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
	IL6012587	A. BUILDING: ______ B. WING ______	05/20/2021

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 Annual Licensure Survey & COVID-19 Focused Infection Control Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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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 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. (Section 3-202.2a of the Act)

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.

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.

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide behavioral health care services and interventions for one of five residents (R30) reviewed for behaviors in the sample of 54. This failure resulted in R30 expressing feelings of worthlessness, recurrent thoughts of wanting to die and expressions of emotional pain. Findings include: Facility Policy/Behavioral Health Services dated 3/21/21 documents: "The facility will develop and implement person-centered Care Plans that include and support the behavioral health care needs identified in the comprehensive assessment. The facility will develop individualized interventions related to the resident's diagnosed condition." Facility Policy/Behaviors of Threat to Harm Others or Themselves (undated) documents: "Residents who are observed or voice a threat to others or themselves will have the following carried out: Resident will be immediately placed on increased supervision to ensure safety to themselves or others. If (Psychiatric) services unavailable, resident is to remain on increased supervision until a licensed practitioner (APRN/Advanced Practice Nurse Practitioner, PA/Physician Assistant, Physician) can evaluate resident to determine risk to harm themselves or	S9999		

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S9999	Continued From page 3 others." Social Service Director Job Description (undated) documents: "Essential Job Functions: Develop a social history, social assessment and care plan which identifies status, pertinent problems and needs of the resident. Establish realistic goals to be accomplished and the specific action to be taken toward resolution of problems and/or needs of each resident." R30's Medical Record documents that R30 was admitted on 8/5/20 with diagnoses that include Seizure Disorder, Diabetes Mellitus, Anxiety Disorder and Major Depressive Disorder - Recurrent. R30's Progress Note dated 8/5/20 documents that (R30) is a "1:1" who was transported by private vehicle: alert and oriented. R30's Medical Record did not contain documentation to indicate how R30 came to be transferred from an out of state Care Center to the current facility on 8/5/20. On 5/18/21 at 12:10pm V5, SSD (Social Service Director) stated that there is not any other admission information in R30's medical record to indicate why R30 was transferred here. V5 stated that (on 5/18/21), R30 told her that he came from out of state but didn't know why he was here. V5 stated that a Social Service admission assessment should have been done and didn't know why it wasn't. R30's Comprehensive Assessment dated 3/12/21 documents that R30 is cognitively intact, able to understand and be understood.	S9999		

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R30's Progress Note dated 9/29/20 at 9:03am indicates R30 verbalized to Physician that he will no longer take any of his medications.

R30's Progress Note dated 10/7/20 at 1:09pm indicates all of R30's medications have been discontinued due to non-compliance and per R30's request (including anti-depressant medication).

R30's Progress Note dated 12/2/20 at 5:34pm indicates R30's family was "coming to accept" (R30's) depression is chronic and severe.

On 5/11/21 at 12:30pm, R30 was observed lying in bed with brown stains and splotches all over bath blanket covering R30 as well as bottom sheet of mattress. R30's room was dark with no lights on and the curtains completely closed. At that time, R30 stated that he was depressed. R30 stated he was constantly sad and further stated, "I want to cry myself to sleep. I sleep too much." R30 stated that he feels hopeless. R30 stated he has family nearby but doesn't get to see them. R30 stated he didn't know what the brown spots were on the linens. (Brown stains were later confirmed by V15, CNA (Certified Nurse Assistant) as feces.) R30 offered his journal stating, "Do you want to look at what I'm writing?" R30's notebook/journal contained handwritten notes about feeling depressed, lonely and missing his family including:
"The pain is there, I feel it. Why can't you? Please help it stop. I can't stand it. I want to die. I'm so alone"
"I have massive depression, my son lives nearby but rarely visits!"
"If only I could die, If only I could."
"To think I went to war, was wounded and lost body parts, got a few awards and wound up

