

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER The Haven on the River		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify a residents POA (Power of Attorney) and Nurse Practitioner of a fall and a decrease in oxygen saturation for 1 of 3 residents (R1) reviewed for notification in a sample of 12. Findings include:1. R1's Face Sheet documented an admission Date of 3/18/26, and listed Diagnoses including Vascular Dementia, Atherosclerotic Heart Disease, and Chronic Obstructive Pulmonary Disease.R1's Minimum Data Set, dated [DATE], documented R1 had moderate deficits in cognition. R1's Care Plan, dated 4/30/26, documented a problem area, The resident is moderate risk for falls related to history of falls, poor safety awareness, impulsivity; Resident sometimes crawls out of bed. A 3/18/26 admission Fall Risk Assessment documented R1 was at high risk for falls.Nursing Progress Notes documented the following:5/19/26 9:36am: During morning med pass resident was resting comfortably in bed, took his meds and had no complaints. Later in the AM (morning) CNA's (Certified Nursing Assistants) got him out of bed, he was complaining about pain at the hip/femur location with verbalization of pain. I assessed and found patient to have a complaint of pain, and I notified management and obtained order for stat (immediate) x-rays of femur, hip, and pelvis. Placed resident into his recliner where he remained awaiting x-ray. Client had no complaints other than that when he got up out of bed. Created by V14 (Licensed Practical Nurse).5/19/26 4:41pm: Late Entry: Resident family arrived after being notified that he had fallen a couple days prior, once we were informed by a CNA that (V7- Agency Nurse) told her that he fell, but stated, He didn't really fall, he sat down on the floor. Upon arrival they called EMS (Emergency Management Systems) for transport to hospital. Created by V14. There was no documentation in the record to indicate R1 fell on 5/17/26, nor that the Nurse Practitioner or the POA was notified.A (NP) Nurse Practitioner Visit Note at 5/19/26 5:45pm by V11 (NP) documented, (R1) is being seen this evening after getting a call today that he was having left hip pain again and that he possibly fell over the weekend. Awaiting on (portable x-ray) (R1) is a [AGE] year-old male with a complex medical history as seen below. He is being seen today since he is a high risk for falls and recently fractured his right acetabulum and right pubis after a fall on the 30th of April (2026). This am when day shift nurse when in to give him his meds he reported that his left hip was hurting. This provider was notified and gave order to get x-rays of hip. When this NP arrived at facility this evening Xray has not been done due to Xray company has not arrived yet. (R1) reported that he fell on Sunday and hurt his left hip. Staff was unaware of this fall. When (R1) was asked about his fall he could not give me much detail except that he landed on left hip, and it hurt. His pain at time of assessment was rated a 4/10. He received pain medication around 2pm. Left leg does look slightly externally rotated, but he is up in recliner and hard to assess. He did not want to move to bed to let me evaluate him better. He had another fall about one month ago and had left hip pain also and Xray was negative. He reported that he has been in bed since Sunday, but staff report that he has been up out of bed in chair and even in his wheelchair. Today was the first day staff was aware of pain in left hip. He does get hydrocodone 5/325mg (milligrams) every 6 hours for pain in his right hip/pelvis for previous fracture. It really is unclear what happened or when it happened. In our discussion I asked him if he was ok (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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He denies any fevers chills nausea vomiting chest pain abdomen pain or shortness of breath. He is on chronic O2 (oxygen) for COPD (Chronic Obstructive Pulmonary Disease). Any movement causes increased pain. Nothing else has made his symptoms better or worse and they are mild in nature. Patient's left lower extremity is externally rotated and he has tenderness to palpation on the hip and pain with any movement. He does have good distal neurovascular exam. Xray of the left hip and pelvis: SI (Sacroiliac) joints are symmetric. Right total hip arthroplasty is in place with anatomic alignment. Intertrochanteric fracture of the left femur with mild impaction. Old right inferior pubic ramus fracture is stable in place. On 5/22/26 at 9:15am, V4, Family Member of R1, stated R1 fell on 5/17/26 and the family did not know about it until they visited R1 on 5/19/26 and noted he was in pain and something was obviously wrong with his hip. V4 stated the family called 911 and R1 was taken to ER, where a right hip fracture was diagnosed. V4 stated R1 had hip surgery on 5/20/26 and then suffered a stroke and his condition has deteriorated. V4 stated staff was apologetic about the lack of notification of the fall. V4 stated the family has decided R1 will not be returning to the facility after he is released from the hospital. On 5/22/26 at 10:45am, V5, R1's Power of Attorney, stated she and V4 went to visit R1 on 5/19/26, and R1 was in pain from his right hip and they could tell by looking at his legs there was something wrong with the left hip, so they called 911 for him to be taken to the ER. V5 stated she is unhappy with the quality-of-care R1 received and he will be going to a different facility. On 5/26/26 at 9:45am, V7, Registered Nurse/Agency, stated on 5/17/26 on the 6pm to 6am shift, she and V12 were in R1's room with him, when all of a sudden, he said he needed to go to the bathroom, he sat up to side of bed and slid out of the bed with his buttocks making contact with the floor. V7 stated, He didn't fall, that is not considered a fall, he slid and then sat down. He said he was fine, nothing seemed to be wrong with him, he said he wasn't in any pain, so we got him back in bed, checked his vital signs, and that was about it. V7 stated since it was not a fall, she did not notify the Physician, R1's POA, V2 (Director of Nursing), or the oncoming nurse at shift change and did not do a progress note or a fall investigation. On 5/26/26 at 1:25pm, V2 stated on 5/19/26, CNA's reported R1 was having severe pain in his right hip when they were doing morning care. V2 stated it was then reported to her that R1 fell about 11:30pm on 5/17/26. V2 stated V7 told her that R1 was sitting up to edge of bed and slid down with butt making contact with the floor. V2 stated V7 did not report it to the POA, the physician, or to her nor did she start a fall report because she did not consider it a fall. On 5/27/26 at 8:30am, V11 stated she last saw R1 on 5/19/26 later on in the afternoon, after V2 had notified her that R1 fell on 5/17/26. V11 stated she was not notified of the fall on 5/17/26. 