

Illinois State Department of Health

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 03/06/2026	
NAME OF PROVIDER OR SUPPLIER The Haven on the River				STREET ADDRESS, CITY, STATE, ZIP CODE 320 SOUTH 2ND STREET , GRAYVILLE, Illinois, 62844			
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S0000	Initial Comments		S0000			03/07/2026	
	First revisit to Complaint Investigation 2650733/2719539						
S9999	Final Observations		S9999			03/07/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1010h)						
	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 300.1010 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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 condition at the time of notification. 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: 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 assess and monitor a resident's change in condition for 1 of 3 (R21) reviewed for quality of care in a sample of 12. This failure resulted in R21's hospital admission for sepsis secondary to UTI (Urinary Tract Infection), Influenza A and acute respiratory failure with hypoxia. Findings Include: R21's Admission Record documented an admission date of 12/25/2025, with diagnoses that included interstitial pulmonary disease, unspecified, cardiomyopathy, cardiomegaly, type 2 diabetes mellitus with hyperglycemia and polyneuropathy, lack of coordination, and orthostatic hypotension. R21's Minimum Data Set (MDS), dated 12/31/2025, documented in Section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. This same			S9999			

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S9999	Continued from page 2 document under Section GG, GG0170 Mobility documented R21 requiring supervision or touching assistance where helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity for toilet transfer and Section O, Special Treatments, Procedures and Program had no documentation of Respiratory Treatments, including Oxygen therapy documented on admission. R21's Care Plan documented a focus area of R21 having a communication problem related to an issue understanding others and making self-understood with an intervention in place to pay attention to body language and facial expressions. This same document had a focus area of R21 has shortness of breath with interventions to monitor and document in orientation, increased restlessness, anxiety, and hunger. R21's Stop and Watch Early Warning Tool completed by V14 (Certified Nurse Assistant/CNA) and signed off by V6 (ADON), dated 2/19/2026 at 12:00 PM, documents R21 seems different than usual; symptoms of new illness, ate less, tired, weak and needs help with walking, transferring, toileting more than usual. R21's Progress Note by V6 (Assistant Director of Nursing/ADON) on 2/19/2026 at 3:45 PM documents, "(R21) not feeling well this afternoon. Skin warm to touch, with oxygen saturations low 83 percent. Oxygen added and oxygen saturation improved. Pulse 87. Respirations even and regular nonlabored. Blood pressure 157/87. R21 will wake up and is oriented. Generalized discomfort. Resident repositioned for comfort. With call light in reach." R21's Progress Note by V9 (Licensed Practical Nurse/LPN), dated 2/20/2026 at 11:41 AM, documents, "(R21) exhibiting altered mental status with supplemental O2 on at 2 Liters per nasal cannula. Spouse present and request to send (R21) to local emergency room for further evaluation and treat per family request." R21's Emergency Medical Services (EMS) Report, dated 2/20/2026 at 11:49 PM, documents under Narrative: "EMS dispatched to facility for an altered mental status. Upon arrival, led by staff to (R21) who was lying in bed with oxygen in place at 2 liters nasal cannula. Per staff, (R21) had been running a fever intermittently today. He is lethargic, has a cough. (R21) had breathing treatment earlier in the day. Current oxygen saturation is at 89% on oxygen. Rhonchi in both lungs. DuoNeb at 3milligrams was initiated. (R21) transported to local emergency room."			S9999			

