STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145651	A. BUILDING ______ B. WING ______	C 02/16/2023

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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F 000	INITIAL COMMENTS Complaint Investigations: #2341088/IL156205 - F686 #2341082/IL156193 - No deficiency #2341174/IL156303 - No deficiency #2341272/IL156431 - F686 #2341375/IL156567 - No deficiency	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to assess and timely identify pressure ulcers/pressure injuries and provide treatment to prevent and/or prevent the worsening of pressure ulcers for 2 of 3 residents (R2, R3) reviewed for pressure ulcers in the sample of 16. This failure resulted in R2 developing an unstageable pressure ulcer requiring bedside debridement, and subsequently being sent to hospital for antibiotic treatment related to pressure ulcer infection.	F 686	Attachment A Statement of Licensure Violations	2/28/23

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

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.

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Findings include:

R2's Face Sheet, undated, documents R2 was admitted on 1/23/23 and had diagnoses of Cerebral Infarction, Hemiplegia to the Left Side, Dehydration, Metabolic Encephalopathy, Hypertension and Need for Assistance with Personal Care.

On 2/9/23 at 9:40AM, R2's pressure ulcer/pressure injury to the left buttock was observed. The pressure ulcer was approximately 7 centimeters (cm) by (x) 4cm with 2 areas of yellow slough in the center measuring approximately 2cm x 2cm each and the surrounding tissue was red and moist.

R2's Care Plan, dated, 1/23/23, documents R2 is at risk for altered skin integrity. The Care Plan documents the following Care Plan Interventions, dated 1/23/23: Apply barrier cream to buttocks/coccyx as needed; complete skin evaluation upon admission, weekly and as needed, notify nurse immediate of any new areas of skin breakdown, redness, blister, bruises, discoloration noted during bathing or daily care."

R2's Progress Note, dated 1/23/23 at 1:54 PM, documents R2 had no skin abnormalities identified upon admission.

R2's Progress Note, dated 1/23/23 at 2:34 PM documents "Skin warm dry and intact."

R2's Minimum Data Set (MDS), dated 1/26/23, documents R2 has moderate cognitive impairment, is at risk of developing pressure ulcers and does not have any pressure ulcers.

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F 686	Continued From page 2 There was no documentation in R2's record that R2's skin condition had been assessed from after the admission assessment on 1/23/23 until the area was identified on 2/4/23. R2's Progress Note, dated 2/4/23 at 6:00 PM, documents "Resident family visiting, curious about treatment order to resident's buttock. Treatment order reviewed with resident and reassured turning and repositioning frequently would continue, pillows used to offload left side to avoid further damage. Personal care provided frequently to avoid moisture associated dermatitis (MASD). Provider aware, family agrees with plan of care as well as resident." R2's Physician's Orders, Treatment Administration Orders and Progress Notes were reviewed and there is no documentation that a treatment order was obtained for R2's pressure injury which was identified in the Progress Note on 2/4/23. R2's Newly Identified Skin Condition, dated 2/4/23 at 8:50 PM, documents R2 has MASD with a skin tear noted to the left buttock measuring 5 cm x 4 cm x 0.1cm. Treatment order in place. The Skin Condition form documented "Reported to nurse that treatment was already obtained from earlier shift. Family aware and education reinforced with family on this shift." R2's Progress Note, dated 2/5/23 at 8:23 AM, documents "Resident's dressing changed to left buttock due to soiling. Measurements to area obtained 5cm (centimeters) x (by) 4cm skin tear with MASD noted. Treatment applied per order. Daughter at bedside. Resident states she doesn't	F 686		

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Continued From page 3

feel any pain to the area. The left side is compromised from previous CVA (Cerebral Vascular Accident). Frequent position changes continue. Staff communicated and educated to assist. Linens also changed this shift."

R2's Wound Evaluation and Management Summary, dated 2/7/23 by V19, Wound Care Physician, documents R2 presents with a wound on her left buttock. The Summary documented R2 has an unstageable (due to necrosis) of the left buttock for at least 9 days duration with moderate serous exudate. The Summary documents the pressure ulcer measures 7cm x 4cm x 0.3cm with 80% thick adherent necrotic tissue. The Summary documents R2's wound was cleansed and 5.6cm(2) of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.4cm. As a result of this procedure, the nonviable tissue in the wound bed decreased from 80% to 60%. The Summary documented "The best medical estimate of the time required for this wound to heal with continued physician evaluation and intervention is 62 days. This estimate is made with an 80% degree of certainty. Dressing treatment plan for calcium alginate and Santyl daily with a secondary dressing of gauze island border for 30 days."