2. R1's May 2026 Physicians Orders documented an order for oxygen at 3 Liters/Minute per nasal cannula, maintain oxygen saturation at 90 percent or greater. On 5/26/26 at 12:10pm, V8, Registered Nurse, stated she did not remember the date but did recall a CNA finding that R1 had been out of his room without portable oxygen for an unknown period of time. V8 stated she recalled R1's pulse oximetry reading in the 80's. V8 stated they put R1 in bed and put oxygen on him and the reading came back up to the 90s. V8 stated she did not notify the nurse practitioner. On 5/27/26 at 8:30am, V11, Nurse Practitioner, stated V8 should have contacted her when R1's oxygen saturation dropped below 90. On 5/27/26 at 1:05pm, V13 (CNA) stated at about 3:30pm, date unknown, R1 was sitting in the dining room and had been without his oxygen for an unknown period. V13 stated R1 was not blue (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was in no distress but tired. V13 stated he notified V8, and they put him in bed, put his oxygen on him, and his oxygen saturation measured 78, rose to 88 after 15 minutes, and a few minutes later had risen to the high 90s. On 5/28/26 at 9:20am, V1, Administrator, stated based on the description of the above events and the staff involved as well as video evidence, the incident regarding V1 and the oxygen situation occurred on 5/13/26 at 3:30pm. There was no documentation in R1's chart of R1's oxygen saturation on 5/13/26 after 11:36am. A Notification of Change Guideline Policy, dated 10/1/21, stated, It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or the resident's representative, according to their authority, and are reported to and consulted with the attending physician. Requirements for notification of resident, the resident's representative, and their physician: A significant change in the resident's physical, mental, or psychosocial status. A significant change includes deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications. A need to alter treatment significantly. A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. An accident involving the resident, which results in injury and has the potential for requiring physician intervention.		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents are free from neglect for 1 of 6 residents (R1) reviewed for neglect in the sample of 12. The failure resulted in R1 not receiving an immediate nursing assessment and treatment for a fall resulting in a hip fracture. Findings include: R1's Face Sheet documented an admission Date of 3/18/26, and listed Diagnoses including Vascular Dementia, Atherosclerotic Heart Disease, and Chronic Obstructive Pulmonary Disease. R1's Minimum Data Set, dated [DATE], documented R1 had moderate deficits in cognition. R1's Care Plan, dated 4/30/26, documented a problem area, The resident is moderate risk for falls related to history of falls, poor safety awareness, impulsivity; resident sometimes crawls out of bed. A 3/18/26 admission Fall Risk Assessment documented that R1 was at high risk for falls. Nursing Progress Notes documented the following: 5/19/26 9:36am: During morning med pass resident was resting comfortably in bed, took his meds and had no complaints. Later in the AM (morning) CNA's (Certified Nursing Assistants) got him out of bed, he was complaining about pain at the hip/femur location with verbalization of pain. I assessed and found patient to have a complaint of pain, and I notified management and obtained order for stat (immediate) x-rays of femur, hip, and pelvis. Placed resident into his recliner where he remained awaiting x-ray. Client had no complaints other than that when he got up out of bed. Created by V14 (Licensed Practical Nurse). 5/19/26 4:41pm: Late Entry: Resident family arrived after being notified that he had fallen a couple days prior, once we were informed by a CNA that (V7- Agency Nurse) told her that he fell, but stated, He didn't really fall, he sat down on the floor. Upon arrival they called EMS (Emergency Management Systems) for transport to hospital. Created by V14. There was no documentation in R1's record to indicate R1 fell on 5/17/26. The was no assessment from a fall noted in R1's records for the date of 5/17/26. R1's May 2026 Physicians orders and May 2026 Medication Administration Report (MAR) both documented an order for Hydrocodone Acetaminophen Oral Tablet 5-325 Mg. (Milligrams) give 1 tablet by mouth every 6 hours as needed for pain. The MAR was left blank for the 6pm to 6am shift on 5/17/26, indicating R1's pain was not assessed, and the pain medication was not given. A (NP) Nurse Practitioner Visit Note at 5/19/26 5:45pm by V11 (NP) documented, (R1) is being seen this evening after getting a call today that he was having left hip pain again and that he possibly fell over the weekend. Awaiting on (portable x-ray) (R1) is a [AGE] year-old male with a complex medical history as seen below. He is being seen today since he is a high risk for falls and recently fractured his right acetabulum and right pubis after a fall on the 30th of April (2026). This am when day shift nurse when in to give him his meds he reported that his left hip was hurting. This provider was notified and gave order to get x-rays of hip. When this NP arrived at facility this evening Xray has not been done due to Xray company has not arrived yet. (R1) reported that he fell on Sunday and hurt his left hip. Staff was unaware of this fall. When (R1) was asked about his fall he could not give me much detail except that he landed on left hip, and it hurt. His pain at time of assessment was rated a 4/10. He