

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2022
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NAME OF PROVIDER OR SUPPLIER RIVER CROSSING OF ROCKFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 1660 SOUTH MULFORD ROCKFORD, IL 61108
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S 000	Initial Comments Complaint Investigation: 2218236/IL152282 2218426/IL152499	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)3) 300.1210d)6) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician</p> <p>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.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents</p> <p>These requirements are not met as evidenced by:</p> <p>A. Based on observation, interview, and record review the facility failed to ensure a resident with dementia received prompt medical care for a closed femur fracture. This resulted in R1 sustaining an injury of unknown origin on 10/11/22. R1 remained in the facility and was transferred multiple times on the fractured left femur. R1's Left Femur X-ray was completed on 10/12/22 (more than 24 hours after the first signs of injury). The facility failed to ensure wound vac orders were entered into R4's EMR (Electronic Medical Records) and failed to ensure these treatments were documented in R4's TAR (Treatment Administration Record). This applies to 2 of 4 residents (R1, R4) reviewed for quality of care in the sample of 7.</p> <p>B. Based on observation, interview, and record review the facility failed to ensure the safety of a resident with dementia that required staff assistance for ADLs (Activities of Daily Living). This failure resulted in R1 sustaining a left femur fracture of unknown origin. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 7.</p> <p>The findings include:</p> <p>1. On 10/19/22 at 1:15 PM, R1 was sitting in her wheelchair in the small dining room with a lunch tray in front of her. R1 was slightly tilted in the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>wheelchair with a pillow placed under her left leg. R1 had facial grimacing, constant moaning, and was rubbing the top of her left thigh. At 1:31 PM, R1 exclaimed, "Oh dear! Dear God!" R1 had facial grimacing, was whimpering, and was pulling on her left pant leg. R1's left leg had slipped off the pillow and footrest that was supporting it. R1's leg was hanging between the footrests, hovering above the ground. R1 stated, "oh, owww... It hurts!" At 1:34 PM, R1 stated, "I can't do it." R1 was fidgeting with her left leg, then tried to reach for items on her tray. R1 continued to moan and rub her left thigh. At 1:39 PM, V7 (CNA - Certified Nursing Aide) told R1 she would be right back to help her get back to bed. V7 walked to V4 (RN - Registered Nurse) and asked if R1 could have anything for pain. V4 replied, "I just gave her something a little while ago." Then V4 and V7 looked over at R1. V4 continued, "Oh look, her leg is not how you left it." V4 and V7 approached R1's wheelchair. V7 (CNA) gently lifted R1's left leg back onto the pillow and footrest. During this movement, R1 loudly said, "Oh, ow!" and reached for her left leg. V7 apologized and stated, "I'm sorry, but we have to make sure your leg is supported. She had a lot of therapy today. I'm sure she's tired." At 1:43 PM, V7 (CNA) pushed R1's wheelchair back to her room and V4 obtained the total lift machine. When V7 passed the sling arm between her legs, R1 stated, "Owww, That's sore." R1 moaned throughout the lift transfer and when V4 and V7 rolled her side to side in the bed R1's body stiffened. R1 said "Owww!" R1 had an ACE wrap from her mid, left thigh down to the middle of her foot. R1's left foot was noticeably swollen with a light purple discoloration, mixed with some green and yellow hues. R1 had varying stages of bruising extending from her left, posterior flank (mid-back), into her pelvis/groin area, and down</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>her left thigh to the top of the Ace Wrap. R1 was thin, cachectic, and her joints were protruding and easily observed. The outline of R1's pelvis, hips, and knees could be observed. R1 had varying stages of bruising to her right cheek, forehead, and bilateral arms.</p> <p>The facility's Final Report dated 10/19/22 showed, "Description of Event: R1 was admitted to the facility with the following diagnoses: Age-related osteoporosis without current pathological fracture; primary osteoarthritis of bilateral knee; history of falling; other symptoms and signs involving the musculoskeletal system; presence of bilateral artificial knee joints; abnormalities of gait and mobility; muscle weakness; Alzheimer's Disease; repeated falls; NASH (Non-Alcoholic Steatohepatitis); reduced mobility; dementia; anxiety disorder; and need to assistance with personal care... R1 noted to have some swelling and complaints of left knee pain on 10/11/22... Preliminary review shows resident's plan of care was being followed at the time of fall... On 10/12/22, X-ray resulted in a femur fracture; NP (Nurse Practitioner) called to relay result; orders to send resident out to hospital for further evaluation and treatment..."