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S9999	Continued From page 5 here?" On 5/12/21 at 9:40am, R30 was again in a darkened room, curtains closed and lights off and stating that he feels depressed and wrote more about it in his notebook. R30 stated that he wishes he was married and is lonely. On 5/13/21 at 1:00pm V5, Social Service Director stated that about a couple weeks ago R30 asked for pencils and paper, however she was unaware R30 had been keeping a journal about his Depression. At that time, R30 allowed V15 to read his journal and after reviewing the journal, V15 stated that she was unaware of the extent of R30's Depression and acknowledged that R30 should be seeing a Psychologist or therapist. V15 stated that there should have been a Care Plan addressing R30's Depression and refusal of all medications. R30's current Care Plan did not address R30's Depression or his refusal to take any and all medications. R30's Social Service Progress Note dated 5/13/21 at 4:27pm documents that R30 shared his journal. These notes document that R30 writes that he feels he has "massive depression." Note indicates that R30 is a Veteran and may be able to talk with a therapist at the VA (Veterans Administration) or in a private practice. Will continue to monitor and encourage "to go outside." On 5/14/21 at 10:40am V5, SSD stated "I went to see (R30) yesterday but he was sleeping both times. I guess I should've notified his nurse that he wrote that he wanted to die."	S9999		

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S9999	Continued From page 6 Social Service Note dated 5/14/21 at 11:10am documents that V5, SSD spoke with R30 about the entry in his journal "I want to die." The Social Service Note documents that R30 stated he did not have a plan and agreed to talk to a therapist. This note indicates V5 notified R30's assigned nurse that R30 needed to be monitored night and day. R30's Nursing Progress Note dated 5/14/21 at 11:30am indicates "1:1 staff member placed with (R30) at this time." R30's Nursing Progress Note dated 5/14/21 at 1:00pm indicates R30 stated he felt depressed when asked about his mood. R30 stated "yes" when asked if he felt suicidal. Note indicates V2, DON (Director of Nursing) offered a local hospital evaluation to which R30 responded "he would like to try." Note indicates R30 is "1:1 at bedside." R30's Progress Note dated 5/14/21 at 8:44pm indicates R30 sent to local hospital, returned with recommendation for outpatient follow-up and medication review. Hospital Emergency Room note dated 5/14/21 at 7:53pm indicates R30 stated came to hospital because feeling depressed and R30 acknowledged having thoughts of harming himself. R30 admitted to to having suicidal thoughts because "life is not worth living." On 5/19/21 at 9:00am V2, DON (Director of Nursing) stated that she would have sent R30 to the hospital for evaluation immediately after reading R30's journal. V2 stated she didn't know why V5 didn't notify nursing right away. R30's Geriatric Depression Scale dated 5/14/21 indicates R30 scored 11. Assessment indicates	S9999		

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S9999	Continued From page 7 "Scores greater than 10 are almost always depression." On 5/14/21 at 1:00pm, V5, SSD stated that this is the first Geriatric Depression Scale she's ever done and that she didn't know she was supposed to be doing them. V5 stated that with a score like that a resident should be referred to a therapist, DON should be notified and referral to Physician/Psychologist. On 5/19/21 at 9:45 am, V5, SSD stated "I don't know why I didn't call on the (May)13th." V5 stated that she did notify (R30's) nurse to keep an eye on R30, however did not tell the nurse about R30's statements of wanting to die. V5 stated that she needed to contact the VA about R30's veteran status because there is nothing in R30's chart that says R30 is a veteran. V5 stated that she took it from (R30's) writings that it was "definite" that he was a Veteran. V5 stated that Social Service should know if a resident is a Veteran when they are admitted. V5 also stated that if R30 had a plan (to harm himself), then she definitely would have called the doctor for an evaluation. V5 stated, "Going forward, I understand I should have taken action sooner." V5, SSD reviewed R30's journal on 5/13/21 and did not notify the Physician or nursing of R30's statements of wanting to die and did not place R30 on immediate supervision. R30 was not placed on supervision until 5/14/21 when V2, DON initiated 1:1 supervision, notified R30's Physician and sent R30 to the hospital for evaluation. (A)	S9999		

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300.610a)
300.696a)
300.696c)6)7)
300.1020a)
300.3240a)

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 300.696 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.