received pain medication around 2pm. Left leg does look slightly externally rotated, but he is up in recliner and hard to assess. He did not want to move to bed to let me evaluate him better. He had another fall about one month ago and had left hip pain also and Xray was negative. He reported that he has been in bed since Sunday but staff report that he has been up out of bed in chair and even in his wheelchair. Today was the first day staff was aware of pain in left hip. He does get hydrocodone 5/325mg (milligrams) every 6 hours for pain in his right hip/pelvis for previous fracture. It really is unclear what happened or when it happened. In our discussion I asked him if he was ok with me sending him to hospital to get evaluated he agreed. Before this NP was able to relate plan to nursing (R1's) family had come in to see him and called EMS themselves. Daughter was at the desk when this NP came to talk with nurse that was working, and she informed me that she wants him sent out. This NP told her that was my plan, and (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she responded that she had already called EMS, and they were on their way. R1's 5/19/26 Emergency Department admission record documented, Patient presents with left hip pain after a fall. Patient states 2 days ago he slipped and fell landing on his left hip at the nursing home. He was not sent out at that time and has been bed-bound since. His family came to visit him and he was complaining of left leg pain and they wanted him transferred here for evaluation. Patient denies any other injuries. He denies any head injury or loss of consciousness. He denies any fevers chills nausea vomiting chest pain abdomen pain or shortness of breath. He is on chronic O2 (oxygen) for COPD (Chronic Obstructive Pulmonary Disease). Any movement causes increased pain. Nothing else has made his symptoms better or worse and they are mild in nature. Patient's left lower extremity is externally rotated and he has tenderness to palpation on the hip and pain with any movement. He does have good distal neurovascular exam. X-ray of the left hip and pelvis: SI (Sacroiliac) joints are symmetric. Right total hip arthroplasty is in place with anatomic alignment. Intertrochanteric fracture of the left femur with mild impaction. Old right inferior pubic ramus fracture is stable in place. An Illinois Department of Public Health (IDPH) Final Investigation Report, dated 5/20/26, documented, Diagnosis: (R1): Hip fracture. A comprehensive investigation was conducted regarding the incident. The resident was found seated on the floor at the foot of his bed, positioned on his buttocks with blankets draped over his legs. The incident was unwitnessed and resident was unable to make a statement as to what caused the fall at that time. Licensed nursing staff immediately assessed resident. During the initial assessment the resident denied any pain or discomfort. Resident showed no signs of distress. A follow up assessment was completed at which time the resident then reported pain in the left hip area. The attending physician and POA (Power of Attorney) were promptly notified. An order was obtained to perform an X-Ray of the left hip area. Before X-Ray was performed attending physician was present to assess resident. Family chose to contact EMS (Emergency Management Systems) to transfer resident to ER (Emergency Room) for further evaluations and treatment. Administrator, Director of Nurses (DON), and IDPH were notified per facility protocol. DON contacted hospital for follow up on resident's condition, and was notified of a diagnosis of left hip fracture. Hospital reported resident was scheduled for surgery the following day. Appropriate notifications were made as indicated. A root cause analysis was completed and determined that the primary contributing factor to the fall was resident attempting to transfer without assistance due to confusion related to a diagnosis of dementia. Resident will not return to facility at this time, as resident's family has chosen to have him placed at another skilled nursing facility. Facility will continue to educate and make adjustments as necessary to ensure residents safety. On 5/22/26 at 9:15am, V4, Family Member of R1, stated R1 fell on 5/17/26 and the family did not know about it until they visited R1 on 5/19/26 and noted he was in pain and something was obviously wrong with his hip. V4 stated the family called 911 and R1 was taken to ER, where a right hip fracture was diagnosed. V4 stated R1 had hip surgery on 5/20/26 and then suffered a stroke and his condition has deteriorated. V4 stated staff was apologetic about the lack of notification of the fall. V4 stated the family has decided R1 will not be returning to the facility after he is released from the hospital. On 5/22/26 at 10:45am, V5, R1's POA, stated she and V4 went to visit R1 on 5/19/26, and R1 was in pain from his right hip and they could tell by looking at his legs there was something wrong with the hip, so they called 911 for him to be taken to the ER. V5 stated she is unhappy with the quality of care R1 received and he will be going to a different facility. On 5/22/26 at 1:05pm, V3, Certified Nursing Assistant (CNA) stated she has recently put in her 2 weeks notice as, She is tired of all the problems going on at the facility. V3 stated on 5/19/26 she arrived onto the floor at about 11:15am after being called in. V3 stated R1 was wet and soiled so she got him ready for a shower, and he was yelling out in pain. V3 stated she asked one of the CNA's about it, that is when V12, CNA, stated she had seen R1 lying on the floor by his bed on 5/17/26. V3 stated she then reported this to V2, Director of Nurses. On 5/26/26 at 9:45am, V7, Registered Nurse/Agency, stated on 5/17/26 on the 6pm to 6am shift, she and V12 were in R1's room with him, when suddenly R1 said he needed to go to the bathroom, sat up (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	to side of bed and slid out of the bed with his buttocks making contact with the floor. V7 stated, He didn't fall, that is not considered a fall, he slid and then sat down. He said he was fine, nothing seemed to be wrong with him, he said he wasn't in any pain, so we got him back in bed, checked his vital signs, and that