</p> <p>The facility's Fall Log dated 7/18/22 - 10/18/22 showed R1 had 5 falls (2 unwitnessed).</p> <p>R1's facility assessment dated 7/26/22 showed she had severe cognitive impairment; required limited assistance of one staff member for bed mobility and transfers; required extensive assistance of one staff member for toilet use and personal hygiene; was incontinent of bowel and bladder; and had a fall since admission that resulted in injury (except major), includes skin tears, abrasions, lacerations, superficial bruises,</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.</p> <p>R1's Progress Note dated 10/11/22 at 4:21 AM showed, "Aide alerted this nurse that residents left knee appeared swollen with complaint of mild pain. Upon assessment found residents left knee to be visually swollen, cool to the touch, pedal pulse present. Resident offered pain medication to which was denied. NP notified, will continue to monitor. The next Progress Note in R1's EMR was at 3:43 PM. This note showed, "left knee X-ray to be completed by (contracted X-ray company)." There were no further progress notes written, assessing R1's swollen left knee until 10/12/22 at 8:44 AM. This was a change in condition note for trauma (fall related or other) and it showed, R1 had complaints of left knee pain with increased swelling. R1 was assessed, an X-ray was completed, and R1 was sent to the emergency room. (There is no progress note showing when R1 left the facility with EMS).</p> <p>R1's NP Visit dated 10/11/22 at 7:20 AM, showed, "Chief complaint: left knee pain, falls, OA (Osteoarthritis), DM (diabetes), HTN (hypertension)... She is having pain in her left knee. She has a history of frequent falls and has been noted to have increased swelling in her ... knee. She has pain with any kind of movement. No bruising or erythema noted. ROS limited due to patient's cognitive status. She appears pale today as well. She is lethargic and interaction is limited... Contusion on forehead improving... General weakness, OA chronic, left knee markedly larger than right, pain with extension and flexion, + crepitus (grating sound when joint moved) ... 7. Debility/fall risk: Continue facility fall precautions to promote safety and prevent injury... Recent fall with contusion. Monitor</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>frequently to assist with ADLs...Plan: BMP (Basic Metabolic Panel) and CBC (Complete Blood Count) labs ordered, and X-ray of left knee ordered..."</p> <p>R1's Left Knee and Femur X-ray completed on 10/12/22 at 8:35 AM, showed, "The knee joint is in alignment, but there is narrowing of the joint space due to mild degenerative changes. There is mild degenerative spurring involving tibial spine and femoral condyles. There is an acute fracture distal femur with marked angulation... There is a fracture involving the distal femur with moderate displacement and angulation. The remainder of the femur is intact. Acute appearing left femur fracture..."</p> <p>R1's ED Notes Addendum dated 10/12/22 at 9:28 AM showed, "Patient comes from (facility), left femur fracture, swelling x 2 days, unknown cause, high fall risk, alert and oriented to pain only, history of dementia, no meds given by EMS. Vitals stable per EMS. On assessment patient has swelling to left upper leg, bruising to right forehead with different stages of healing, and bruising to right cheek bone. Facility denies any falls."</p> <p>R1's Pelvis X-ray completed at the hospital on 10/12/22 showed diffuse osteopenia involving the pelvis and an acute displaced and mildly angulated fracture involving the distal femur.</p> <p>R1's Ortho Consult dated 10/12/22 showed, "...Sustained interprosthetic femur fracture. Pt fell at nursing home. She has dementia and doesn't ambulate. She does use her legs to transfer. Recommend fixation of fracture for patient to comfortably use legs to transfer..."</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>R1's Hospital Records printed 10/14/22 showed R1 had surgical repair of her left femur fracture and received blood transfusions.</p> <p>On 10/18/22 at 8:00 AM, V33 (R1's Family Member) said she received a call on Wednesday morning, before 9:00 AM (10/12/22) that R1 fell and broke her femur. I asked how and they told me, "They don't know." They did an X-ray, and she had a femur fracture and a corkscrew fracture of her pelvis. I just don't know why they aren't saying anything. I had a meeting with V2 (DON), V14 (Social Services Director), V17 (Rehab Director), and V18 (NP)."</p> <p>On 10/18/22 at 1:49 PM, V7 (CNA) said she worked 10/10/22 during the day shift and R1 was fine. I came back in on the next morning and the third shift CNA (V12) reported to me that she had some swelling in her knee. I went in to see R1 with V4 (RN). Her left knee was swollen, but she got up that day and was up most of the day (10/11/22). By the next morning (10/12/22) she was complaining of pain. We don't know what happened.