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S9999	Continued From page 9 c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 6) Guideline for Isolation Precautions in Hospitals 7) Guidelines for Infection Control in Health Care Personnel Section 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to construct a secure barrier between the COVID-19 positive unit and the non-COVID-19 unit, cohort quarantined residents, provide dedicated staff for the COVID-19 positive unit, follow transmission based precautions, provide an anteroom for donning and doffing of personal protective	S9999		

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equipment (PPE) for the COVID-19 positive unit and failed to ensure non-quarantined residents, staff and vendors wore required PPE while in the facility during a COVID-19 outbreak. These failures resulted in the spread of COVID-19 among residents and staff and have the potential to affect all 102 residents residing within the facility.

Findings Include:

The current corporate Infection Control training for facility employees documents, "Staff members required to wear a mask during their shift will be issued a mask that will be used until it becomes moist or otherwise degraded. The mask will be worn at all times, while in the facility, even when you are in an area by yourself such as an office. N95 and face shield/goggles to be worn at all times in the facility. PPE to be worn in isolation rooms. All residents out of room must have face mask on unless diagnosis does not tolerate."

The Facility Transmission Based Precautions policy revised 3/27/21 documents, "A single resident room is preferred for residents who require droplet precautions. When a single-resident room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other resident placement options (e.g. cohort, keeping resident with an existing roommate)."

The Facility COVID-19 Performance Improvement Plan/To House COVID Positive Residents dated 5/6/21 documents the following:
- Barrier is to be closed at all times and free from penetration.
- Consistent assignment to be carried out
- Implement enhanced droplet/contact

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precautions. Wear gloves, gowns, goggles/face shields and masks (N95) covered with surgical mask, upon entering COVID-19 unit.
- Keep resident room doors closed - if safe for resident. Facility will increase frequent monitoring of residents related to decreased visibility with doors closed. Education with staff regarding additional focus on resident safety and frequent observations.
- Add signage on Unit Doors stating, "Decreased Traffic on Hall" If assignment limited to one unit.

The Facility COVID-19 Performance Improvement Plan/To House COVID Positive Residents dated 5/6/21 documents the following: "Compassionate visitors, vendors and practitioners are to wear N95, eye protection (and gown in an abundance of caution,)."

The Facility Policy/COVID-19 Exposure Control Plan/Outbreak Management revised 12/21/20 documents the following: "Post signage at visitor/vendor entrances to notify staff if COVID-19 signs or symptoms are present."

1) On 5/11/21 at 12:50pm and 5/12/21 at 10:00am, during a tour of CCC hall, there was a plastic partitioned curtain at the far end of the unit. The plastic curtain had a zippered area in the center that was unzipped from floor to ceiling. One side of the curtain did not reach from floor to ceiling leaving an open area of approximately six inches across the entire bottom length of the curtain. No signage was present to designate the area as COVID-19 positive. There was also no signage to designate appropriate precautions to take when entering the COVID Unit.

On 5/11/21 at 3:40pm, a tour of the COVID-19 unit at the end of CCC hall found the plastic

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partition still unzipped and unsecured at the floor. At that time V16, CNA (Certified Nurse Assistant) stated that staff were "to don the required PPE after going through the plastic partition into the COVID positive unit." On the other side of the partition (within the COVID-19 unit), barrels containing "clean" linen gowns and other PPE were on one side of the hall. Directly across from the clean PPE were barrels identified as "dirty" - one barrel for soiled disposable items and one barrel for soiled linen gowns. To access the necessary clean PPE required walking past an open door identified as COVID positive resident/room. At that time, five residents were identified as being COVID-19 positive residing in three rooms on the unit. All of the resident room doors were open.

On 5/11/21 at 3:55pm V16, CNA stated that there are no staff that stay in the COVID unit. V16 stated that the CNA and the nurse that are signed to the CCC hall have to take care of the residents inside and outside of the COVID unit. V16 stated that the facility does not use Agency staff.

On 5/13/21 at 10:00am, the COVID unit zippered curtain remained unzipped and open between curtain and floor. All doors to COVID positive resident rooms were open during this time.