On 2/8/23 at 10:50 AM, V4, R2's family, states R2 did not have any wounds/pressure ulcers when she came to the facility on 1/23/23 after a massive stroke. V4 stated a few days after R2 arrived she developed a "shear" to her back. V4 stated she saw the wound this past Saturday 2/4/23 and the dressing was off, the nurse replaced it but didn't clean it and didn't perform any hand hygiene. V4 stated the wound is more

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F 686	Continued From page 4 than a shear. V4 stated R2 saw the wound doctor yesterday and he debrided it and changed the wound care orders to Santyl. V4 stated the nurses don't follow the wound care orders and frequently when she comes in the mornings, the bandage is either soiled or not on and R2 is soiled with urine. V4 stated they have family coming in around the clock because R2 isn't being taken care of and they can't do this anymore, so they are transferring R2 to another facility. On 2/9/23 at 7:35 AM, V5, Registered Nurse, RN, states she admitted R2 and R2's bottom was red when she was admitted and then it opened up, like a sheared area, only the top layer of skin was gone, then over this past weekend, she noticed there was a dark area in the center of the wound, she notified the MD and got orders for a Medi honey dressing. V5 stated prior to that they were applying a protective foam dressing daily. V5 stated R2 is turned and positioned every 2 hours, she didn't like being off of her back, but she has gotten better with going onto her sides. V5 stated on a rare occasion, she has had residents that didn't get their wound dressing changed as ordered but this happens very rarely. On 2/9/23 at 9:40 AM, V15, LPN/Wound Care Nurse, states she saw R2's wound on Monday 2/6/23 for the first time and it was red with a dark area in the center, resembling a DTI (Deep Tissue Injury). V15 stated V19 came in on Tuesday 2/7/23, debrided it and changed the treatment order. V15 stated it looks much better today than it did on Monday, states the dark area is gone and now there is the yellow slough area, but it does look better. V15 stated residents with a pressure ulcer are turned and repositioned at a	F 686		

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F 686	Continued From page 5 minimum every 2 hours, more frequently if needed. V15 stated all residents are to have a skin check weekly. V15 stated the treatments are documented on the TAR when complete. R2's Fall Report, dated 2/10/23 at 6:20 AM, documented that R2 fell out of bed. On 2/14/23, at 12:06 PM, V4 stated that she requested that R2 be sent to the hospital after the fall and that R2 was admitted to the local hospital because her facility acquired pressure ulcer was infected and she is currently in the hospital on IV antibiotics. R2's Hospital Record, dated 2/10/2023 documents R2 was admitted to the hospital on 2/10/2023. The Record documented R2's pressure ulcer was cultured and was determined to be positive for Methicillin-resistant Staphylococcus aureus (MRSA). R2 was prescribed IV (intravenous) antibiotics Unasyn and Vancomycin. 2. R3's Face Sheet, undated, documents R3 had diagnoses of Paraplegia, Cardiomegaly and Hypothyroidism. R3's MDS, dated 12/20/23, documents R3 is cognitively intact, is at risk of developing pressure ulcers and has 2 stage 3 unhealed pressure ulcers. R3's Care Plan, dated 12/28/22, documents R2 has a pressure injury with an intervention for wound care as ordered by the physician. R3's Wound Progress Note, dated 2/8/23, documents R3 has stage 3 pressure ulcer to the	F 686		

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F 686	Continued From page 6 right ischium measuring 2cm x 2cm x 0.1cm. R3's Weekly Skin Integrity Review, dated 1/10/23, documents R3's stage 3 pressure ulcer to the right ischium measures 1cm x 2cm x 0.2cm. R3's Weekly Skin Integrity Review, dated 1/17/23, documents R3's stage 3 pressure ulcer to the right ischium measures 1cm x 2cm x 0.1cm. R3's Weekly Skin Integrity Review, dated 1/24/23, documents R3's stage 3 pressure ulcer to the right ischium measures 0.7cm x 2cm x 0.1cm. R3's Weekly Skin Integrity Review, dated 1/31/23, documents R3's stage 3 pressure ulcer to the right ischium measures 2cm x 2cm x 0.1cm. R3's Wound Culture, dated 12/31/23, documents R3's pressure ulcer, has a heavy growth of pseudomonas aeruginosa and streptococcus agalactiae. R3's Physician Progress Note, dated 1/4/23, documents R3 wound care continues to follow for wound on buttock. Was recently started on an antibiotic due to concern for infection in wound. R3's Treatment Administration Record (TAR), documents the following physician orders: 12/28/22 - 1/31/23 and 2/2/23 - 2/8/23 - Gentamicin Sulfate Ointment 0.1%, apply to right ischium every evening for wound; 12/28/23 - 1/31/23 and 2/1/23 - 2/8/23 - Santyl Ointment 250 units/gram, apply to right ischium every evening shift for wound. The TAR fails to document that the gentamicin or Santyl treatments were completed to R3's wound on 1/5/23.,1/9/23, 1/31/23 and 2/8/23.	F 686		

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F 686	Continued From page 7 On 2/8/23 at 1:10 PM, R3 states he has wounds to his bottom, and they change the dressings every other day. The "Wound Care" policy, dated 3/1/08, documents: "2. Skin will be assessed/evaluated for the presence of developing pressure injuries or other changes in skin condition on a weekly basis at least once each week or as needed by a licensed nurse. 6. Wound care procedures and treatments should be performed according to physician orders."	F 686		