Illinois D	epartment of Public	Health		**************************************		FORM A	PPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		łL6012165	B. WING			C 01/13	3/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·		4.
RIVERC	ROSSING OF PEORI	1500 WE PEORIA,		IOOR ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ACTION SHOULE TO THE APPROP	DBE	(X5) COMPLETE DATE
S 000	Initial Comments	· ·	S 000				
	Complaint Investiga	ation 22210280/IL154741				se e	** g
S9999	Final Observations		S9999	10		i	
=	Statement of Licens	sure Violations:		*		Ser.	
=	300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6)		1	8.		XX)	."
* = = = = = = = = = = = = = = = = = = =	a) The facility of procedures governification. The written be formulated by a Committee consisting administrator, the amedical advisory confiners of nursing and other policies shall compiled the facility and shall by this committee, of the facility and shall be committeed.	dvisory physician or the ommittee, and representatives in services in the facility. The y with the Act and this Part, shall be followed in operating be reviewed at least annually documented by written, signed	# E		25:		
18	Nursing and Person b) The facility s care and services to practicable physical well-being of the res each resident's com plan. Adequate and care and personal or resident to meet the care needs of the res	General Requirements for all Care shall provide the necessary attain or maintain the highest mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing are shall be provided to each total nursing and personal		Statement	Attachment A of Licensure Vi	olations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois D	epartment of Public	Health	\$2 00	4 1 - 1 1 - 1 - 1			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				LE CONSTRUCTION			(X3) DATE COMP	SURVEY LETED
		IL6012165	B. WING				01/1	3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	51			
RIVERC	ROSSING OF PEORI	1500 WES PEORIA,		IOOR ROAD				.t.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  BY PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)				D BE COMPLETE			
S9999 <sub>.</sub>	Continued From pa	ge 1	S9999					
8 8	respective resident d) Pursuant to nursing care shall in	able about his or her residents' care plan. subsection (a), general nclude, at a minimum, the be practiced on a 24-hour.	8					. A
w_ =	seven-day-a-week l 6) All nece taken to assure tha	basis: essary precautions shall be t the residents' environment	*:	\$ 5				- AT
	All nursing personnesee that each reside	accident hazards as possible. el shall evaluate residents to ent receives adequate sistance to prevent accidents.	×	T.				=
2 2	These requirements	s are not met as evidenced by:	3	4 /	3			-
	review, the facility fa interventions of low prevent a fall with in residents reviewed:	on, interview, and record ailed to implement fall bed position and floor mats to jury for one (R2) of three for falls in a sample of three. In acute fractures to R2's						
i i	Findings include:		y -4					C
e 2	12-28-22, documen cognitively impaired for Mental Status) sunderstand and be	with a BIMS (Brief Interview	er er er		¥ (8)		et S.	2
88		ens, dated 10-12-22 and R2 is at high risk for falls with	8	,			,	- C
		en, dated 12-3-22, documents falls with a score of 75.	-			ž.		30 30

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

	I OF CORRECTION	IDENTIFICATION NUMBER:	` '	i:	COMPLETED	
		IL6012165	B. WING		01/13/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVERC	ROSSING OF PEORI	1500 WES PEORIA, I		IOOR ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
\$9999	Continued From pa	ge 2	S9999	17		
	for falls and include initiated 11-12-22, c strips on the floor b in bed. Place mats intervention, date in	lan documents R2 is at risk is a fall intervention, date of "Place floor mats/landing eside the bed while resident is on (both sides)." A second itiated 5-12-21, states "Keep on acceptable by the resident is in bed."			44	
	signed by V10, Lice documents, "Nursin 6:15am (R2) was fo	eport, dated 1-5-23 and nsed Practical Nursing/LPN, og Description: On 1-5-23 at ound laying on the floor face d." R2 was sent to the			\$ S	
5	left knee without co documents, "Finding indicating acute fractionacute nondisplaced inferomedial patella	ized Tomography) scan of the ntrast, dated 1-5-23, gs: 1. Large lipohemarthrosis sture. 2. Two possible areas of fracture through the and through the medial he medial femoral condyle."	± # - gi			
	which is positioned	am, R2 lay supine in R2's bed at regular height. R2 stated cap yesterday by falling out of ed to R2's left leg.	* 8	5 K		
W ==	floor mat is on the fl There is no floor ma R2's bed is at regula stated he fell out of R2 stated he fell to	pm, R2 is laying in bed. A oor to right side of bed only. It on the left side of R2's bed. It on the left side of R2's bed. It height. At this time, R2 bed and broke his knee cap. It is that been own. R2 stated, "If it had been				
		m, R2 is laying in bed with right side of his bed only;		22	2	

Illinois Department of Public Health

Illinois D	epartment of Public	Health		· · · · · · · · · · · · · · · · · · ·	= FORWIT	AFFROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6012165	B. WING	<u> </u>	01/1	; 3/2023
NAMEOF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	_	. U.
RIVERC	ROSSING OF PEORI	4	ST NORTHM	IOOR ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999	·		
-		ar height. R2 stated, "I need is usually down but it wasn't ainst the wall."			=	
e .  	time, R2 does not h left side, and R2's b stated R2 is suppos side of his bed. A se	om, V13, LPN, verified at this have a floor mat down on the hed is at regular height. V13 hed to have floor mats on each econd floor mat could not be n. V13 stated R2's bed is the lowest position.				м ————
	following regarding was low but not in the if they were ready to (R2's) bed should h	7pm, V10, LPN, stated the R2's fall on 1-5-23: "The bed he lowest position. I wondered o get (R2) up or something. ave been the the lowest as up about 1/12 to 2 feet	≅	8 · · · · · · · · · · · · · · · · · · ·		
	stated the following "(R2's) bed was at t for getting in and outposition. (R2) rolled	Opm and 1:48pm, V11, LPN, regarding R2's fall on 1-5-23: he position of regular height of bed and not in the lowest and his incontinence pad and him." V11 did not see a floor				= x2
		om, R2 was in bed with only a t side of R2's bed only.				
	time, R2 does not h side of his bed. V12	pm, V12 LPN verified at this ave a floor mat along the left stated according to R2's care d to have a floor mat on both				N.

On 1-10-23, between 2:30pm and 3:05pm, V2, Director of Nursing, stated the following: "(R2) should have bilateral floor mats at all times and Illnois Department of Public Health

Illinois D	epartment of Public	Health		Compression of the compression o	FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
50 85	· · · · · · · · · · · · · · · · · · ·	IL6012165	B. WING			C 13/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVER C	ROSSING OF PEORI	A 1500 WES		OOR ROAD	18	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 4	S9999			
	(R2's) bed should a when (R2) is in it.	always be in the lowest position				
= =	The facility's Standards of Clinical Care - Fall Prevention policy, revised 3-27-21, documents, "Standard: 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 facility's Standards and Guidelines for					
				***************************************		- 25
	Comprehensive As- revised 4-5-21, doc- services provided o outlined by the com- provided by qualifie each resident's writ	sessments and Care Plans, uments "Guidelines: 11. The arranged by the facility, as prehensive care plan, will be d persons in accordance with ten plan of care and will also etent and trauma-informed."		* 3* •	*	G
	(A)	\$**				-X <sub>2</sub> ,
				¥1		