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S9999	Continued from page 3 R21's Local Emergency Department to Hospital Admission paperwork by V35 (Physician) on 2/20/2026 at 1:09 PM documents, "Patient presents via EMS from local nursing home for concern regarding fever, cough, congestion and hypoxia. (R21) is very hard of hearing, (V36, Family) is at bedside and contributes to history. States that patient started with congestion and cough about 2 days ago. States he had a 101 temp this morning at the nursing home. States that he is not typically on oxygen therapy, but they started him on oxygen at the nursing home this morning. (V36) states that he was admitted to the hospital around Christmas for pneumonia and was discharged on oxygen at that time which was weaned at the nursing home over about 2 weeks. But he has been stable off of oxygen since that time. Resident denies significant shortness of breath. States he is only coughing a little bit. (V36) states he was told he had Chronic Obstructive Pulmonary Disease (COPD) during his last hospitalization." Physical Exam: "Nose: Congestion present, Pulmonary: Comments: Course breath sounds, bilateral in the bases." Clinical Impression: "1. Sepsis secondary to UTI (urinary tract infection), 2. Community acquired pneumonia, unspecified laterality, 3. Recurrent UTI, 4. Influenza A, 5. Acute respiratory failure with hypoxia with Disposition: Admit." R21's Imaging of the CHEST SINGLE VIEW on 02/20/26 at 1:36 PM documents, "development slight patchy infiltrates or atelectasis in the lower lungs bilaterally. 2. Scattered fibrosis with mild scarring in the lung bases. Stable small amount of pleural thickening at the costophrenic angles. No pneumothorax. 3. Moderate cardiomegaly. Atherosclerotic aorta. No Congestive Heart Failure (CHF)." R21's History and Physical Assessment Notes by V34 (Physician) documents "Review of Systems: Respiratory: Positive for cough. Negative for chest tightness, shortness of breath and wheezing.... Musculoskeletal: Positive for gait problem. Neurological: Positive for weakness. Physical Exam: Vital signs documented on 2/20/2026 at 1:01 PM were as follows blood pressure 140/66, temperature 98.2 degrees Fahrenheit, respirations 24 with 91% oxygen saturation." Lab results dated 2/20/2026 of White Blood Count (WBC) of 17.73 (High). R21's Laboratory results from 2/20/2026 documented an abnormal B-type natriuretic peptide of 2,080 and urinalysis with dark yellow appearance, positive for nitrates, WBC 1+, bacteria, urine and squamous epithelial cells with small amounts.			S9999			

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S9999	Continued from page 4 R21's Laboratory results from 2/22/2026 documented culture results from urine sample on 2/20/2026 at 1:59 PM documented greater than 100,000 CFU/ML(colony forming units per milliliter) pseudomona s aeruginosa. On 2/27/2026 at 12:00 PM, V6 (Assistant Director of Nursing/ADON) stated she had been working on 2/19/2026 when R21 had not been feeling well. V6 stated R21 had presented with feverish skin, felt warm to touch, increased weakness, and needed more assistance with toileting. V6 stated R21 did have a pulse oximeter placed on his finger with oxygen saturation reading of 83% and she applied 2 liters of oxygen via nasal canula. V6 stated she did not feel this was a change in condition for R21 and did not notify V33 (Nurse Practitioner/NP). On 2/27/2026 at 12:56 PM, V2 (Director of Nursing/DON) stated all changes in condition are to be reported to V33 (Nurse Practitioner). V2 stated feverish, warm to touch, increased weakness, pulse oximeter readings below 90%, and increased assistance to the bathroom should have been reported to V33. V2 stated her expectation is for nursing staff to follow the facility's policy and procedure. On 2/27/2026 at 1:16 PM, V33 (NP) stated she does take calls from the facility up until 5 pm Monday - Thursday and after that it would be the V27 (Medical Director). V33 stated she had not been notified on 2/19/2026 regarding R21's change in condition and there is no documentation of any provider being notified. V27 stated she was notified by the facility when she came in the evening on 2/20/2026 that R21 had been sent to the local emergency room with influenza-like symptoms. V27 stated she should have been notified of R21's change in condition by V6 (ADON) on 2/19/2026. V27 stated warm to touch, weakness, needing increased assistance, and an oxygen saturation reading of 83%, should have been reported to her immediately. V27 stated V6 (ADON) should have assessed R21's lung sounds at that time while applying supplemental oxygen. V27 stated even if R21's oxygen saturation reading reached above 90% with supplemental oxygen, she would have ordered an imaging test with further orders. On 2/27/2026 at 2:00 PM, V14 (Certified Nursing Assistant/CNA) stated she did work in the facility on 2/19/2026 and did have direct patient care with R21. V14 stated she completed the stop and watch early warning tool form that included R21 needing increase with assistance, shortness of breath, being red in the face, etc. V14 stated she turned the form into V6 (ADON) and then the form would go to V2 (DON) for			S9999			