</p> <p>On 10/18/22 at 2:05 PM, V4 (RN) said she left work at 9:00 PM on 10/10/22 and R1 was fine. When I came back into work on 10/11/22, V10 (RN) said R1's left leg was swollen. I asked V2 (DON) if the NP was coming in to see R1, then I went to assess R1. This was new swelling that we had never seen before, but V10 (RN) said nothing happened. V13 (NP) assessed R1 and ordered the X-rays that morning. The X-ray was done on 10/12/22. The radiology tech told me that it didn't look right, and I let V2 (DON) and V18 (NP) know right away. R1 was sent to the emergency room before the X-ray report came back. It was surprising that R1 had a fracture because there</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>was no trauma that we know of. I let V33 (R1's Family Member) know that R1 had a femur fracture and she wanted to know what happened. She was upset and I let her vent.</p> <p>On 10/18/22 at 2:30 PM, V13 (NP) said R1 had marked swelling in her left leg, and she ordered an X-ray. At that time, R1 had a good pedal pulse, no bruising, and no reported fall. She does have osteoporosis, but I have no idea what happened. She had no other signs or symptoms of trauma at that time, so I ordered the labs and X-ray routine, not STAT (immediately).</p> <p>On 10/19/22 at 7:26 AM, V12 (CNA) said he did his normal routine when he arrived to work the evening of 10/10/22. I went into R1's room around 12 - 12:15 PM. I noticed that her cries sounded more agitated than usual. She does moan and say help me regularly, but this was different. I pulled back her blankets and noticed her swollen knee right away. R1 said, "My leg," and she usually doesn't talk like that. The nurses (V9 and V10 - RNs) came in to assess her. One of them said, "I hope it's not a clot. We'll continue to monitor it and they told me not to move it." I did not get any report of falls on the previous shift. And I did minimal care that night.</p> <p>On 10/19/22 at 7:32 AM, V10 (RN) said V12 (CNA) got me and said that R1's leg was swollen. I checked it out and it was noticeably swollen and cooler than her right leg. V9, a nurse from the other hall, came over too. We could move her leg and V9 said he could feel a pedal pulse. I sent a text message to V18 (NP) and let V3 (ADON) know.</p> <p>On 10/19/22 at 7:36 AM, V11 (CNA) said she heard a commotion early in her shift (10/10/22</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>10PM - 6 AM). R1 was yelling, "Help." and V10 (RN) went to check on her. R1 said something about her leg. V10 came out of R1's room and got another nurse to look at her leg. She threw up earlier that night too. She threw up when we just got there. V12 (CNA) checks all his resident's right away and when he got to R1's room she had already thrown up and the 3-11 CNA was changing her. The 3-11 CNA said R1 already threw up once and "I'm not changing her again." I've seen someone puke from a broken bone before, but nobody reported that R1 had fallen.</p> <p>On 10/19/22 at 7:55 AM, V15 (Orthopedic Surgeon) said he assessed R1 when she came into the hospital on 10/12/22. R1's fracture could be caused from any kind of fall, drop, or twisting motion. It is possible that R1's fracture was pathological but is most commonly from trauma. V15 said left knee swelling combined with a cold extremity and a weak pedal pulse are signs of a potential blood flow concern and medical treatment should be provided as soon as possible.</p> <p>On 10/19/22 at 10:30 AM, V3 (ADON) asked, he said he called me? I don't recall the conversation. I get a lot of calls in the middle of the night. V10 will usually call and text me if there is a fall, but I don't have any texts from V10 on that day (10/11/22). This surveyor asked what he would have done if V10 had reported that R1's left leg was markedly swollen, her pedal pulse was weak, and her left leg was much cooler than the right leg. V3 replied, I would have told him to notify the NP. There was no fall reported to me. I would have reviewed R1's notes to see if this is out of her norm. If it's new, then I would know that something was going on. Who knows what happened? She may have bumped her knee or</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>twisted it during a transfer. R1 was able to stand and pivot with one assist. We tried getting her up yesterday and she had facial grimacing and moaning, so we stopped.</p> <p>On 10/19/22 at 11:18 AM, V19 (CNA) said she was R1's CNA on 3-11 PM shift, on 10/10/22. R1 can be shaky at times with transfers. I'm not sure who helped me put R1 to bed on 10/10/22. It was pretty busy that day. (V21, V22, V23, and V24 (CNAs) were interviewed and none of them assisted with transferring R1 that evening). R1 was yelling "Help! Help!" when I went in the room, she was sitting up on the bed with her legs hanging over the side. I was off for a couple days and R1 wasn't there when I came back. I asked where she was, and they told me she was in the hospital. I didn't know she got hurt.