was about it. Since it wasn't a fall, there was no need to do an assessment. V7 stated since it was not a fall, she did not notify the Physician, R1's POA, V2, or the oncoming nurse at shift change and did not do a progress note or a fall investigation. V7 stated, Three days after the fact, management called me and said I had to do a report because it turned out he had a fractured hip. On 5/26/26 at 1:25pm, V2 (DON) stated on 5/19/26, CNAs reported R1 was having severe pain in his right hip when they were doing morning care. V2 stated it was then reported to her that R1 fell about 11:30pm on 5/17/26. V2 stated V7 told her R1 was sitting up to the edge of bed and slid down with butt making contact with the floor. V2 stated V7 did not report it to the POA, the physician, or herself nor start a fall report because she did not consider it a fall. V2 stated V7 did do vital signs and a nursing assessment but didn't document it. V2 stated she immediately notified V11, Nurse Practitioner, who ordered a portable x-ray and stated she would evaluate R1 that afternoon. V2 stated in the afternoon, R1's family came and they called 911 to ask for transport to the ER due to R1's hip pain. V2 stated she has since talked to V7 and stressed that what occurred with R1 was indeed a fall and should have been processed as such. V2 was informed V7 was still maintaining it was not a fall. On 5/27/26 at 8:30am, V11, Nurse Practitioner, stated she last saw R1 on 5/19/26 later on in the afternoon, after V2 had notified her R1 fell. V11 stated when she arrived, although she had ordered a portable x-ray, the provider had not yet been here to do it. V11 stated when she examined but R1 he was not able to tell her what happened due to issues with his memory. V11 stated he was complaining of right hip pain, and the right leg was externally rotated. V11 stated it is her understanding from staff was that a CNA found him lying on the floor by his bed on 5/17/26, and the nurse responsible for his care did not document an assessment, did not contact V11, did not contact the POA, nor facility management. V11 stated in the meanwhile R1's family came in and called 911 before she had a chance to speak with them about his condition. V11 stated it was confirmed by the hospital that R1 had a hip fracture. V11 stated R1 had a history of a previous hip/pelvis fracture from a fall. V11 stated R1's medical history documented poor bone density, and sliding onto a sitting position could definitely cause a fracture. V11 stated if V7 had assessed R1, she would have noted the external rotation, and had she contacted V11 she would have ordered him sent to ER (Emergency Room). On 5/27/26 at 9:30am, V12 (CNA) stated on 5/17/26 about 11pm or so, she was rounding doing bed checks when she saw R1 lying on floor at the foot of his bed and he couldn't say what happened. V12 stated she and V7 got R1 back in bed, got him cleaned up as he had been incontinent, and V7 checked his vitals. V12 stated R1 was in a lot of pain from his right hip. V12 stated V7 did not assess R1 for injuries. When told about the account V7 gave, V12 stated, It absolutely did not happen that way, it happened the way I explained it. I found him on the floor. On 5/27/26 at 1:55pm, V14, Licensed Practical Nurse, stated he was informed by V3 that R1 fell and V7 didn't document it or tell anybody about it. V14 stated he asked V7 about it, and she told V14, (R1) fell out of his chair. V14 stated he wrote the progress notes and V15, Regional Nurse Consultant, Gave him a 30-minute lecture about not documenting too thoroughly because if the state comes in on this fall, they could see those notes and ask too many questions, and the information was based on hearsay, not facts. V14 stated he felt V15's agenda in saying this was to encourage V14 to strike through those notes, which V14 then did. On 5/27/26 at 2:10pm, V1 (Administrator) provided a document titled, Fall, dated 5/17/26. V1 stated when the 5/17/26 fall was discovered to have happened a fall investigation was initiated on 5/19/26. V1 stated the document was dated 5/17/26 as that was when the fall occurred although the report was not done until 5/19/26. A 5/17/26 Fall document dated 5/17/26 documented, The resident was in residents' room with staff (CNA) and slipped onto the floor. Nurse assessed resident. No injuries noted. No complaints of pain. Nurse and CNA assisted resident back to bed. Resident stated he was trying to use the restroom. Staff explained he had a brief on and assisted changing him when (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	in bed. Statement from V12, 5/19/26: (V12) reported she walked by the resident's room and observed him sitting on the floor next to the foot of his bed. She called for the nurse who completed vitals and assessment before assisting him back to bed. Statement from V7, 5/19/26: (V2) interviewed (V7) who reported CNA alerted her to resident being on floor next to his bed and presumed he crawled onto floor from bed. She completed vital signs and assessment before assisting him back to bed. His condition was monitored throughout the rest of the shift. On 5/28/26 at 9:30am, V15 was asked if he knew why V14's progress notes had been struck through, and he said no. V15 stated, I had a conversation with (V14) about charting and that he should not chart hearsay or conversations with other staff members. Nobody has the ability to strike out anybody's else's notes. V15 was asked if V14 had struck through the notes as a result of that conversation and he stated he didn't know. On 5/29/26 at 12:20pm, V1 stated V7 had not been blacklisted, was on the schedule for 5/27/26 but had called in, and V1 believed she was on the schedule for a shift tonight at 6pm. On 5/29/26 at 12:30, V1 stated he checked with V2 and she had cancelled all V7's future shifts. V1 stated he did not view V7's actions as neglect and thus did not do a neglect investigation. The facility's undated Abuse Prevention Policy documented, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents'. This will be done by: Conducting pre-employment screening of employees and pre-admission screening of residents; Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; Identifying occurrences and patterns of potential mistreatment; Identifying concerns of residents' allegations of deprivation of goods and services by staff; Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; Assuring that physical restraints are used sparingly and properly, and that chemical restraints are not used; and, filing accurate and timely investigative reports. Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish (42 CFR 483.5). Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident (201 ILCS 45/1-117) including deprivation of goods and services by staff. Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER The Haven on the River		STREET ADDRESS, CITY, STATE, ZIP CODE 320 South 2nd Street Grayville, IL 62844	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately initiate an investigation into a resident fall and failed to ensure a door remained closed to prevent elopements from residents at risk for elopement for 7 or 7 residents (R1, R4, R8, R9, R10, R11, R12) reviewed for accidents and supervision in a sample of 12. Findings include: 1. R1's Face Sheet documented an admission Date of 3/18/26, and listed Diagnoses including Vascular Dementia, Atherosclerotic Heart Disease, and Chronic Obstructive Pulmonary Disease. R1's Minimum Data Set, dated [DATE], documented R1 had moderate deficits in cognition. R1's Care Plan, dated 4/30/26, documented a problem area, The resident is moderate risk for falls related to history of falls, poor safety awareness, impulsivity; resident sometimes crawls out of bed. A 3/18/26 admission Fall Risk Assessment documented that R1 was at high risk for falls. Nursing Progress Notes documented the following: 5/19/26 9:36am: During morning med pass resident was resting comfortably in bed, took his meds and had no complaints. Later in the AM (morning) CNA's (Certified Nursing Assistants) got him out of bed, he was complaining about pain at the hip/femur location with verbalization of pain. I assessed and found patient to have a complaint of pain, and I notified management and obtained order for stat (immediate) x-rays of femur, hip, and pelvis. Placed resident into his recliner where he remained awaiting x-ray. Client had no complaints other than that when he got up out of bed. Created by V14 (Licensed Practical Nurse). 5/19/26 4:41pm: Late Entry: Resident family arrived after being notified that he had fallen a couple days prior, once we were informed by a CNA that (V7- Agency Nurse) told her that he fell, but stated, He didn't really fall, he sat down on the floor. Upon arrival they called EMS (Emergency Management Systems) for transport to hospital. Created by V14. There was no documentation in R1's record to indicate R1 fell on 5/17/26. There was no assessment from a fall noted in R1's records for the date of 5/17/26. A (NP) Nurse Practitioner Visit Note at 5/19/26 5:45pm by V11 (NP) documented, (R1) is being seen this evening after getting a call today that he was having left hip pain again and that he possibly fell over the weekend. Awaiting on (portable x-ray) (R1) is a [AGE] year-old male with a complex medical history as seen below. He is being seen today since he is a high risk for falls and recently fractured his right acetabulum and right pubis after a fall on the 30th of April (2026). This am when day shift nurse when in to give him his meds he reported that his left hip was hurting. This provider was notified and gave order to get x-rays of hip. When this NP arrived at facility this evening Xray has not been done due to Xray company has not arrived yet. (R1) reported that he fell on Sunday and hurt his left hip. Staff was unaware of this fall. When (R1) was asked about his fall he could not give me much detail except that he landed on left hip, and it hurt. His pain at time of assessment was rated a 4/10. He received pain medication around 2pm. Left leg does look slightly externally rotated, but he is up in recliner and hard to assess. He did not want to move to bed to let me evaluate him better. He had another fall about one month ago and had left hip pain also and Xray was negative. He reported that he has been in bed since Sunday, but staff report that he has been up out of bed in chair and even in his wheelchair. Today was the first day staff was aware of pain in left hip. He does get hydrocodone 5/325mg (milligrams) every 6 hours for pain in his right hip/pelvis for previous fracture. It really is unclear what happened or when it happened. In our discussion I asked him if he was ok with me sending him to hospital to get evaluated, he agreed. Before this NP was able to relate plan to nursing (R1's) family had come in to see him and called EMS themselves. Daughter was at the desk when this NP came to talk with nurse that was working, and she informed me that she wants him sent out. This NP told her that was my plan, and she responded that she had already called EMS, and they were on their way. R1's 5/19/26 Emergency Department admission record documented, Patient presents with left hip pain after a fall. Patient states 2 days ago he slipped and fell landing on his left hip at the nursing home. He was not sent out at that time and has been (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed-bound since. His family came to visit him, and he was complaining of left leg pain, and they wanted him transferred here for evaluation. Patient denies any other injuries. He denies any head injury or loss of consciousness. He denies any fevers chills nausea vomiting chest pain abdomen pain or shortness of breath. He is on chronic O2 (oxygen) for COPD (Chronic Obstructive Pulmonary Disease). Any movement causes increased pain. Nothing else has made his symptoms better or worse and they are mild in nature. Patient's left lower extremity is externally rotated and he has tenderness to palpation on the hip and pain with any movement. He does have good distal neurovascular exam. Xray of the left hip and pelvis: SI (Sacroiliac) joints are symmetric. Right total hip arthroplasty is in place with anatomic alignment. Intertrochanteric fracture of the left femur with mild impaction. Old right inferior pubic ramus fracture is stable in place. On 5/22/26 at 9:15am, V4, Family Member of R1, stated R1 fell on 5/17/26 and the family did not know about it until they visited R1 on 5/19/26 and noted he was in pain