STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014658	A. BUILDING: _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

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S 000	Initial Comments Complaint Investigation #2312500/IL157995.	S 000		
S9999	Final Observations Statement of Licnsure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 requirments are not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify a pressure ulcer for 1 resident, failed to provide wound care in a manner to prevent infection for 1 resident and failed to perform and document weekly wound assessments for 1 resident. These failures	S9999		

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S9999	Continued From page 2	S9999		

resulted in R1 obtaining a stage 3 pressure ulcer to her sacrum requiring debridement. These failures apply to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 17.

The findings include:

R1's electronic face sheet printed on 3/30/23 showed R1 has diagnoses including but not limited to frost bite with tissue necrosis of left hand and fingers, nontraumatic intracerebral hemorrhage, rhabdomyolysis, and hypertension.

R1's facility assessment dated 3/1/23 showed R1 has no cognitive impairment, requires 2+ staff assistance with bed mobility, is at risk for developing pressure ulcer injuries, and has no current pressure ulcers as of 3/1/23.

R1's care plan dated 3/20/23 showed, "The resident is resistive to care related to repositioning and cares. Allow the resident to make decisions about treatment regimen, to provide a sense of control ...educate resident/family/caregivers of the possible outcomes of not complying with treatment or care as needed."

R1's care plan dated 3/10/23 showed, "The resident has pressure injury to sacral area related to incontinence, limited/impaired mobility. Assist with turning and positioning if resident is able. Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, edema noted during bathing or daily care. Report changes in skin status (ie: non-healing or new areas) to nurse/physician."

R1's wound physician note dated 3/8/23 showed, "This patient has multiple wounds ...Stage 3

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S9999	Continued From page 3 pressure wound sacrum full thickness ...etiology: pressure ...duration > 5 days ...wound size 5.5x7.6x0.2cm (centimeters) ....light serous exudate (light clear drainage)....surgical excision debridement procedure ...curette was used to surgically excise 8.36 square centimeters of devitalized tissue including slough, biofilm and non-viable subcutaneous level tissue were removed at a depth of 0.3cm." R1's wound physician note dated 3/1/23 showed no documentation of R1 having a stage 3 pressure ulcer to her sacrum. (1 week prior to identification of R1's stage 3 pressure ulcer). R1's medical records showed no weekly wound assessments have been performed by the facility for R1 since 2/22/23. (5 weeks) On 3/29/23 at 9:36AM, V14 (wound care nurse) and V15 (Registered Nurse) were providing wound care to R1's sacrum. V14 applied Dakin's solution to a 4x4 gauze then blotted the wound 8 times with the same side of the gauze. V14 then folded the gauze and blotted the wound again several times. V14 stated larger wounds are cleansed from the center towards the outer edges but R1's wound is smaller and difficult to do that. V14 stated R1's wound definitely should have been identified prior to a Stage 3 during her weekly skin assessments. V14 stated, "For new admissions, I do the wound care assessments and (V19-wound physician) does the weekly measurements and assessments. This is only my second week here so I can't speak to (R1's) initial wound assessment." On 3/29/23 at 1:29PM, V2 (Director of Nursing) stated, "I would expect all wounds to be identified prior to a stage 3. They should be identified as soon as possible, ideally at a stage 1 but	S9999		

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S9999	Continued From page 4 sometimes they aren't caught until a stage 2 but a stage 3 is definitely way too late. Wounds should be cleansed from the center towards the outer edges to prevent bacteria from getting into the wound. When a new wound is identified, the floor nurse will do an assessment on the wound if the wound nurse is not in the building and then notify her of the wound. The floor nurse is responsible for calling the physician and obtaining treatment orders to be utilized until the wound physician visits the resident. Wound assessments should be documented on the wound assessment, weekly skin assessment, or progress note. I don't really care where they put it as long as it's done and treatment is initiated. Our weekly wound assessments are completed by our wound physician and then scanned into the medical record. I wasn't aware we had to document our own assessment in the medical record as well." On 3/31/23 at 1:52PM, V19 (Wound Care Physician), stated, "If there is any new wound I would look at it, there's no way I wouldn't assess an area that the facility told me about. (R1's) stage 3 pressure wound should have for sure been identified prior to a stage 3. They visualize that area multiple times a day and are instructed to report any changes to the skin to the nurse right away. If a true skin assessment was being performed, they would have identified this earlier at a stage 1 or even stage 2. When cleansing a wound, staff should not dab the area because of two reasons, one of them is infection control and the other reason is your not getting the full effect of the cleaning solution being applied. I'm not saying they should sit there for 10 minutes with the area saturated but they should at least saturate the gauze and clean the area in the correct manner."	S9999		

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S9999	Continued From page 5 The facility's policy titled, "Wound Care" revised on 3/27/2021 showed, "It will be the standard of this facility to provide assessments and identification of residents at risk of developing pressure injuries, other wounds, and the treatment of skin impairment ...6. Wound care procedures and treatments should be performed according to physician's orders. 7. Wound care treatment should maintain proper technique, as is indicated by the type of wound and physician orders. 8. Preventative 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 ...10. Document in the clinical record when treatments are performed. 11. Document the progression of the wound being treated. Such observations should include items size, staging (if applicable), odors, exudate, tunneling, etiology, etc." (A)	S9999		