</p> <p>On 10/19/22 at 12:05 PM, V9 (RN) said he was working on a different hall when V10 came down to the nurses' station. V10 said he was concerned about R1 because her leg was swollen, extremely cold, and he couldn't feel a pedal pulse. I went into R1's room. I could feel a faint pedal pulse. R1's leg was cold. I was able to move R1's leg. It's hard to tell if she's in pain because R1 is always moaning or saying, "help." I told V10 to call the NP and documented his assessment. I told him that he should ask for orders for a Doppler study and/or an X-ray. I did not see the NP come in; it was the middle of the night. If there is an emergency, then we can call them or the on-call service. If it's not an emergency, then we just text the NP. During shift change, I heard V10 tell the day shift nurse that R1 needed an order for an X-ray. I didn't see X-ray come that night. This should have been considered an emergency because her leg was cold, and the pedal pulse was faint. R1 could have had a blood clot or lost</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>her leg. I expected V10 to call the NP. I went back to my assigned residents, and I just assumed he had called the NP.</p> <p>On 10/19/22 at 2:43 PM, V20 (LPN) said R1 is pleasantly confused. She will moan or say, "help me," but usually she just needs the toilet or to lay down. I remember getting in report (10/11/22) that R1 had swelling to her left knee, but she was sitting in her wheelchair in the small dining room when I came in. I remember a night when a CNA was saying that R1 had vomited, and it happened between shifts. It happened at the very end of 2nd shift. The night CNA (V12) said R1 had vomited, and he was looking for the 3-11 PM CNA. If R1 had a swollen leg, faint pulse, and her leg was cooler than the other, then that would be an emergency. I would call the NP, not text her.</p> <p>On 10/20/22 at 9:14 AM, V13 (NP) said she was notified that R1 had leg swelling right when she walked into the facility (10/11/22). I assessed her immediately. The staff have our cell phone numbers and they can reach out to myself or V18, but there is also an "on-call service." V18 sent me a text at 8:23 AM on 10/11/22, so V10 must have texted V18 during the evening. The only information that was provided was that R1's leg was swollen. I was not told that her left leg was considerably colder than her right or that she had a weak pedal pulse. If I was told, then I would have asked more questions. How is the capillary refill? What is the color of the limb? I didn't get that in my notification. A fracture could cause these symptoms, that's why I ordered an X-ray. When I assessed R1, her whole body was pale, and she didn't look like herself. That's why I also ordered labs. I had done a CBC last month and it was normal, but she was very pale. The nurses are supposed to call us if there is an emergency</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>situation. No one reported to me that R1 was vomiting. I've seen vomiting from pain associated with a fracture. I specifically asked if she had fallen and I was told, "No, not since the last time (10/1/22)."</p> <p>On 10/20/22 at 9:57 AM, V18 (NP) said she was notified, via text message at 4:27 AM on 10/11/22, that R1 had swelling in her left knee, but her pedal pulses were present. The text reported that R1's legs were cool to the touch, but there was no evidence of trauma. I did not wake up to this text message. If the nurse calls me, then I wake up. The nurses know they are supposed to call us or the "on-call service," in the case of an emergency. The text didn't make sense to me. I think it was an incomplete assessment. If V10 (RN) would have called me, then I would have walked him through a more thorough assessment. If I was worried about vascular compromise, then I would have sent R1 to the emergency room right away. When V13 (NP) assessed R1, she did not report faint pedal pulses or a cold extremity. With a displaced femur fracture, it is possible for the bone to move and change the assessment of R1's leg. R1 vomiting was never mentioned to me.</p> <p>The facility's Change in Condition Policy (revised 3/27/21) showed, "It will be the standard of this facility to notify the physician, family, resident, and/or responsible party/resident representative of significant changes in condition and providing treatment(s) according to the resident's wishes and physician's order. Guidelines: 1. Observe resident during routine care and during monthly/quarterly/annual assessment periods to identify significant changes in physical or mental conditions, orientation, change in vital, weights, etc. 2. When a change is noted, gather pertinent</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>data... 4. When significant change sin skin condition or weight are noted, it is appropriate to contact the physician and responsible party/resident representative to notify them and receive orders such as consultations, root cause analysis or implementation of further monitoring. 5. Contact licensed co-workers for assistance if the change in condition is considered potentially life threatening... 7. Contact the primary physician to update him/her to change in condition... 8. If the resident's condition is considered to be life threatening and the resident requires immediate medical care, notify the emergency medical system (911) ... 