and something was obviously wrong with his hip. V4 stated the family called 911 and R1 was taken to ER, where a right hip fracture was diagnosed. V4 stated R1 had hip surgery on 5/20/26 and then suffered a stroke and his condition has deteriorated. V4 stated staff was apologetic about the lack of notification of the fall. V4 stated the family has decided R1 will not be returning to the facility after he is released from the hospital. On 5/22/26 at 10:45am, V5, R1's Power of Attorney, stated she and V4 went to visit R1 on 5/19/26, and R1 was in pain from his right hip and they could tell by looking at his legs there was something wrong with the left hip, so they called 911 for him to be taken to the ER. V5 stated she is unhappy with the quality of care R1 received and he will be going to a different facility. On 5/22/26 at 1:05pm, V3, Certified Nursing Assistant (CNA) stated she has recently put in her 2 weeks notice as, She is tired of all the problems going on at the facility. V3 stated on 5/19/26 she arrived onto the floor at about 11:15am after being called in. V3 stated R1 was wet and soiled so she got him ready for a shower, and he was yelling out in pain. V3 stated she asked one of the CNA's about it, that is when V12, CNA, stated she had seen R1 lying on the floor by his bed on 5/17/26. V3 stated she then reported this to V2, Director of Nurses. On 5/26/26 at 9:45am, V7, Registered Nurse/Agency, stated on 5/17/26 on the 6pm to 6am shift, she and V12 were in R1's room with him, when suddenly R1 said he needed to go to the bathroom, sat up to side of bed and slid out of the bed with his buttocks making contact with the floor. V7 stated, He didn't fall, that is not considered a fall, he slid and then sat down. He said he was fine, nothing seemed to be wrong with him, he said he wasn't in any pain, so we got him back in bed, checked his vital signs, and that was about it. Since it wasn't a fall, there was no need to do an assessment. V7 stated since it was not a fall, she did not notify the Physician, R1's POA, V2, or the oncoming nurse at shift change and did not do a progress note or a fall investigation. V7 stated, Three days after the fact, management called me and said I had to do a report because it turned out he had a fractured hip. On 5/26/26 at 1:25pm, V2 stated on 5/19/26, CNAs reported R1 was having severe pain in his right hip when they were doing morning care. V2 stated it was then reported to her that R1 fell about 11:30pm on 5/17/26. V2 stated V7 told her R1 was sitting up to the edge of bed and slid down with butt making contact with the floor. V2 stated V7 did not report it to the POA, the physician, or V2 or start a fall report because she did not consider it a fall. V2 stated V7 did do vital signs and a nursing assessment but didn't document it. V2 stated she notified V11, Nurse Practitioner, who ordered a portable x-ray and stated she would evaluate R1 that afternoon. V2 stated in the afternoon, R1's family came, stating they had heard about the fall from a CNA, and they called 911 to ask for transport to the ER. When asked what was determined as the root cause of the fall, V2 stated, I would assume toileting. V2 stated she has since talked to V7 and stressed that what occurred with R1 was indeed a fall and should have been processed as such. On 5/27/26 at 8:30am, V11 stated she last saw R1 on 5/19/26 later on in the afternoon, after V2 had notified her that R1 fell. V11 stated when she arrived, although she had ordered a portable x-ray, the provider had not yet been here to do it. V11 stated when she examined R1 he was not able to tell her what happened due to issues with his memory. V11 stated he was complaining of right hip pain, and the right leg was externally rotated. V11 stated it is her (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understanding from staff was that a CNA found him lying on the floor by his bed on 5/17/26, and the nurse responsible for his care did not document an assessment, did not contact V11, did not contact the POA, nor facility management. V11 stated in the meanwhile R1's family came in and called 911 before she had a chance to speak with them about his condition. V11 stated it was confirmed by the hospital that R1 had a hip fracture. V11 stated R1 had a history of a previous hip/pelvis fracture from a fall. V11 stated R1's medical history documented poor bone density, and sliding onto a sitting position could definitely cause a fracture. V11 stated if V7 had assessed R1, she would have noted the external rotation, and had she contacted V11 she would have ordered him sent to ER. On 5/27/26 at 9:30am, V12 stated on 5/17/26 about 11pm or so, she was rounding doing bed checks when she saw R1 laying on floor at the foot of his bed and couldn't say what happened. V12 stated she and V7 got R1 back in bed, got him cleaned up as he had been incontinent, and V7 checked his vitals. V12 stated R1 was in a lot of pain from his right hip. V12 stated V7 did not check R1 for injuries. When told about the account V7 gave, V12 stated, It absolutely did not happen that way, it happened the way I explained it. I found him on the floor. On 5/27/26 at 2:10pm, V1 (Administrator) provided a document titled, Fall, dated 5/17/26. V1 stated when the 5/17/26 fall was discovered to have happened a fall investigation was initiated on 5/19/26. V1 stated the document was dated 5/17/26 as that was when the fall occurred although the report was not done until 5/19/26. A 5/17/26 Fall document, dated 5/17/26, documented, The resident was in residents' room with staff (CNA) and slipped onto the floor. Nurse assessed resident. No injuries noted. No complaints of pain. Nurse and CNA assisted resident back to bed. Resident stated he was trying to use the restroom. Staff explained he had a brief on and assisted changing him when in bed. Statement from V12, 5/19/26: (V12) reported she walked by the resident's room and observed him sitting on the floor next to the foot of his bed. She called for the nurse who completed vitals and assessment before assisting him back to bed. Statement from V7, 5/19/26: (V7) interviewed (V7) who reported CNA alerted her to resident being on floor next to his bed and presumed he crawled onto floor from bed. She completed vital signs and assessment before assisting him back to bed. His condition was monitored throughout the rest of the shift. A Falls Clinical Protocol Policy, dated August 2008, documented, As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. In addition, the nurse shall assess and document/report the following: a. Vital signs b. Recent injury, especially fracture or head injury, c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc. d. Change in cognition or level of consciousness e. Neurological status f. Pain g. Frequency and number of falls since last physician visit h. Precipitating factors, details on how fall occurred i. All current medications, especially those associated with dizziness or lethargy. j. All active diagnoses. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. a. Falls should be categorized as a) those that occur while trying to rise from a sitting or lying to an upright position, b) those that occur while upright and attempting to ambulate, and c) other circumstances such as sliding out of a chair or rolling from a low bed to the floor. They should also be identified as witnessed or unwitnessed events. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. 2. On 5/22/26 at 9:15am, V4, Family Member of R1, stated the family has a friend who is a CNA at the facility who told them that about two weeks prior, R1 got out onto the smoking patio and was not noticed missing for 4 hours, and by the time he was found, R1 was freezing, his fingertips were blue from having gone without his oxygen, and his oxygenation level was low. V4 stated she did not want to reveal the CNAs identity as she feared losing her job. On 5/22/26 at 10:45am, V5, R1's Power of Attorney, stated she found out from V3, CNA, that on date and time unknown, (R1) had got out of the building and into the smoking area, they are not sure how it happened, and apparently there is no incident report on it. V5 stated when R1 was found he was cold and had blue fingertips. V5 stated she was told, They didn't send him to the ER (Emergency Room) but they thought about it. V5 stated the facility is known to (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prop open the smoking area door so independent smokers can go in and out on their own. On 5/22/26 at 1:05pm, V3 stated she was not sure of the date, but R1, Ended up in the smoker's area for about 4 hours and nobody realized he was out there. V3 stated she had found him there. V3 stated, He had been without his oxygen that whole time, and his fingertips were blue. It wasn't cold out, it was in the 80s. V3 stated R1 is a supervised smoker and she doesn't know if staff left him out there, if another resident helped him get out there, or if he self-propelled out there. V3 stated sometimes the alarmed door leading onto the patio is propped open with a rock so the independent smokers can go in and out without staff. V3 stated R1 was wearing a personal perimeter alarm, and V3 didn't remember if the door was propped open. V3 stated V9, Registered Nurse, checked his oxygenation level, and it was 87, and V9 put his oxygen back on him. V3 stated R1's oxygen level returned to his baseline within a few minutes. V3 stated it is her understanding that V2, Director of Nurses, was investigating the incident. V3 stated she informed R1's family about the incident. On 5/26/26 at 12:10pm, V8, RN, stated she does not remember the day, but does recall one of the CNA's telling her of finding R1 alone outside on the back smoking area and nobody knew how long he had been out there. V8 stated she did not recall him being blue or cold but did recall his blood oxygenation level being in the 80s. V8 stated staff put him in bed, put his oxygen on him and it returned to the 90's quickly. V8 stated she did not call the physician or the POA, nor document it, nor start an investigation, but one of the CNA's who is friends with the family called the family and reported it. V8 stated she didn't recall reporting it to the oncoming nurse at shift change. V8 stated she was not sure how he got out there but the residents often prop the door open so the unsupervised smokers can go in and out freely. V8 stated R1 could possibly have gone out by himself if the door was propped open. On 5/26/26 at 1:25pm, V2, when asked about the staff and family reports of R1 being left alone in the smoker's area, stated she had not heard anything about it. On 5/27/26 at 9:45am and 5/29/26 at 11:20am, there was a rock holding open the door to the smoker's patio. On both occasions, the Surveyor walked out onto the patio and back in without moving the rock, and the door alarm didn't sound. The adjacent fence gate did not have a lock and was easily opened, accessing a parking lot area. On 5/27/26 at 9:50am, R5 and R6, both alert and oriented, were observed on the smoker's patio and interviewed. Both stated they were acquainted with R1 and that he was a supervised smoker. Both stated they had never noticed him unsupervised on the patio. Both stated residents often prop the door open with a rock so that unsupervised smokers can come and go as desired. Both stated several residents know the door code to get out onto the area, but to get back in you must hit a buzzer to notify staff to let you back in the building. On 5/27/26 at 11:15am, V1, Administrator, stated he was unaware of any incident involving R1 and the smoker's patio. V1 stated he interviewed V3 and V8, and was told by V3 that V13, CNA, had also been working with R1 when it happened. V1 stated based on his interviews, date unknown, V3 asked V13 to locate R1 and R1 was located in the dining room by himself in his wheelchair. V1 stated these three interviews comprised the totality of the investigation. V1 was informed about finding the rock propping open the door and the gate with no lock. V1 stated there are cameras in the facility including the dining room, but it would take a long time to review them since the date of occurrence was unknown. On 5/27/26 at 1:05pm, V13 stated at about 1:30pm, date unknown, V3 asked him to look for R1, whom V13 stated was sitting in the dining room drinking coffee. V13 stated he was not blue or cold and was in no distress but tired. V13 stated they put him in bed, put his oxygen on him and checked his pulse oximetry which was 78. V13 stated