STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012074	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ALTON	3490 HUMBERT ROAD ALTON, IL 62002

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S 000	Initial Comments Complaint Survey: 2344336/IL160239	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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 were not met as evidenced by: Based on observation, interview, and record review the facility failed to utilize proper equipment, appropriate assist during resident care, and utilize care plan interventions to prevent accidents for 1 of 4 residents (R14) reviewed for supervision to prevent accidents in the sample of 14. This failure resulted in R14 falling out of bed during care and sustaining a subdural hematoma, requiring a 7-day hospitalization for treatment. Findings include: On 5/30/23 at 1:40 PM R14 was lying in bed with head of bed elevated and oxygen on per nasal cannula. R14's bed height was raised and there was a mat on the right side of her bed on the floor. There were no landing strips on the floor and R14 was lying in a standard sized bed, not an expanded bed. V14, Registered Nurse (RN)	S9999		

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S9999	Continued From page 2 entered the room to assist R14's roommate, and she also lowered R14's bed to the lowest position at that time. R14 was yelling out but did not appear to be in any distress but yelling out in response to voices she heard in the room when V14 was talking to her. The facility's document, "Federal Initial/Final Report" dated 3/6/23 documents, "92 year old female with history of Alzheimer's dementia, A fib, Chronic CHF (Congestive Heart Failure), HTN (Hypertension), COPD (Chronic Obstructive Pulmonary Disease) and GERD (Gastro-esophageal Reflux Disease) had a fall from bed. Patient noted to have lip laceration and complains of all over pain during assessment. ER (Emergency Room) assessment via CT scan (Computed Tomography Scan) reveal 4 mm left parietal subdural hematoma with 0 mass effect or midline shift. There are also multiple intracranial calcifications. CT of the cervical spine demonstrates diffuse degenerative disease, but without acute fracture or malalignment. Final Report Findings: Investigation revealed when patient was turned towards right side for care to be provided, mattress was over the frame of the bed. Patient weight on mattress caused mattress to fold and patient to slide off bed. " R14's Progress Note dated 3/5/2023 at 8:00 PM documents, "Resident rolled out of bed during care. Landed on L (left) side. Bit lip and complained of pain all over. ROM (Range of Motion) performed. VS (Vital Signs): BP (blood pressure)118/69, P (pulse)59, R (respirations) 20, T (temperature) 98F (Fahrenheit), O2 (oxygen saturation) 98 on RA (room air). MD (Medical Doctor) notified and NO (new order) to send to ED (Emergency Department) for further eval. POA (Power of Attorney) notified."	S9999		

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S9999	Continued From page 3 R14's Progress Note dated 3/6/2023 at 1:09 AM documents, "Called (local hospital) for update on resident and was informed resident had subdural hematoma and was being transferred to (outlying trauma hospital)." R14's Progress Note dated 3/14/2023 at 9:07 AM documents, "Son here, discussed patient edema in left hand. Son noted patient was not alert as she was in the hospital. Discussed hospice services. Son will think about hospice as he sees how patient condition evolves the next couple of days. " R14's Physician Order dated 3/17/23 documents, "Admit to (Hospice) as of 3/16/23. Dx (Diagnosis): Alzheimer's Disease." R14's Minimum Data Set (MDS) dated 1/11/23 documents R14 is severely cognitively impaired, and she requires extensive assist of 2 staff for bed mobility and transfers. This MDS was completed prior to R14's fall from bed. R14's Care Plan dated 1/20/23 (prior to fall) documents, "The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia, weakness, terminal Illness." Interventions for this care plan include: Mechanical Lift for transfers (Full Body Mechanical Lift). This intervention was dated 1/30/2023 and documents "Resident currently requires assistance with ADLs: Bed Mobility: extensive/2 Transfer: Extensive-Total/2-3 Uses (full body mechanical lift) but can be too aggressive causing lift to be unsafe." R14's current MDS dated 4/13/23 documents R14 is severely cognitively impaired and is	S9999		

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S9999	Continued From page 4 dependent on 2 staff to assist with bed mobility, transfers, and toileting. R14's Care Plan dated 1/20/23 documents, "Resident is at risk for falls. The resident has impaired cognition and impaired safety awareness, the resident experiences weakness, the resident has vision impairments., The resident has urinary incontinence which may create a wet floor and increase fall risk." Interventions for this care plan were updated on 3/14/23 (after her fall) with, " Bed expanded out in width. Place floor mats/landing strips on the floor beside the bed while resident is in bed. The intervention, "Keep bed in lowest position acceptable by the resident when the resident is in bed" was dated 1/20/23. R14's Physician Progress, written by V15, Physician Assistant, dated 3/2/23 documents, "I am seeing patient for routine monthly nursing home visit. She is severely demented. She is sitting comfortably in her wheelchair (w/c). Says she feels "okie dokie". She is currently pleasant and cooperative. She denies any pain, says she has a good appetite, denies any GI (gastrointestinal) symptoms. Disposition: Patient is from (Assisted Living) but hopes to return there after completion of her therapy." R14's Physician Progress Note written by V15, dated 3/14/23 documents, "Seeing patient acutely today for hospitalization follow-up. The patient was hospitalized at (outlying trauma hospital) from 3/6 through 3/13/23 for a subdural hematoma that she sustained after falling out of bed in the nursing facility while being cleaned by a CNA (Certified Nursing Assistant). She arrived to the facility yesterday with supplemental oxygen on. Since she arrived, she has been lethargic.	S9999		

