STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146119	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven on the River	320 South 2nd Street Grayville, IL 62844

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that includes post fall assessment and treatment, monitoring, reporting, and investigating for 1 of 3 residents (R1) reviewed for quality of care in the sample of 6. This failure resulted in R1 falling and sustaining a hip and femur fracture without timely assessment and treatment after the fall. A reasonable person would experience feelings of discomfort and distress due to not receiving timely after fall care. This past non-compliance occurred between 11/14/25 and 11/16/25.Findings include:R1's Transfer/Discharge report, dated 12/2/25, documents an admission date of 12/3/2021 and a discharge date of 11/20/2025.R1's diagnosis report, dated 12/3/25, documents the following diagnoses in part, fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, muscle weakness (generalized), other abnormalities of gait and mobility, pain in right hip, unsteadiness on feet.R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 9, indicating R1 is moderately cognitively impaired. Section GG-Functional Abilities documents R1 is dependent on staff for all transfers.R1's Care Plan documents R1 is at risk for falls, risk for injury from falls with an initiation date of 2/28/22.R1's Fall Risk Assessment, dated 9/25/25, documents R1 is at high risk for falls.On 12/1/25 at 2:29pm, V12 (family member) stated V14 (family member) had visited R1 on 11/15/25 and said R1 was not wearing socks and she appeared to be in pain. V12 stated she went to visit R1 on 11/16/25 and noticed her leg did not look right and she was in pain. V12 stated one of the aides told her she had been in pain the day before and she had told the nurse about it. V12 stated she did not know the aide's name. V12 stated, Staff were using a mechanical lift with her and her leg was so messed up, it was rotated, and her foot was flat on the recliner. V12 stated she told V8 (Registered Nurse/RN) something was not right with R1's leg; she stated V8 tapped her leg and said it looked a little swollen. V12 stated the hospital diagnosed R1 with a right hip fracture and a left leg fracture. V12 stated V2 (Director of Nursing/DON) called her and said a nurse admitted R1 had fallen and she didn't do anything about it. V12 stated V2 told her some staff stated they had reported R1 was in pain and the same nurse didn't do anything about it; he told her they got rid of the nurse. On 12/1/25 at 12:56pm, V2 (DON) stated there is an event that should be triggered in a resident's medical record when they have a fall or incident. V2 stated it will show up in the progress notes. V2 confirmed this was not done for R1's fall on 11/16/25.On 12/1/25 at 2:54pm, V2 (Director of Nursing/DON) stated they realized there was an issue with R1 and quickly went into action to correct it.On 12/2/25 at 11:31am, V8 (RN) stated she was the nurse that sent R1 out on 11/16/25. V8 stated she had noticed R1 had some increased edema more so in her left leg than in the right. V8 stated, (R1) had edema, but it was a little more this day. She did not complain of pain; she did grimace a little when she touched it. (R1) was sent out because her daughter wanted her sent out. V8 stated she had pulses, and she had no complaint of pain prior to. V8 stated she had no knowledge of R1 falling until after she was sent to the hospital.On 12/2/25 at 1:27pm, V9 (Certified Nursing Assistant/CNA) stated she was not working on R1's hallway on Friday, the day she fell. V9 stated one of the other CNA's told her she had to help V11 (Licensed Practical Nurse/LPN) put R1 back into bed after finding her on the floor. V9 stated the only nurse they worked with that following weekend was V11, and she reported to her two different nights that R1 was in pain. V9 stated she was not there the day R1 was sent out.On 12/2/25 at 1:37pm, V10 (CNA) stated she was working the night that R1 fell. V10 stated she helped V11 (Licensed Practical Nurse/LPN) get R1 up after she fell; she stated she did not appear to be in pain. V10 stated V11 did not really assess R1, and she did not call her family or physician. V10 stated R1 did appear to be in pain later in the weekend, it was reported to V11, but to her knowledge V11 did not address it. On 12/2/25 at 11:08am and 12/3/25 at 9:37am; attempts to contact V11 (LPN) were made but unsuccessful. On 12/2/25 at 2:19pm, V2 (DON) stated they held a meeting on 11/16/25 with himself, V1; and V13 (RN, Minimum Data Set (MDS)/Care plan coordinator) to investigate and develop a plan of correction. V2 stated they interviewed all staff and residents and educated all the staff; and V11 (LPN) was terminated.On 12/2/25 at 2:40pm, V1 (Administrator) stated V2 (DON) jumped into action as soon as they found out that all the events that had taken place with R1. V1 stated as soon as he found out everything that went on with R1, he terminated V11 (LPN). V1 stated all staff and residents were interviewed, and staff were educated immediately.Facility document titled Fall Scene investigation for R1 documents the date of fall as 11/14/25. This documents states under Fall Summary R1 was found on the floor (unwitnessed). This document states