they checked it again in 15 minutes and it was up to 88, and within a few more minutes it was in the high 90s. V13 stated he was unaware of any instances of R1 being alone on the patio for an extended period. V13 stated nobody is supposed to be propping open the patio door with a rock but, it is not being enforced. On 5/27/26 at 2:10pm, V1 stated V3 had requested to be reinterviewed. On 5/27/26 at 2:35pm, V3 stated she needed to clarify her previous interview. V3 stated she did not find R1 on the smoking patio alone, that V13 found him. V3 stated she was not aware of R1 being on the patio alone nor of R1 being without oxygen for an extended period. V3 stated she did not call R1's family to notify them of R1's fall or the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking patio incident. On 5/28/26 at 920am, V1 stated based on the staff working, he had determined the date of the alleged incident with the smoker's patio was 5/13/26. V1 stated he had checked video footage and noted that on that date at 12:59pm, R1 had been taken out to smoke with a housekeeping staff member and came back in the building with her at 1:20pm and was then in the dining room until retrieved by V13. On 5/29/26 at 10:20am-10:50am with V1 and V2 present, the video footage was observed from 5/13/26 at 11:55am. R1 was observed sitting in his wheelchair directly in front of the door of the smoker's patio. At 11:59am, a staff member was observed bringing the cart with smoking supplies into the dining room. R1 was then observed independently self-propelling through the door onto the patio. At 1:20pm, the staff member opens the door and R1 self-propels back into the building through the dining room and out of the cameras view. A 6/2/26 Elopement Risk Residents List provided by the facility identified R4, R8, R9, R10, R11, and R12 as residents who were confused, ambulatory, and at high risk for elopement. An Elopement and Search Guidelines Policy, dated 9/4/24, documented, 1. All nursing personnel are responsible for: A. Knowing the whereabouts of residents for which they are assigned. C. Staff are responsible for keeping the nurse informed of a resident's whereabouts. D. Observations are made at no less than two-hour intervals by nursing staff during scheduled activity programs, at meals, bedtime, and during medication and treatment administration. 3. Residents are not permitted to leave the building alone unless a physician order is present.		

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide administrative oversight to ensure the facility implemented their policy to facilitate cooperation with regulatory bodies in connection with IDPH (Illinois Department of Public Health) surveys. This failure has the ability to affect all 45 residents living at the facility. Findings include: R1's Face Sheet documented an admission Date of 3/18/26 and listed Diagnoses including Vascular Dementia, Atherosclerotic Heart Disease, and Chronic Obstructive Pulmonary Disease.R1's Minimum Data Set, dated [DATE], documented R1 had moderate deficits in cognition. R1's Care Plan, dated 4/30/26, documented a problem area, The resident is moderate risk for falls related to history of falls, poor safety awareness, impulsivity; resident sometimes crawls out of bed. A 3/18/26 admission Fall Risk Assessment documented that R1 was at high risk for falls.R1's Nursing Progress Notes, authored by V14, Licensed Practical Nurse, documented the following, with both notes being struck through (effectively deleted):5/19/26: Resident family arrived after being notified that he had fallen a couple days prior, once we were informed by a CNA (Certified Nursing Assistant) that (V7, Registered Nurse, Agency) told her that he fell, but stated he didn't really fall, he sat down on the floor. Upon arrival they called EMS (Emergency Management Systems) for transport to hospital.5/21/26: During morning hand off and reporting it was shared by (V7) as stated family was pissed about a fall that didn't happen, he didn't fall, he sat in the floor, he didn't get hurt on my watch, it happened after my shift. Then there's no way he broke anything that day. Then it was reported to me that the family called state, resident had surgery, a rod placed, and is not returning to facility, he is going to (another facility).On 5/27/26 at 1:55pm, V14, stated he was informed by V3, CNA, that R1 fell and V7 didn't document it or tell anybody about it. V14 stated he asked V7 about it, and she told V14, (R1) fell out of his chair. V14 stated he wrote the progress notes and V15, Clinical Nurse Consultant, Gave him a 30-minute lecture about not documenting too thoroughly because if the state comes in on this fall, they could see those notes and ask too many questions, and the information was based on hearsay, not facts. V14 stated the documentation was accurate and factual. V14 stated he felt V15's agenda in saying this was to encourage V14 to strike through those notes, which he then did.On 5/28/26 at 9:30am, V15 was asked if he knew why V14's progress notes had been struck through, and he said no. V15 stated, I had a conversation with (V14) about charting and that he should not chart hearsay or conversations with other staff members. V15 denied asking V14 to strike through the notes and denied making the statement that the state would ask too many questions. The Surveyor asked V15 if he believed V14 had struck through the notes as a result of the conversation, and V15 stated he didn't know. V15 stated in their computer system, only the author of the note can strike through it. On 5/28/26 at 10am, V1, Administrator, stated he felt he needed to inform the Surveyor that V14 had been terminated due to poor customer service, and he hoped the Surveyor had not been influenced by anything he might have said.A Regulatory Investigations Policy, dated January 2016, documented, Purpose: To facilitate cooperation with regulatory bodies in connection with their investigations/surveys. 1. All employees are expected to cooperate in investigations/surveys conducted by regulatory bodies.A Charting and Documentation Policy, dated August 2006, stated, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.A Resident Matrix, dated 5/22/26, documented a total of 45 residents living at the facility.		