back for further assessment. Right eye noted to be swollen shut and bleeding. Upper lip also swollen. Resident states she does not know how she ended up on the floor. States she had a Tramadol HS and thinks the medication caused her to not remember. Resident also stated she wanted to use her call light, but she'd rolled over on it. The report documents 911 phoned. EMT (Emergency Medical Technician) transferred resident to (local hospital). (Physician) notified. Son, (Son's name) notified."

R3's Health Status Note, dated 10/9/2023 documents "Contacted (local hospital) to f/u (follow-up) on resident's status. Resident is being sent to (City Hospital in different state) with DX (diagnosis): closed facial FX (fracture)."

The facility's Final Report Notifications dated 10/16/2023 at 2:42PM documents "Final Report Findings: Resident is alert and orientated time 3-4 with period of forgetfulness. Brief Interview Mental Status (BIMS) 12, able to make needs known. Diagnosis Neurocognitive Disorder with Lewy Bodies Parkinson's Disease without Dyskinesia, without mention of fluctuations, Cognitive communicating deficit and Depression." The report documents R3 had an unwitnessed fall on 10/9/2023 and was observed lying prone on the floor next to her bed. 911 was called and transported R3 to the hospital for evaluation and was admitted with diagnosis of displaced right

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maxilla/maxillary sinus fracture and acute fracture of right inferior orbital floor. Per medical review resident is at risk for fall. R3 has balance and walking impairments. R3 experiences weakness. R3 takes medications that may cause dizziness, loss of balance, or impair judgement. R3 stated she rolled out of bed. R3 returned to the facility on 10/13/2023. Bruising noted to right orbital area. R3 remains alert and orientated and ambulatory with wheelchair mobility.

On 10/18/2023 at 2:41PM V21, Licensed Practical Nurse (LPN) stated she was on duty when R3 fell. V21 stated the CNA came and got her. V21 stated R3 was face down on floor, and her bed was in low position and against the wall. V21 stated there was no mat on the floor and there was blood all around. V21 stated rolled R3 over and R3's right eye was swollen shut. V21 stated she called 911 because could see R3 had serious injury. V21 stated R3 would sleep leaned up against the wall, and the last bed check R3 was against the wall. V21 stated that R3 told her she was looking for her call light. V21 stated "I guess she just kept rolling and rolled out of bed." V21 stated that R3's roommate is alert and looks out for R3. V21 stated she was surprised R3 did not have a mat by her bed as R3 had fractured her hip in past.

On 10/19/2023 at 8:32AM R6, R3's room mate who is cognitively intact, stated that R3 is always trying to get out of bed. R6 stated that R3 can and does use her call light, but R3 is very impatient and does not realize staff have other people to take care of besides R3. R6 stated she did not witness R3's fall.

On 10/19/2023 at 10:13AM R3 was in bed. There was a high edged mattress on right side

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with a mat beside bed. R3 stated she fell out of bed and pointed to the floor. R3 stated her head really hurt but is feeling better now. R3 stated she was trying to get her call light but could not find it. R3 stated her call light is supposed to be in reach but staff do not check. R3 stated you have to take care of it yourself. R3 stated the new mattress on bed is a little thicker. R3 said that the new mattress was not on the bed when she fell.

R3's Care plan initiated 4/22/2022 documents that R3 had a fracture of Left femur from a fall on 8/8/2023. R3's Care plan documents that R3 is at risk for falls, has a balance or walking impairment. R3's care plan documents that R3 experiences weakness and takes medications that may cause dizziness, loss of balance, or impair judgement. R3's care plan documents that R3 has urinary incontinence which may create a wet floor and increase fall risk. R3's care plan document the following interventions: 4/22/2022 be sure residents call light is within reach and encourage the resident to use for assistance; 5/2/2022 raised edge mattress; and 7/2023 anticipate and meet resident's needs, remind to request assistance when getting up if needed. R3's care plan does document a new intervention of floor mats beside the bed while resident in bed. Place mats on open side, bed against wall dated 10/9/2023.

On 10/19/2023 at 11:35AM V1, Administrator stated she would expect staff to implement interventions for falls as identified in R3's care plan.

The facility Standard and guideline, Falls dated revised 9/1/2023 documents it is the standard of the facility to complete initial assessment, ongoing monitoring and routine and periodic

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S9999	Continued From page 5 evaluation of resident's condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls. The fall standard and guideline documents based on evaluation of risk factors and history of fall. A plan of care will be developed with pertinent interventions to be implemented by staff. (A)	S9999		