STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012587	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF MOLINE	7300 34TH AVENUE MOLINE, IL 61265

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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 300.1010 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 notification. 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. 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. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2	S9999		

Based on observation, interview and record review, the facility failed to notify the physician for an identified sign of infection in a pressure ulcer for one resident (R7). The facility also failed to identify a pressure ulcer and notify the physician for one resident (R18). These failures effected two out of four residents reviewed for pressure ulcer in a sample of 47. This failure caused a delay in treatment resulting in R7 being admitted to the Intensive Care Unit (ICU) for septic shock due to an infection in his stage IV right hip pressure ulcer.

Findings include:

The facility's "Standards and Guidelines: SG Wound Care" policy dated 3/27/21, documents "11. Document the progression of the wound being treated. Such observations should be items size, staging (if applicable), odors, exudate, tunneling, etiology etc. 12. Contact the physician for additional order changes as appropriated or to notify of skin condition changes or refusals of care."

1. On 02/14/23 at 12:14 PM, V4 (Licensed Practical Nurse/LPN), stated "(R7) isn't here, he had an appointment this morning at the wound clinic, but he's not coming back. I was just informed the wound clinic sent him to the emergency room (ER) due to an elevated heart rate, low blood pressure and fever. They think he may have sepsis."

R7's wound assessment dated 2/8/23 documents "Left hip pressure ulcer stage IV and Right hip

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S9999	Continued From page 3 pressure ulcer stage IV." R7's physician order sheet dated 2/6/23 documents "Change wound vacuum to left and right ischial ulcers using black foam at 175 millimeters of mercury (mmhg) for left 125 mmhg for right continuous changing three times a week and utilize xeroform, with a bordered gauze changing three times per week to his left lower extremity. (Wound solution, a mixture of sodium hypochlorite (0.4% to 0.5%) and boric acid (4%) diluted in water) soak for five to ten minutes with dressing changes. Cleansing all wounds with normal saline or wound wash of choice with dressing changes." 2/13/23 12:16pm R7's medical record documents "Late Entry: Note Text: Wound vacuum to right and left hip changed per orders. Right hip noted to have foul smell and necrotic tissue. Resident to follow up with wound clinic on 2/14/23. Resident denies any pain at this time. Will continue to monitor." V29's (Medical Director) physician visit note dated 2/7/23 document's "Of note, (R7) also reportedly had a seizure in the setting of acute infection in October. Of note, upon further review of his chart, it appears that he was admitted locally in October 2022 with sepsis and seizure like activity requiring intubation for airway protection. During that hospitalization, he underwent bilateral ischial wound debridement with left ischial bone biopsy by general surgery. Cultures grew klebsiella pneumoniae, proteus mirabilis, enterococcus faecalis, enterococcus faecium, corynebacterium, bacteroids thetaiotaomicron. Surgical pathology was consistent with necrotic skin and soft tissue with acute inflammation and acute osteomyelitis."	S9999		

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S9999	Continued From page 4 On 2/14/23 2:11 PM, V7 (Wound Clinic Registered Nurse/WCRN), "I was the one that saw him today. (V28 Nurse Practitioner), assessed his wounds and he had signs of infection in his right hip wound along with a low blood pressure, elevated heart rate and fever, so she had him sent to the ER for possible sepsis. If the facility identified a foul smell with necrotic tissue yesterday during his wound vacuum dressing change, they should have contacted us prior to putting the wound vacuum back on because his symptoms indicated an infection." 2/14/23 at 2:24 PM, V3 (Assistant Director of Nursing/ADON), stated "I changed the wound vacuum yesterday and noticed the wound had a foul smell with some necrotic tissue. When I changed it yesterday, I knew he had an appointment today, so I didn't contact the wound clinic or his physician because I knew he was going to the wound clinic today. Yes, the foul smell and necrotic tissue typically indicates an infection. If the resident is being followed by a wound clinic, we normally notify the clinic of any wound changes, but like I said, he was being seen the next day and that's why I didn't. I guess it was just poor communication of why I didn't notify anyone." On 02/15/23 at 9:17 AM V7 (WCRN) stated "After our conversation yesterday, I spoke to (V28 NP) about (R7). She agreed that the facility should have called when they noticed the foul smell and necrotic tissue in his right hip wound. It indicates a possible infection and given his history of sepsis; we would have had him sent to the ER for evaluation instead of waiting the next day for his appointment. I looked at his medical record he's currently in the ICU for septic shock. He shouldn't have waited for his appointment here. He should	S9999		

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S9999	Continued From page 5	S9999		

have gotten immediate treatment when they identified the infection."

R7's hospital medical record dated 2/14/23 documents R7 was admitted to the intensive care unit for septic shock and pressure injury of contiguous region involving right buttock and hip, stage IV.

2. On 2/14/23 at 10:20 AM, R18 was lying in bed on her back and stated "I have a sore near my tailbone that is very painful. They just gave me some medicine so hopefully will be better soon."

02/15/23 at 11:15 AM V3 (ADON/Wound Nurse) stated she is not aware of any pressure ulcers to R18's bottom and R18 is not on her list of wounds to assess weekly.

On 2/15/22 at 11:22 AM, V24 (Certified Nursing Assistant/CNA) and V3 assisted R18 onto her left side, removed R18's incontinence brief and revealed an open area to R18's coccyx area that did not have any ointment or dressing over it. V3 stated the wound is an open stage II pressure ulcer and measures 1.0 cm (centimeters) by 0.2 cm with depth of 0.2 cm. V3 stated she was unaware of R18's pressure ulcer and the staff should have notified her at the time they found it. V3 stated she would call R18's doctor and get a treatment order.

On 2/15/23 at 11:35 AM, V2 (Director of Nurses/DON) stated she spoke with the nurse who took care of R18 yesterday and said the nurse saw the area and notified hospice yesterday but forgot to chart it.

On 2/15/23 at 12:02 PM V26 (Hospice Registered

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S9999	Continued From page 6 Nurse), stated she was at the facility on the morning of 2/14/23 and R18 had complained to her about her bottom being sore and when (V26) asked the nurse about it the nurse said it was only a small shearing area. V26 stated she asked the nurse specifically if the area was a pressure ulcer and the nurse said no. V26 stated no one called her about a pressure ulcer on R18's bottom. On 2/15/23 at 12:45 PM, V25 (Licensed Practical Nurse/LPN), stated she was the nurse for R18 on 2/14/23 and only saw a friction/shearing area to R18's sacrum that measured about 2 cm. V25 stated the area was only red at the time and was not open. V25 stated she did not call R18's family or R18's Physician and probably should have. V25 stated she thought V26 (Hospice RN) would notify the family. The Progress Note for R18, dated 2/14/23 at 1:00 pm, documents "During cares patient observed to have skin shearing/red in color, area to coccyx. Area was not open. No drainage or warmth to area. Hospice nurse was at facility at the time, and it was reported. Hospice nurse stated we may use topical cream or zinc to area daily and prn until resolved. Zinc cream was applied to area at this time." The Physician Order Summary, dated 2/15/23, does not include any pressure ulcer treatment orders for R18. "A"	S9999		