11. Notify the family or resident party/resident representative regarding the resident condition change and need to send to hospital or notify emergency services of transport..."</p> <p>The facility's Fall Policy (revised 3/27/21) showed, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls..."</p> <p>The Illinois Long-Term Care Ombudsman Program: Residents' Rights (revised 3/17) showed, "You have the right to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction..."</p> <p>2. R4's Admission Record, provided by the facility on 10/20/22 showed she had diagnoses including encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and encounter for change or removal of surgical wound dressing. R4's facility assessment dated</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>9/27/22 showed she had surgical wound(s).</p> <p>On 10/19/22 at 6:06 PM, V32 (R4's family member) said R4 was admitted to the facility from (a local hospital) after a fall and subsequent need for a wound vac machine for a wound on her right leg. V32 said R4 also had another wound that required a dressing on her left leg.</p> <p>R4's progress note dated 9/24/22 showed "Patient arrived from (a local hospital) via two person assist bed stretcher ambulance.... Diagnoses: Post fall incident at home; right lower leg hematoma, underwent an evacuation procedure on 8/27, wound vac dressing in place, clean and intact..." R4's progress note dated 9/26/22 showed "Resident's wound vac monitor displaying air leak. Wound reinforced with transparent dressing but still displaying air leaks. Wound vac dressing taken out and was reinforced with wet to dry dressing. ADON (Assistant Director of Nursing), and wound nurse notified. Family notified."</p> <p>R4's electronic medical record did not show any orders for a wound vac on her right leg, or a dressing change for the wound on her left leg. R4's 9/1/22-9/30/22 Medication Administration Record and Treatment Administration Record did not show any orders for the wound vac to her right leg or dressing change to her left leg.</p> <p>On 10/20/22 at 9:43 AM, V25 (Wound Nurse) said she did an assessment on R4's wounds on admission. V25 said she did not do any other assessments of R4's wounds. V25 said she changed the dressing on R4's legs prior to her being discharged, however she did not document any assessment or that a dressing change was completed. When asked what the orders were</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>for R4's wound vac and dressing changes, V25 said she was not sure. This surveyor asked her to make a copy of R4's orders regarding her wound care needs. V25 said she would have V2 (Director of Nursing-DON) make a copy. At 12:43 PM, V2 (DON) said the orders from R4's discharge regarding her wound vac and wound care were not transcribed into R4's electronic orders and were not added to R4's Treatment Administration Record. V2 said V25 should have made sure the orders from the hospital were put in the emar (electronic medication administration record). V2 said R4's medical record did not have orders for monitoring the wounds. V2 said V25 should have assessed R4's wound on Monday (9/26/22) and documented in R4's electronic medical record. V2 said V25 did a dressing change for R4's wounds on 9/28/22 before she was discharged. V2 said V25 should have documented the status of the wounds and the tasks she performed in R4's electronic medical record. V2 said V25 did not do this.</p> <p>R4's hospital discharge documentation, printed on 9/24/22, showed "After Hospital Care Plan...How should you care for your wound? RLE (right lower extremity): Cleanse choice wound vac. Barrier rings to frame wound, 42 ml (milliliter) saline instillation: soak for 10 minutes every two hours. Suction 125 mmHg (millimeters of mercury) to right lower leg. Wound care to see three times a week (M-W-F). Left medial knee region deflated blister. Keep clean, cover with bordered foam. Change M-W-F and PRN (as needed)." The document showed R4 was hospitalized for fall, weakness and wound treatment.</p> <p>R4's Weekly Skin Integrity Review form dated 9/24/22 showed each of the areas of identified in</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>the form (left lower inner leg area, right lateral torso area and right lower extremity inner calf, in addition to bruising on left arm and left lateral breast) had a treatment order in place. R1's care plan addressing her wound or skin abnormality showed interventions in place were "Provide treatments as ordered by physician. See medication and/or treatment administration record."</p> <p>The facility's policy and procedure titled Standard and Guidelines: Wound Care, with a revision date of 3/27/21, showed "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...6. Wound care procedures and treatments should be performed according to physician orders. 7. Wound care treatment should maintain proper technique, as is indicated by the type of wound and physician's orders...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."</p> <p>(A)</p>	S9999		