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	IL6012165	A. BUILDING: _____ B. WING _____	C 05/31/2022

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RIVER CROSSING OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

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S 000	Initial Comments Original Complaint Investigations #2223816/ IL146950 #2223777/ IL146904 #2223842/ IL146982 #2223817/ IL146951 #2224113/ IL147296	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210 c) 300.1210d)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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: A. Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent falls, investigate falls, determine a root cause analysis, implement new fall prevention interventions after a fall, and obtain neurological checks after unwitnessed falls and falls with a resident striking her head/face for three of four residents (R5, R6, R41) reviewed for falls in the sample of 43. These failures	S9999		

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S9999	Continued From page 2 resulted in R41 having repeated falls and sustaining multiple head injuries. B. Based on interview and record review, the facility failed to transfer one of three residents (R1) reviewed for transfers with a mechanical lift in the method ordered by his physician and deemed safe for him in the sample of 43. This failure resulted in R1 sustaining skin tears and bruising and a large chest wall hematoma. Findings include: A. The facility's "Standards and Guidelines: Falls" policy, revised 3/27/21, states, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent development in an attempt to prevent falls and injuries related to falls. Guidelines: 4. The staff will evaluate, and document falls that occur while the resident is active in the facility census. Fall investigations should include time of day, any known activity occurring when the fall transpires, witnesses to the fall (if any) rolls out of bed, injuries (type, location, etc.) and new interventions as needed and appropriate. Following a fall, post event monitoring should occur to monitor vital signs, change in function, change in cognition, increased pain or changes in skin condition, etc. 5. If a resident sustains a fall while a resident, staff should attempt to identify possible causes of the fall. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old stroke or recent (stroke). After a fall, the Interdisciplinary Team (IDT) should review circumstances surrounding the fall and develop an appropriate intervention(s) and plan of care. If the cause of the fall is unclear, the IDT will	S9999		

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S9999	Continued From page 3 attempt to establish reasonable interventions related to the current condition of the resident to attempt to prevent recurrence. 6. Based on evaluation of an existing fall(s) pertinent interventions will be implemented by staff such as, but not limited to: resident education if appropriate, staff re-education regarding transfer techniques and safety during ADL (Activities of Daily Living) care, resident footwear, appropriate lighting, maintaining close proximity of frequently used items, medication reviews, toileting programs, use of hip protectors, referral to therapy for strengthening/coordination of balance, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications, use of fall prevention programs that provide more frequent supervision and restraints, if warranted." Findings include: 1. R41's Physician Order's dated 5/2022 document R41 was admitted on 2/24/22 with diagnoses of Parkinson's Disease and Multi-System Degeneration of the Autonomic Nervous System. R1's Minimum Data Set (MDS) assessment dated 3/3/22 documents R41 is severely cognitively impaired, requires extensive assist with transfers and toileting, is unable to stabilize without staff assistance, and has limitations of her lower extremities. R41's fall investigations and progress notes document R41 had falls on 3/17/22, 3/23/22 (hit her head), 3/30/22 (hit her head), 4/9/22, two falls on 4/10/22 (both unwitnessed), 4/18/22, 4/20/22 (hit her head), two falls on 4/22/22 (fell on her face), 4/24/22, 5/2/22 (hit her head), 5/4/22 (hit her head), 5/11/22 (hit her head), 5/15/22 (unwitnessed/hit head), and 5/26/22 (hit her face).	S9999		

