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 03/09/2023

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 Investigation: 2341788/IL157072	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)5 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent, assess and monitor 1 of 3 residents (R3) reviewed for pressure ulcers in a sample of 19. This failure resulted in R3 developing an unstageable coccyx pressure ulcer that required debridement and developed into a Stage IV pressure ulcer. R3's Baseline Care Plan, dated 4/27/2022 documents resident is at risk for altered skin integrity. Interventions documented: apply barrier cream to buttocks/coccyx as needed, apply skin prep to heel(s) as needed, avoid prolonged periods of skin to skin contact, complete Braden Risk Assessment upon admission, quarterly and as needed, complete skin evaluation upon admission, weekly, and as needed, consult dietician as needed, discuss non-compliance issues with resident/responsible party and	S9999		

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S9999	Continued From page 2 educate about primary risk factors and prevention PRN, (when needed), and notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care. R3's Quarterly Minimum Data Set, (MDS), dated 10/14/2022 documents moderately cognitively impaired, limited assist of one person for bed mobility, transfers, personal hygiene, toilet use and dressing. Walked with one-person physical assist. At risk of pressure ulcers. No pressure ulcers. R3's Nursing Readmission Assessment, dated 10/25/2022 documents no pressure ulcers. The Facility's Assessment Outcomes documents R3's Braden Scale, (risk for pressure ulcers), dated 10/25/2022 documents moderate risk. R3's Admission Summary Progress Note, dated 10/25/2022 at 6:45 PM documents no pressure ulcers. R3's Progress Notes dated 10/25/2022 through 11/01/2022 documents no assessment of R3's skin. R3's NRS, (Nursing), Wound Progress Note, dated 11/01/2022 documents a facility acquired left buttock unstageable pressure ulcer (The NPUAP, (National Pressure Ulcer Advisory Panel) at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf documents the definition,) "Unstageable Pressure Injury: Obscured full- thickness skin and tissue loss, Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer	S9999		

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S9999	Continued From page 3 cannot be confirmed because, it is obscured by slough or eschar. If eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed." Measured 4 centimeters, (cm), by 4 cm. Wound bed tissue: firmly adherent eschar with no undermining/tunneling. Wound edges were attached and defined. No odors or drainage. Surrounding tissue intact. R3's Initial Wound Evaluation & Management Summary, dated 11/01/2022 documents R3 has an unstageable DTI, (deep tissue injury), of the left buttock for at least 10 days duration. The pressure ulcer measured 4 cm by 4 cm with no exudate, (drainage). Recommendations: limit sitting to 60 minutes and reposition per facility per protocol. R3's Wound Evaluation & Management Summary, dated 11/08/2022 documents unstageable DTI to left buttock was resolved. New Unstageable pressure ulcer, (due to necrosis), on coccyx measured 2 cm x 2 cm x 0.2 cm with moderate serous exudate. 100% thick adherent necrotic tissue. A new Stage III pressure ulcer of the left medial buttock measured 1 cm x 2 cm x 0.1 cm with moderate serous exudate.100% granulation tissue. No recommendations documented. R3's Significant Change MDS, dated 11/08/2022 documents moderately cognitively impaired, total dependence with 2 physical assist for bed mobility, toilet use and transfers. Walking did not occur. Extensive assist of one person for dressing and personal hygiene. At risk for pressure ulcers and has a Stage III and an unstageable pressure ulcer. R3's NRS Wound Progress Note, dated	S9999		

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S9999	Continued From page 4 11/09/2022 documents "Left buttock Stage IV pressure ulcer resolved. A new facility acquired coccyx unstageable pressure ulcer measured 2 cm x 2 cm x 0.2 cm. Wound bed had firmly adherent eschar with no undermining/tunneling. Moderate serous drainage. No odor. Surrounding tissue intact. A new facility acquired left medial buttock Stage III pressure ulcer on measured 1 cm x 2 cm x 0.1 cm. Wound bed firmly adherent granulation tissue. No undermining/tunneling. Moderate serous drainage. No odor. Surrounding tissue intact". R3's Wound Evaluation & Management Summary, dated 11/15/2022 documents "Stage IV pressure ulcer on coccyx full thickness measured 4 cm x 2 cm x 0.2 cm with moderate serous exudate with 100% thick adherent necrotic tissue wound progress: deteriorated. Stage III pressure ulcer left, medial buttock measured 1 cm x 2.2 cm x 0.1 cm with moderate serous exudate, 10% slough and 90% granulation tissue. Wound progress: no change. No recommendations documented." R3's Care Plan documents it was not updated after she was readmitted to the facility on 10/25/2022. It did not address R3 was refusing ADLs, pressure ulcer treatments, to get out of bed or to turn/reposition or to eat. R3's Physician's Order Sheet, (POS), dated 11/01/2022 through 12/11/2022 documents pressure ulcer treatments were ordered. R3's Treatment Administration Record, (TAR), dated 11/01/2022 through 12/11/2022 documents staff documented pressure ulcer treatments was administered per physician's orders.	S9999		