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident was properly assessed for injury and pain and to address resident complaints of pain post fall for 1 of 3 (R1) residents reviewed for pain in a sample of 6. R1 fell and sustained a hip and femur fracture without proper assessment of injury/pain. A reasonable person would experience feelings severe pain and discomfort due to not receiving pain relief medication. Findings include:R1's Transfer/Discharge report dated 12/2/25 documents an admission date of 12/3/2021 and a discharge date of 11/20/2025.R1's diagnosis report, dated 12/3/25, documents the following diagnoses fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, muscle weakness (generalized), other abnormalities of gait and mobility, pain in right hip, unsteadiness on feet.R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 9, indicating R1 is moderately cognitively impaired. Section GG-Functional Abilities documents that R1 is dependent on staff for all transfers.R1's Care Plan documents R1 is at risk for falls, risk for injury from falls with an initiation date of 2/28/22.R1's Order Recap Report, printed 12/2/25, documents R1 had an order for Ibuprofen Oral Tablet 600 milligrams (mg) give 600 mg by mouth every 8 hours as needed for pain started 8/24/23 and an order for Tylenol Extra Strength Tablet 500 mg give 2 tablets by mouth every 4 hours as needed for mild pain, take 1-2 tablets every 4-6 hours as needed for mild pain with a start state of 12/26/21. On 12/1/25 at 2:29pm, V12 (family member) stated V14 (family member) had visited R1 on 11/15/25 and said R1 was not wearing socks and she appeared to be in pain. V12 stated she went to visit R1 on 11/16/25 and noticed her leg did not look right and she was in pain. V12 stated one of the aides told her she had been in pain the day before and she had told the nurse about it. V12 stated she did not know the aide's name. V12 stated, Staff were using a mechanical lift with her and her leg was so messed up, it was rotated, and her foot was flat on the recliner. V12 stated she told V8 (Registered Nurse/RN) something was not right with R1's leg; she stated V8 tapped her leg and said it looked a little swollen. V12 stated the hospital diagnosed R1 with a right hip fracture and a left leg fracture. V12 stated V2 (Director of Nursing/DON) called her and said a nurse admitted R1 had fallen and she didn't do anything about it. V12 stated V2 told her some staff stated they had reported R1 was in pain, and the same nurse didn't do anything about it; he told her they got rid of the nurse. On 12/2/25 at 11:31am, V8 (RN) stated she was the nurse that sent R1 out on 11/16/25. V8 stated she had noticed R1 had some increased edema more so in her left leg than in the right. V8 stated R1 had edema, but it was a little more this day. 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V10 stated R1 did appear to be in pain later in the weekend, it was reported to V11, but to her knowledge V11 did not address it.On 12/2/25 at 11:08am and 12/3/25 at 9:37am, attempts to contact V11 (LPN) were made but unsuccessful. R1's progress notes, dated 11/16/2025 at 2:15pm, documents, Residents daughter requests her mother to be transferred to (local emergency room) to have left hip evaluated. Resident has edema to ble (bilateral lower extremities) and has had bil (bilateral) knee replacements in the past, she is non-weight bearing. Resident does not c/o (complain of) pain or ask for medications, she will grimace when foot is pulled. non emergent EMS (Emergency Medical Services) notified to transport, report called to ER (emergency room) .R1's Medication Administration Record for November of 2025 documents R1 did not receive the as needed Tylenol Extra Strength 500 mg tablet or the as need Ibuprofen Oral Tablet 600 mg pain medications between the dates of 11/14-11/16/25. R1's MAR documents R1 had pain assessments done day and night shift on 11/14/25 and 11/15/25 with a pain level of 0. On 11/16/25 during the morning shift, R1's pain level was documented as a 2 on a 1-10 scale. R1's Progress Notes from 11/14/25-11/15/25 did not document any reference to R1 being in pain. R1's medical record from the local hospital documents in the emergency room Triage notes, dated 11/16/25 at 3:28pm, Patient presents from a local nursing home with complaints of left knee pain. Patient states she has had pain for a long time. Her daughter states that staff noticed she was complaining about it