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S9999	Continued From page 4 R41's Fall Investigations and Progress Notes document the following: R41's root cause analysis for her falls on 4/20/22, 4/22/22, 4/24/22, 5/2/22, and 5/4/22 determined that she stood up from her wheelchair by herself and fell, hitting her head. R41's two falls on 4/22/22 and fall on 4/24/22 had no new interventions to prevent falls, and on 5/2/22 R41 again stood up from her wheelchair and fell, sustaining another head injury. R41's new intervention for her fall on 5/4/22, when she again stood up from her wheelchair and fell backwards hitting her head, was visual observation when out of bed. On 5/11/22 R41 fell striking her head on the floor after she was seen ambulating in the hallway alone, and on 5/15/22 R41 was found on the floor after she had fallen out of her wheelchair and sustained a right temporal hematoma and a bruise on her right forehead. R41's care plan does not document any fall interventions initiated after either fall on 4/22/22 or after the fall on 4/24/22. R41's Medical Record and Progress Notes document neurological checks (assessments) following falls were completed on 3/30/22 at 8:00am, and 4/10/22 from 9:45am-2:00pm. R41's medical record documents no other neurological checks for R41's falls that were unwitnessed or involved hitting her head/face on 3/23/22, 3/30/22, 4/10/22, 4/20/22, 4/22/22, 5/2/22, 5/4/22, 5/2/22, 5/4/22, 5/11/22, and 5/15/22. On 5/26/22 at 2:00pm, V1, Administrator, stated and confirmed that no other neurological checks were documented for R41's falls, and no new fall interventions were put into place following both	S9999		

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S9999	Continued From page 5 falls on 4/22/22 or the fall on 4/24/22. R41's Emergency Department (ED) notes document the following: 3/23/22 Clinical Impression: 1. Fall, 2. Blunt head trauma 3. Traumatic hematoma of head. History of present illness (HPI): Fell out of her wheelchair hitting her head on the floor. R41's head CT dated 3/23/22 documents "Small left frontal scalp hematoma." 4/20/22 Admission diagnoses: Fall, Subarachnoid hemorrhage, Right orbital fracture, Right maxillary fracture. HPI: Slid out of wheelchair and hit her head. R41's CT of her facial bones dated 4/21/22 documents "1. Acute post traumatic displaced fractures of the right anterior and lateral maxillary sinus walls with hemorrhage into the maxillary sinus. 2. Acute post traumatic mildly displaced fracture of the right lateral orbital wall and orbital floor. 3. Acute post traumatic mildly depressed fracture of the right zygomatic arch. 4. Acute post traumatic right preseptal periorbital soft tissue contusion." R41's head CT dated 4/21/22 documents "Acute post traumatic subarachnoid blood laying of left greater than right prefrontal sulci." 4/22/22 Clinical Impression: "1. Fall, 2. History of falls, 3. Contusion of face, 4. contusion of knee, right. 5. Contusion of knee, left." 5/2/22 Chief Complaint: Fall, unwitnessed. Clinical Impression: 1. Head injury. 2. Contusion of scalp. R41's physical exam documents "Head: Swelling with tenderness to hematoma of right forehead." R41's head CT dated 5/2/22 documents "Acute post traumatic right frontal scalp with right preseptal periorbital post	S9999		

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S9999	Continued From page 6 traumatic hematoma." 5/4/22 Clinical Impression: "1. Fall, 2. Head Injury." R41's head CT dated 5/4/22 documents "Small right frontal scalp, periorbital, and premalar soft tissue contusions." 5/11/22 Chief complaint: Fall. HPI: Stood up from her wheelchair, walked a few steps, fell, hit the back of her head on the right side. R41's head CT dated 5/11/22 documents no acute changes. Clinical Impression: Fall. 5/15/22 Clinical Impression: "1. Fall, 2. Head contusion. Was found at her nursing home with a bump on her head after falling out of her wheelchair." R41's head CT dated 5/15/22 documents "Small post traumatic right frontal-temporal scalp contusion." On 5/26/22 at 12:00pm, V35, Advance Practice Registered Nurse/Certified Nurse Practitioner/ Neurology Practitioner, stated "(R41) is not being properly supervised by staff at the facility. (R41) has had too many falls and hit her head many times. A lot of the falls are unwitnessed falls. (R41) sits at the facility with nothing to do. (Staff) will leave (R41) sitting somewhere, and when a dietary person or housekeeping staff comes by, (Nursing staff) will tell them to keep an eye on her. Just random people who don't know how to take care of (R41). I just now received this message- (R41) is in the ED again with an unwitnessed fall and having head and neck pain." R41's Hospital Neurology Follow up with V35 dated 5/23/22 documents "(R41) needs closer monitoring due to continued falls, she has had too many falls in the past three months."	S9999		