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S9999	Continued From page 5	S9999		

Minimally interactive. On my exam she is awake, however she is not answering any questions meaningfully. She is mumbling incomprehensible speech when asked a question. She is not following most commands. The nurse tells me this is actually an improvement as this morning she was very difficult to arouse. She has not eaten anything today and spat out liquids when the nurse tried to give her water. I had a long discussion with son and daughter-in-law that if patient's mental status does not improve and she continues to not eat then will need to strongly consider changing code status and also hospice needs to be considered." Under "Assessment/Plan", this Physician Progress Note documents, "The obvious possible causes for altered mental status are the SDH (Subdural Hematoma) and RSV (Respiratory Syncytial Virus) pneumonia causing a delirium on top of her already advanced dementia."

R14's Hospital Record, Post-Acute Care Transfer Report, dated 3/13/23, documents her Principle Problem during hospitalization as Subdural Hematoma.

On 5/30/23 at 1:50 PM V2, Director of Nursing (DON), stated the staff involved with R14's care at the time of her fall was V13, Certified Nurse's Aide, CNA. V2 stated V13 reported to her that he was providing incontinent care for R14 and turned her onto her side facing the wall. V2 stated the bed was against the wall, but the mattress was bigger than the bed frame and the edge of the mattress folded down and R14 slid straight to the floor. V2 stated R14's mattress was an oversized mattress on a regular size bed frame, so part of the mattress was over hanging the side of the bed. V2 stated they put a regular sized mattress on the standard sized bed frame, and it was fine

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S9999	Continued From page 6 then. V2 stated she doesn't know why R14's care plan documents she is on an expanded mattress; they put a regular sized mattress on a standard sized bed frame. V2 stated R14 does not need a larger mattress. On 5/30/23 at 2:01 PM V12, CNA, who was taking care of R14, stated he does R14's incontinent care by himself when he is working. V12 stated R14 is heavier than she looks and can stiffen up, so some of the other CNAs will use two assists with R14's care, but he stated he is able to turn her by himself and provide incontinent care without help. He stated, "I can do her on my own." On 5/30/23 at 2:11 PM V13, CNA, was interviewed by phone. He stated he was the CNA providing care for R14 on 3/6/23 when she fell out of bed. He stated he was getting ready to change her and had rolled her onto her side, facing the wall. He stated the mattress was too big for the bed and the mattress flipped up on his side because of her weight on the other edge, and she fell face first off, the bed. V13 stated R14 had a cut on her lip that was bleeding. He stated he ran and got the nurse and another CNA, and they used a sheet and papoosed lifted R14 back into bed and then she was sent to the emergency room. V13 stated he always changed R14 on his own. He stated R14 had just recently moved from another room, so this was the first he had an issue with her mattress. He stated he reported the problem with the mattress to the DON the next day and she took care of it. He stated the mattress would not have worked for any resident because it was too big for the frame that it was on. On 5/31/23 at 1:36 PM V3, Assistant Director of	S9999		

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S9999	Continued From page 7 Nursing (ADON) stated he would expect staff to follow a resident's care plan, including having the appropriate number of staff needed to assist a resident with cares. If the plan of care stated a resident requires the assist of two staff for turning and positioning, there should be two staff providing the care for that resident. V3 stated the correct mattress should be utilized with the bed frame. The facility' policy, "Standards and Guidelines: Falls" 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. 5. If a resident sustains a fall while a resident, staff should attempt to identify possible causes of the fall. After a fall, the interdisciplinary team (IDT) should review the circumstances surrounding the fall and develop an appropriate intervention(s) and plan of care. Based on evaluation of an existing fall (s) pertinent interventions will be implemented by staff such as, but not limited to: staff re-education regarding transfer techniques and safety during ADL care." The facility's policy, "Standards and Guidelines: ADL Care and Assistance" revised 3/27/21 documents, "It will be the standard of this facility to provide the resident with Activities of Daily Living (ADL) care and assistance while attempting to maintain the highest practicable level of function for the resident. Guidelines: 1. Each resident will be assessed/evaluated upon admission or shortly after for their level of resident ability/function and staff assistance required to safely perform ADLs. 2. Each ADL should be provided at the level of assistance that	S9999		

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S9999	Continued From page 8 promotes the highest practicable level of function for the resident, while ensuring the needs and desired goals of the resident are met safely. Extensive assistance-resident is involved in activity; staff provide weight-bearing support." The facility's policy, "Standards and Guideline: Environmental Equipment Care" revised 11/2017 documents, "Standard: It will be the standard of this facility that staff shall properly use and care for the property, equipment and supplies that are assigned and/or necessary for use in their work. Guidelines: 1. Employees are expected and required to exercise due care and safety in the use of all facility property, equipment, and supplies. 2. Property, equipment and supplies should be used only for the purposes for which they are intended. 8. Mechanical, electrical, and patient care equipment shall be maintained in safe operating condition." (A)	S9999		