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S9999	Continued from page 5 review. V14 stated she had been told in report that morning that R21 did not want to get up and eat the day prior either. On 3/5/2026 at 11:07 AM, V23 (CNA) stated she did work the evening shift on 2/19/2026 from 6:00 AM to 6:00 PM and had direct patient care with R21. V23 stated she had notified V25 (Licensed Practical Nurse/LPN) that R21 had not been acting himself and was extremely hot to touch. V23 stated V25 directed her to strip R21 down to only his shirt and a light blanket. V23 stated R21 had still felt warm to touch after this intervention. V23 stated V25 did give him medicine to help with his fever but does not recall when that was. V23 stated R21 does become very confused when he has a fever. V23 stated R21 did have oxygen at 2 liters on during her shift. V23 stated R21 had been too confused to be assisted out of bed. On 3/5/2026 at 11:22 AM, V36 (Family) stated she did not visit R21 on 2/19/2026 but had on 2/18/2026 where she notified staff on that day that R21 had been starting to have a cough that needed to be watched. V36 stated R21 had been sick back in December 2025 with a hospital admission related to his lungs and received some supplemental oxygen. V36 stated R21 did not require supplemental oxygen since December 2025 that she is aware of. V36 stated when she arrived around 11:30 AM to the facility on 2/20/2026 to pick R21 up for lunch, he was very sick. V36 stated she had been notified when she arrived that he had been having a fever of 101 degrees Fahrenheit since 2/19/2026 and had supplemental oxygen on all night. V36 stated she requested R21 be sent to the local emergency room for further evaluation. V36 stated she should have been called on 2/19/2026 when R21 was not feeling well and felt R21 was not being watched close enough. On 3/5/2025 at 11:35 AM, V2 stated she did not complete an assessment on R21's lungs on 2/19/2026 prior to or after applying supplemental oxygen of 2 liters with an oxygen saturation reading of 83%. On 3/5/2026 at 12:25 PM, V25 (LPN) stated she does recall working on the night of 2/19/2026. V25 stated V23 did notify her of R21 being extremely warm and she directed her to remove R21's clothing except his t-shirt and a light blanket. V25 stated she does remember giving him acetaminophen for a fever that was between 101.0 - 101.6 degrees Fahrenheit and should have been documented in her progress note. V25 stated R21 did have supplemental oxygen on throughout the night but does not recall if he had been confused or having a low oxygen saturation reading.		S9999				

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S9999	Continued from page 6 On 3/5/2026 at 12:14 PM, V1 (Administrator) stated his expectation for staff is to follow all policy and procedures including, administration of oxygen, and change in condition with physician notification. On 3/6/2026 at 8:30 AM, V18 (Registered Nurse/RN) stated she does have direct patient care with R21. V18 stated R21 does not typically use supplemental oxygen. V18 stated R21's order for oxygen is for as needed. V18 stated if R21 required supplemental oxygen, had an oxygen saturation reading of 83%, increased weakness, etc. that would be a change in condition for him and the provider should be notified. V18 stated a lung assessment would be standard of care prior to placing supplemental oxygen on. The facility could not provide reproducible documentation of R21's oxygen saturation being re-evaluated after V6 (ADON) applied supplemental oxygen at 3:45 PM on 2/19/2026 for oxygen saturation of 83%, until 2/19/2026 at 11:51PM. The facility's policy "Notification of Change Guideline" (dated 10/1/2021) documents, "Purpose: It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and are reported to and consulted with the attending physician. The resident and/or the resident representative will be educated about treatment options and supported to make an informed decision." This same document under "Objective of the Notification of Change Guideline: documented the objective of the notification guideline is to ensure facility staff make appropriate notification to the physician or delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in condition. Requirements for notification of resident, the resident representative, and their physician: A significant change in the resident's physical, mental, or psychosocial status, (a significant change includes deterioration in health, mental, or psycho- social status in either life-threatening conditions or clinical complications), A need to alter treatment significantly (a significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)." The facility's policy "Oxygen Administration" (revised March 2004) documents, "Assessment, Before administering oxygen, and while the resident is		S9999				

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S9999	Continued from page 7 receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable." (A)		S9999				