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S9999	Continued From page 7 R41's Progress Notes dated 5/4/22 at 1:11pm, document R41 had an unwitnessed fall and hit the back of her head," and "(R41) is a high fall risk and would benefit from a one on one; due to only having one CNA (Certified Nursing Assistant) per hall to cover multiple people, and (the CNA) cannot focus on the high fall risk residents." On 5/25/22 at 12:32pm, V28, Licensed Practical Nurse (LPN) who wrote R41's Progress Note on 5/4/22 at 1:11pm, stated "We do the best we can, but it's hard for staff to always keep an eye on (R41). They (Administration) will have staff from the offices up front come and sit with (R41) as they can." At this time R41 sat unaccompanied behind the nurse's station and was bent over in her wheelchair rubbing the floor with her fingers. V28 was passing medications at this time, left her cart, and went to the nurse's station to redirect R41. On 5/18/22 from 9:25am-9:37am, R41 sat behind the nurse's station, unattended, and able to propel her wheelchair forward and backward. 2. R5's Incident Report on 4/6/22 documents that R5 was last seen in bed and then the nurse was summoned to R5's room by R5's roommate because R5 was on the floor. This same report states, "(R5) did hit her head but refused to go to the hospital. Staff used the (Mechanical Lift) to safely pick (R5) up off the floor." This same report documents no witnesses were found. As of 5/18/22, R5's medical record did not contain documentation that 72-hour neurological checks were completed after R5's unwitnessed fall in which R5 hit R5's head. As of 5/18/22, R5's current Care Plan did not	S9999		

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S9999	Continued From page 8 contain a newly implemented fall intervention after R5's 4/6/22 fall. 3. R6's Incident Report on 2/5/22 documents R6 had a fall in the dining room and R6 was found lying prone on the floor. This same report documents R6 was sent to the local area hospital for evaluation. R6's medical record does not contain documentation that R6's 2/5/22 was investigated determining a root cause and adding new fall prevention interventions. R6's current Care Plan does not document any fall prevention interventions after R6's 2/6/22 fall. On 5/18/22 at 2:43 P.M. V1 (Administrator) stated that after a resident has an unwitnessed fall, 72-hour neurological checks should be completed. V1 stated the neurological charting is completed in the resident's electronic medical record. V1 stated V1 could not provide any information showing that R5's neurological checks were completed and stated they should be since R5 hit R5's head during the fall. V1 stated no fall investigation with root cause analysis and newly implemented fall interventions could be provided for R5's fall on 4/6/22 or R6's fall on 2/6/22. V1 verified newly implemented fall interventions after a resident fall should be placed on the resident's care plan. V1 verified R5's care plan for falls had not been updated after R5's 4/6/22 fall and verified R6's care plan for falls had not been updated after R6's 2/5/22 fall and should have been. B. The facility's Standards and Guidelines: SG Mechanical Lifts (revised 3/27/21) policy documents, "The Nursing and Therapy	S9999		