On 5/13/21 at 12:20pm V2, DON (Director of Nursing) stated that the zipper on the partition to the COVID unit is broken. V2 also stated, "(I am) Not sure for how long (the zipper had been broken)."

2) On 5/14/21 at 1:10pm V20, Food Vendor Driver, was observed transporting boxes of food into the kitchen through the side entrance of the facility. V20 was not wearing any type of face

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mask or PPE to transport the boxes into the store room at the far end of the kitchen.
There was no signage found outside of the entrance into the kitchen to notify vendors of COVID -19 Positive residents in the building or to instruct vendors on donning PPE prior to entrance into the facility. At that time, V20 was asked about wearing a mask into the facility. V20 stated that he has has been told by V6, CDM (Certified Dietary Manager) that he needs to wear a mask when entering the building, however he was preoccupied with "talking on the phone (via an earpiece)."

On 5/14/21 at 1:30pm V6, CDM stated that there are only two delivery drivers and they have both been told to wear a mask into the kitchen. V6 acknowledged that there are no signs outside the entrance to the kitchen informing vendors of COVID status or necessary PPE. V6 stated, "There should be signs posted."

3) On 5/12/12 at 12:00pm V9, LPN (Licensed Practical Nurse) stated that R50 is on quarantine because he received his 2nd COVID vaccine yesterday and needs to be quarantined for 14 more days. V9 stated that R83 (R50's roommate) is not in quarantine. At this time, R50 and R83's door had signs indicating Droplet precautions. R83 was observed roaming throughout the facility, often times not wearing a face mask/covering during frequent observations between 5/11/21 and 5/14/21.

4) R32's Physician orders, dated 5/5/21, documents "Droplet Precautions - Presumptive for possible exposure every shift for 14 Days until 5/19/2021."

On 5/11/21 at 2:30pm, V10 CNA, was observed

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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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passing ice water to residents on the DDD hallway. While R32 was in his room in bed, V10 went into R32's room only wearing an N95 mask and goggles. Outside of R32's room, there was a three drawer cart full of PPE and R32 had a sign on his door documenting, "Special droplet/contact precautions in addition to standard precautions everyone must clean hands when entering and leaving room, wear face mask, wear eye protection (face shield or goggles) and gown and glove at the door." At that same time, V10 stated "I do not know what (R32) is on isolation for and I was told not to wear PPE in an isolation room unless I come into contact with the resident. I am working with all the residents on this hall."

On 5/11/21 at 3:10 PM, V2 Director of Nursing (DON) verified the facility was currently in an outbreak status for COVID-19, and staff should be wearing the appropriate PPE as documented by the signs on the doors. V2 also verified that the staff should be wearing PPE any time they go into an isolation room for any reason.

5) On 5/11/21 at 12:40 PM, V3, Infection Preventionist (IP) stated, "All the residents that are on droplet isolation are quarantined to their room and not allowed out because they refused the vaccine. Because of the COVID-19 outbreak in the facility, the isolation of unvaccinated residents is for their protection. The vaccinated residents are not on isolation precautions and are allowed out of their room and throughout the facility."

On 5/12/21 at 11:43 AM, R1 was sitting in dayroom watching television with no mask on. Facility staff were walking by R1 and did not remind R1 to put on a mask or face covering.

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S9999	Continued From page 15 On 5/12/21 at 12:00 PM, V3, IP, stated, "All residents in the facility have been exposed to COVID-19 equally. That's why we quarantined the unvaccinated and allowed the vaccinated access to the facility." V2, DON, and V3, IP, stated the lock down procedures of the facility and the isolation of unvaccinated residents while at the same time allowing the vaccinated residents access to the facility was a direction given to them by the local health department. On 5/12/21 at 1:05 PM, V4, Local Health Department Nurse, stated, "I've been in constant contact with (V2, DON and V3, IP) since the outbreak. We're not allowed to give directives, we're only allowed to help them with the resources and information put out by the CDC (Center for Disease Control) and CMS (Center for Medicare/Medicaid Services). The only thing we specifically discussed was the guidance given out in regards to communal activities because they were asking about Bingo. I never recommended the isolation of unvaccinated resident while at the same time allowing vaccinated residents to roam free in the facility. That's not allowed under the new guidance." On 5/12/21 at 2:03 PM, R83 was sitting in the front lobby with no mask covering R83's face. Facility staff were walking by R83 and not reminding resident to put on a mask or face covering. On 5/12/21, 5/13/21, 5/14/21, and 5/18/21, R1, R43, R80 and R83 were moving throughout the facility with no mask covering their face. Facility staff members passed by R1, R43, R80 and R83 and did not remind the residents to put on masks. On 5/13/21 at 3:00 PM, V3, IP, stated "(R83) and	S9999		