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S9999	Continued From page 5 On 3/08/23 at 11:10 AM, V39, R3's family representative stated, "In my opinion, if they were turning (R3) every 2 hours like they were supposed to (R3) wouldn't have developed pressure ulcers in the first place. I usually visited two or three times a week for at least an hour. I had to bring pillows from home so they could help prop her up and reposition. (R3) probably did refuse to be turned at times, but I always helped encourage her when I was at the facility up until the very end." On 3/08/23 at 10:28 AM, V38, LPN/Treatment Nurse, stated, "I don't recall (R3) ever having any open areas. I know for a while the CNAs were putting barrier cream on her bottom because, there was a mild redness there. It was blanchable, and they were proactive with putting that on her right away. We tried to turn her from side to side and put a pillow behind her, but she would always pull the pillow out and scoot over on the bed. I talked to (R3) about why it was important to turn and reposition and what could happen if she didn't. I might have documented that; it would be in the nurse's notes. I don't ever remember the family refusing (R3) to be turned and repositioned, but they usually tried to encourage her and help us out that way. I don't think I ever reported it because, it was just a little red and blanchable." R3's Electronic Medical Record, dated 10/25/2022 through 12 documents no skin breakdown or redness and no documentation R3 refused to turn/reposition or that she refused pillows for positioning. On 3/08/23 at 10:40 AM, V40, LPN/Treatment Nurse, stated, "Every resident here can get barrier cream. It's a standing order on admission.	S9999		

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S9999	Continued From page 6 I never put barrier cream on (R3) and I don't know if she was getting it." On 3/09/2023 at 8:15 AM V40, LPN/Treatment Nurse stated, she does wound treatments at the facility when the wound specialist sees residents. V40 didn't assess R3's skin upon readmission on 10/25/2022, that would have been the floor nurse. She couldn't recall if she did wound rounds with the wound specialist on 11/01/2022 or not but, that she would have done the wound treatment after 11/01/2022. V40 recalled the left buttock pressure ulcer "spread out" to the coccyx and that became one pressure ulcer. V40 couldn't recall when the left buttock pressure ulcer began to "spread" to the coccyx or if she notified anyone of this occurring. V40 drew a picture of R3's pressure ulcer progression on a piece of paper, a small circle was drawn representing the left buttock pressure ulcer and a small circle was drawn representing the coccyx pressure ulcer; V40 connected the 2 separate circles/pressure ulcers to show the one coccyx pressure ulcer and colored the circle in to show that it was it black/necrotic. V40 stated, the coccyx pressure was black but, it did open at one point and there was tunneling. On 3/08/2022 at 9:17 AM V2, Director of Nursing, (DON), stated, (R3) was readmitted to the facility after she had a fall and a right hip fracture in 10/2022. After (R3) was readmitted to the facility she was in a lot of pain and often refused to turn and reposition and her psychiatric behaviors got worse. (R3) had a standard pressure relieving mattress. (R3) was resisting care including pressure ulcer treatment. (R3's) family was here visiting often and they would tell staff not to touch (R3) because, she was in pain. V2 started talking to (R3's) family regarding hospice the day she	S9999		

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S9999	Continued From page 7 was readmitted, but they weren't ready for that. V2 stated, from the get go she knew when (R3) developed the facility acquired pressure ulcer on her buttocks/coccyx area she knew it would be bad. On 3/08/2023 at 1:30 PM V27, Physician's Assistant stated, when (R3) was readmitted to the facility after she broke her hip she refused therapy, refused to eat, refused to get out of bed and refused to turn/reposition. He expected staff to frequently turn and reposition (R3) to prevent skin breakdown. If (R3's) buttocks/coccyx was red staff should have applied barrier cream or a comfort pad to prevent direct pressure to the area and should have documented the reddened area in (R3's) electronic medical record. He expected staff to document when (R3) refused activities of daily living, (ADLs). Staff should have done their best to ensure (R3) was on her side to prevent skin breakdown on her buttocks/coccyx. He expected staff to follow the skin/pressure ulcer policies and procedures. On 3/09/2023 at 9:00AM V27, Physician's Assistant stated, he took care of (R3) medically and the wound specialist took care of her wounds. It is abnormal for normal skin to become necrotic but, it could be that the previous pressure ulcer was tunneling and created a fistula connecting to the other pressure ulcer, it had to be pretty advanced at that point. The facility treatment nurse should have notes regarding R3's pressure ulcer. When you think of skin/pressure ulcers think of an iceberg you only see the top of the iceberg 10%, you can't see the other 90% of the iceberg and by the time you do its pretty advanced. On 3/08/2023 at 10:15AM V37, Wound Specialist	S9999		

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S9999	Continued From page 8 stated, he didn't recall R3 as a resident, he has over 1,000 residents he sees a month and couldn't recall R3 specifically. The facility should document a head-to-toe skin assessment upon admission and readmission, keep the resident clean and dry and follow the facility's positioning and skin policies/procedures. If the resident was refusing to reposition/wound treatments he expected staff to document that in the resident's medical record. The Facility's Wound Care policy, revised 3/27/2021, documents it will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. Guidelines: preventive measures, such as barrier creams can be employed to help maintain skin integrity as well as utilization of pressure relieving surfaces, floating heels, protective boots and use of positioning devices. Use of barrier creams may vary according to product and may be used following incontinent care for additional prevention, provided there is no clinical contraindication. (B)	S9999		