STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012587	A. BUILDING: _____ B. WING _____	C 07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF MOLINE	7300 34TH AVENUE MOLINE, IL 61265

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S 000	Initial Comments Facility Reported Incident of July 1, 2021/IL135681	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1210 a) 300.1210 b) 5) 300.1210 c) 300.1210 d) 6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 and assistance to prevent accidents.	S9999		

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S9999	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement fall prevention interventions for one resident (R1) of three residents reviewed for falls. This failure resulted in R1 sustaining a ground level fall resulting in a head laceration injury that required local Emergency Room Care and sutures. Findings include: Facility Fall Prevention policy, revised 3/27/21, documents: "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls; The staff will discuss the resident's risk factors for falling and obtain orders from the Physician for appropriate fall preventative devices as needed; After a fall, the interdisciplinary team (IDT) should review the circumstances surrounding the fall and develop an appropriate intervention and plan of care; And if the cause of the fall is unclear, the IDT will attempt to establish reasonable interventions related to the current condition of the resident to attempt to prevent recurrence." The Facility's Initial Federal Report, dated 7/7/21, documents that on 7/1/21, (no time documented), R1 was observed laying on the floor in a prone (on stomach) position. Upon assessment, bleeding was noted to the right eyebrow as well as a hematoma above right eye. This Report does not document non-skid socks on R1. R1 was sent to the local Emergency Department for evaluation and treatment. R1 was found to have a two centimeter/cm laceration about right eye that	S9999		

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S9999	Continued From page 3 required four sutures. R1's Hospital Record, dated 7/1/21, documents that R1 presented to the Emergency Department with a fall. A Computed Tomography/CT of the Facial Bone, Maxillofacial Forehead, Orbit/Periorbital area and Cervical Spine was completed. Findings included swelling, contusion and laceration to the right eye and right side of the forehead, requiring four sutures. On 7/11/21, at 9:05 am, R1 was lying in bed on R1's back with R1's eyes closed. R1's right forehead and cheekbone were yellow/brown in color and four sutures above R1's right eyebrow were noted. R1's Nursing Note, dated 6/29/21, at 10:19 pm, documents that R1 had a fall at 9:40 pm. This Notes states, "(R1) was found sitting on the side of (R1's) bed. (R1) had no apparent injuries at this time. (R1) is alert and confused within (R1's) normal with drowsiness that is not a new change. (R1's) Power of Attorney (POA) and Hospice (Local Hospice Agency) on call Nurse aware. Hospice contacted about low bed with floor mats." R1's Nursing Note, dated 6/29/21, at 10:35 pm, documents, "Neuro (Neurological) checks in place. Hospice stated they would order floor mats." R1's Nursing Note, dated 6/29/21, at 11:39 pm, documents, "Non-skid socks were put into place at time of fall." R1's Nursing Note, dated 6/30/21, at 6:29 am, documents, "(R1) up all night with staff at nurses station, would not stay in bed, offered food and beverage, no behaviors, no ideations of self-harm	S9999		

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S9999	Continued From page 4 voiced, (R1) now in bed sleeping will continue to monitor." R1's Nursing Note, dated 7/1/21, at 5:02 am, documents that R1 was noted face down on floor next to R1's bed at 3:25 am. The Nursing Note does not document that R1 had on non-skid socks or that a low bed or fall mats were in place. R1 was noted to have a laceration and hematoma above the right eyebrow with moderate bleeding from the laceration. R1 was sent to the local Emergency Department for sutures of the laceration. R1's Nursing Note, dated 7/1/21 at 11:37 am, documents that R1 has a "Laceration above the right eye with sutures and bruising that is purple with a hematoma." R1's current Care Plan, dated 6/29/21, documents 6/29/21 Fall Interventions of Non-Skid Socks on 6/29/21, ordered Low Bed/Platform Bed on 6/30/21, delivered 7/1/21, and Dycem (non-skid adhesive) under floor mat on 7/1/21." R1's Minimum Data Set/MDS Assessment, dated 6/26/21, documents that R1 requires limited assistance with one-person physical assist for walking and toilet use. The MDS Assessment also documents that R1 requires extensive assistance for bed mobility and transfers. On 7/12/21, at 10:28 am, V3 (Registered Nurse/RN) stated, "On 7/1/21, I was the nurse on duty when (R1) fell. It appeared that R1 was attempting to get out of bed. (R1) was lying face down on the floor and had blood and a laceration to his right forehead. I notified his Physician, Hospice and our Director of Nursing, and I sent him to the Emergency Department. (R1) did not	S9999		

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S9999	Continued From page 5	S9999		

have any socks on at the time of the fall.. (R1's) low bed and floor mats still had not been delivered yet from Hospice, and they were requested as intervention from the 6/29/21 fall. Our facility did not have a low bed or any fall mats available in house for (R1) because they were all being used."

On 7/12/21, at 11:17 am, V4 (Hospice Registered Nurse) stated, "We were notified on 6/29/21, at 10:24 pm, of (R1's) 6/29/21 fall and the facility requested that we order fall mats. According to our dispatch records, the fall mats' order was acknowledged and completed on 6/30/21 at 9:58 am. According to our Durable Medical Equipment/DME Supplier, it appears that the fall mats were delivered on 6/29/21, at 12:15 pm. We have no record from the facility requesting a low bed for (R1) and we never ordered a low bed at that time."

On 7/11/21, at 4:38 pm, V2 (Director of Nursing/DON) stated, "(R1) admitted with us on 6/2/21 and received therapy. Therapy ended on 6/11/21 and (R1) was put on Hospice. Then (R1) had the first fall out of bed on 6/29/21, at 10:04 pm, and our interventions were that we requested Hospice to order a low bed and fall mats and put non-skid socks on as an immediate intervention. Then, two days later, on 7/1/21 at 3:25 am, (R1) fell out of bed again and was sent to the hospital for a laceration above the right eye and required four sutures. (R1) was attempting to get out of bed on both falls. We did not get the low bed and floor mats in until after (R1's) second fall on 7/1/21, two days after we requested them for (R1's) first fall on 6/29/21. We did not have low beds or floor mats in the building, they were all being used by other residents. It usually does not

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S9999	Continued From page 6 take Hospice this long to get equipment in. The only intervention that was implemented on 6/29/21 was non-skid socks, while we were waiting for the equipment to come in." On 7/12/21, at 2:13 pm, V1 (Administrator/ADM) stated, "Per a discussion with (V3), (V3) did have a recollection that (R1) did not have non-skid socks on and thought they were in (R1's) bed." "B"	S9999		