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(R50) share a room together, but since (R83) is vaccinated he's not in isolation. (R50) is in isolation because he's not vaccinated. (R83) is allowed to come and go and (R50) is quarantined to his room." V3, IP, verified that R14, R23, R27, R29, R36, R40, R50, R56, R71, R72, R73, R94 and R105 are all quarantined with droplet isolation precautions due to COVID-19 exposure, but their roommates are not on transmission based precautions and are free to come and go from the room and access the common areas of the facility.

6) On 5/14/21 at 11:50 AM, V25, Environmental Services, exited the environmental services office with no face mask or eye protection on and walked down the hall, that's next to the CCC and DDD unit nurses station, to the men's restroom, stopped, turned around and walked back down the hall to the environmental service office. V25 verified that V25 did not have a mask on and stated, "I left my mask and eye protection in the office because I was just going to the bathroom."

On 5/14/21 at 11:56 am, V1, administrator, stated, "All employees are to wear face mask and eye protection at all times in the facility."

7) On 5/11/21 between 10:00 am and 3:00 PM, R89, R47, R75, R100 and R81 were residing in the 300 hall COVID-19 positive unit. During these times, there was not a dedicated Nurse or Certified Nursing Assistant/CNA working on that unit.

On 5/11/21 at 12:15 PM, V22 CNA, entered the COVID unit. On 5/11/21 at 12:20 PM V22 CNA exited the COVID unit and walked up to the electronic charting system on the wall of the 300

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hall.

On 5/11/21 at 12:22 PM, V22 CNA stated, "I am responsible for the residents on the COVID unit and also work the 300 hall in between. If one of the residents in the COVID unit puts on their call light, then I go in and answer it and come back out to help on CCC hall. There is no one person scheduled to stay on the COVID unit."

On 5/11/21 at 12:50 PM, V11 RN (Registered Nurse) stated she is the only nurse scheduled for the CCC hall and COVID-19 unit.

On 5/11/21 at 2:30 PM, during change of shift, V11 RN was giving report to V18 LPN (Licensed Practical Nurse) to take over as the CCC hall Nurse.

8) On 5/12/21 between 9:30 AM and 3:00 PM, R89, R47, R75, R100, and R81 were residing in the CCC hall COVID-19 positive unit and there was not a dedicated Nurse or CNA on the CCC hall COVID-19 positive unit. V11 RN was the CCC hall and COVID-19 unit Nurse for day shift and V12 RN was the second shift Nurse.

On 5/12/21 at 12:00 PM, V24 CNA entered the COVID-19 unit and exited the unit into the CCC hall at 12:04 PM and began answering call lights on the non- COVID-19 CCC hall.

On 5/12/21 between 11:00 AM and 12:00 PM, V11 RN entered the COVID-19 unit with medications and then exited the unit into the non-COVID-19 CCC hall.

On 5/12/21 at 1:00 PM, V11 RN stated she is the nurse working the 300 hall. V11 stated she cares for all the residents on the CCC hall, including the

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S9999	Continued From page 18 residents on the COVID unit because they don't have enough nurses to put one nurse on the COVID unit. The Facility's CMS (Center for Medicare and Medicaid Services) Resident Census and Conditions of Residents form- 672, dated 5/12/21 signed by V1, Administrator, documents that 102 residents reside in the facility. (A)	S9999		