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S9999	Continued From page 9 department will coordinate the screening of residents to determine the appropriateness of mechanical lift transfers and/or repositioning," and "5. When using the mechanical lift staff will adhere to manufacturer guidelines, physician's orders and/or the plan of care." R1's medical record and physician orders document R1 was admitted to the facility on 4/21/22 with diagnoses of Radiculopathy, Lumbar Region, Abnormalities of gait and mobility, and Muscle weakness (generalized). R1's physician orders document R1 is to be transferred using "(Full mechanical) lift unless changed by therapy." R1's Hospital Discharge Orders dated 4/21/21 document diagnosis of Lumbar Laminectomy and an order to transfer using a full mechanical lift. R1's baseline and current care plan dated 4/21/22 and revised on 5/12/22 documents "Transfer: the resident is not able to help with a transfer at all and will need the assistance of two staff and a (full mechanical lift) to move from bed to chair and back." R1's Incident investigation dated 5/10/22 at 10:46am documents R1 was being transferred from his bed to a chair with a sit-to-stand lift when he began to have a bowel movement, started coughing phlegm up, his knees buckled, and he could not hold himself up. The investigation documents R1 was lowered into a chair, and sustained skin tears/shearing to his chest from the buckle on the sling, and that "(V8, family member) (was) educated (R1) not strong enough for sit-to-stand but (V8) refuses to allow (full mechanical lift)." R1's Incident investigation documents R1 was sent to the Emergency Department (ED) on 5/11/22.	S9999		

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S9999	Continued From page 10 R1's Hospital Discharge Notes dated 5/16/22 document Primary Discharge Diagnosis as "Chest wall Hematoma and large upper extremity hematomas due to coagulopathy and sit to stand lift straps." R1's chest CT report dated 5/12/22 documents: "IMPRESSION: 1. Large left chest wall hematoma involving the pectoralis major muscle measuring up to 16.2 cm (centimeters) in greatest dimension. " R1's ED notes dated 5/12/22 document "extensive bruising/bleeding from skin tears (chest)." On 5/17/22 at 2:05pm, V6, Licensed Practical Nurse (LPN), stated on 5/10/22 she had cleaned up and dressed R1, then had V29, Certified Nursing Assistant (CNA) assist her in using the sit-to-stand lift to stand R1 to pull up his pants and transfer to a chair. V6 stated the sling was positioned correctly, snug, and fastened securely, and R1 was holding on to the lift handles. V6 stated when the lift began to raise R1 from the bed, he began coughing and having a bowel movement, could not hold on to the lift handles, and his knees buckled, so they sat him quickly in the chair. V6 stated the movement of the sling caused an abrasion/skin tear to R1's chest. On 5/17/22 at 2:40pm, V7, Therapy Director, stated the sit-to-stand lift was not an appropriate transfer method for R1 due to his Covid 19 infection, fatigue, weakness, and inconsistency in his daily abilities to perform therapy tasks. V7 stated on some days R1 could shave himself and on other days he could not shave himself. V7 stated they did work with R1 on sit-to-stand lift transfers in therapy, R1's ability to safely transfer with the sit-to-stand lift was inconsistent, and it was not safe to be used on the general floor by staff. V7 stated she has had multiple	S9999		

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S9999	Continued From page 11 conversations with V8, family member, explaining that the sit-to-stand lift was not safe and that only a full mechanical lift should be used for R1's transfers. V7 stated "We (therapy staff) documented the sit-to-stand lift wasn't safe and was only to be used in therapy, and we gave the staff the same instructions. (V8) flat out demanded the sit-to-stand lift was to only be used, and he was loud and aggressive with staff, demanding they use only the sit-to-stand lift." R1's Physical Therapy treatment notes document the following: 4/26/22 Multiple attempts at sit to stand, unable to complete even with max (maximum) assist and bed raised. 5/4/22 Work on sit to stand transfers and standing balance/tolerance, able to stand on two of four attempts. 5/11/22 Has order for (full mechanical lift). On 5/18/22 at 11:00am, V5, Physician's Assistant (PA), stated that she was notified of R1's bruising and skin tears from the sit-to-stand lift transfer on 5/10/22, and that she came to the facility on 5/11/22 to examine R1. V5 stated that due to R1's diagnoses and Warfarin and steroid use, his skin was fragile and at high risk for injury/bruising. V5 stated she discussed with V8 and staff that the use of the sit-to-stand lift was not safe for R1 and only the (full mechanical) lift is to be used. (A)	S9999		