STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145651	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE REHAB & HEALTHCARE	**3490 HUMBERT ROAD ALTON, IL 62002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat wounds per physician's orders for 2 of 3 residents (R47, R65) reviewed for wounds in the sample of 50. Findings include: 1. On 03/11/2020, from 2:00 PM to 3:30 PM, based on 15 minutes observations, R65 was up in her reclining geriatric chair. R65's right lateral thigh wound was exposed with no dressing in place. R65's wound was necrotic with slough and was visible from a distance. On 3/12/2020 at 4:00 PM, V24, Registered Nurse (RN) and V34, Licensed Practical Nurse (LPN) performed care for R65. When care was completed, R65's blanket was removed, and R65's right lateral thigh was exposed. R65's right lateral thigh wound did not have a dressing covering. V24 placed the physician ordered dressing to the right lateral thigh. R65's Specialty Physician Wound Evaluation and Management Summary, dated 03/03/2020, documents, Arterial wound of the right lateral thigh. It continues to document, Dressing treatment plan, primary dressings, Alginate calcium apply once daily for 30 days; Collagen powder apply once daily for 30 days; Foam silicone boarder and faced apply once daily for 30 days; silver [MEDICATION NAME] apply once daily for 30 days. 2. R47's Minimum Data Set (MDS), dated [DATE], documents R47 has an arterial wound. R47's Wound Management Consultation Notes, dated 3/10/2020, documents, (R47) has an arterial wound to the left upper medial ankle, moderate serous exudate. Wound size: 2 x 2 x 0.2 centimeters, moderate serous exudate, 100% necrotic tissue. Dressing treatment plan: [REDACTED]. R47's Care Plan, dated 3/14/2020, documents,5/16/19 Deep Tissue Injury (DTI) Left upper medial ankle- staged as arterial wound. Interventions (in part): Prevalon boot to left foot at all times. Check placement. Treatment as ordered. R47's Treatment Administration Record (TAR), dated 3/2020 documents,Left upper medial ankle clean with Normal saline (NS), apply santyl, [MEDICATION NAME] ointment, and calcium alginate, then cover with foam bordered dressing. On 3/10/20 at 1:28 PM, R47 was in bed slightly turned to her left side with her left and right foot together. R47 was not wearing any kind of boot on her left foot. On 3/12/20 at 10:37 AM, V23 LPN, and V24, RN, provided wound care to R47 in bed. R47 was turned to her left, knees bent and legs and feet were together. R47 was not wearing a prevalon boot on her left foot. R47's left foot and ankle had an elastic gauze wrapped around it loosely, but the wound on the medial ankle was visible and did not have any dressing on. V23 removed the elastic gauze. The wound measured approximately an inch square covered with dead tissue, with slight amount of yellowish drainage staining the elastic bandage. V23 cleansed the wound and applied santyl, [MEDICATION NAME] ointment, calcium alginate and covered the with a bordered foam dressing. On 3/12/20 at 10:51 AM, V21, Certified Nursing Aide (CNA), stated she saw the white bandage around the ankle and did not look if the dressing over the wound was still in place. V21 stated if she had seen that the wound did not have any dressing she would have reported it right away to the nurse.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess, monitor, treat, utilize pressure devices and utilize turning and position for 5 of 8 residents (R30, R49, R53, R65, R89) reviewed for pressure ulcers in a sample of 50. This failure resulted in R30's shearing to the left lower ischium progressing to a stage 4 pressure ulcer. Findings include: 1. On 3/12/2020 R30 was observed from 8:15 AM until 1:56 PM sitting in a wheelchair without any benefit of repositioning based on 15-minute intervals. On 3/12/2010 at 2:00 PM, R30 was transferred to bed. R30's buttocks were extremely red and dressing to ischium was crinkled. On 3/12/2020 at 3:00 PM V57, Certified Nurse's Aide (CNA), stated He (R30) is a midnight get up. I did not get him up. I'm on day shift. I haven't done any care with him. I'm on the other hall. On 3/12/2020 at 3:12 PM V50, CNA, stated, He is a midnight get up. He was up when I got here. I got here about 6:00 AM and he was up. I haven't done anything with him. He likes sitting up. On 3/12/2020 at 3:30 PM, R30, stated, I'm glad to be in the bed. I like sitting up, but that was long. I would rather be in the bed. My butt feels so much better. It was hurting there for a while. On 3/16/2020 at 2:55 PM, V24 Registered Nurse (RN), performed a treatment to R30's left lower ischium. V24 and V55, CNA, assisted with positioning R30 onto his side. V24 and V55 slid buttocks across the surface of the bed. V24 and V55 did not clear the surface of the bed when turning R30. R30 was heavily soiled with urine and stool. R30's incontinent brief, draw sheet were heavily soiled. R30 had no dressing in place. On 3/16/2020 at 3:20 PM, V24 stated, I am not sure how he got the area. I believe it's from shearing. He is to be repositioned at least every 2 hours. He does lay down a lot. The dressing should be in place. If the staff see the dressing is not in place, the staff is to notify the nurse so that the dressing can be applied. On 3/16/2020 at 3:48 PM, V55, CNA, stated, If the dressing comes off or there isn't one, we go get the nurse. We don't apply the incontinent brief until after the treatment is done. We wait for the nurse. R30's Care Plan, documented 10/28/2019, Unstageable left lower ischium. Monitor frequently for incontinence and change if wet or soiled. Apply barrier ointment after each incontinence care. 10/28/2019 Turn and reposition every 2 hours. R30's Narrative Nurse Progress Notes, dated 10/10/2019, documents Incontinent care was being given at 8:00 AM and noted open area to left buttock. R30's Narrative Nurse's Progress Note, dated 10/26/2019 5:00 PM Resident noted to have opens areas to bottom. Coccyx area measures 1.5 x (by) 2.5 CM (centimeter), left buttocks measures 2.2 x 2 CM and left ischium measures 3 x 1.5 CM. Resident doesn't like to lay down and moves around when in bed. R30's Initial Wound Evaluation and Management Summary, dated 10/29/2019, documents Unstageable (due to necrosis) of the left, upper ischium. Pressure 3.00 cubic centimeters with 100% thick adherent devitalized necrotic tissue measuring 1.5 x 2 x 0.2 cm. Unstageable (due to necrosis) of the left, lower ischium. Pressure 3.00 cubic centimeters with 100% thick adherent devitalized necrotic tissue measuring 2 x 1.5 x 0.1 cm. Both areas requiring surgical excisional debridement of 3.0 cubic centimeters of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 0.3 cm. R30's Wound Evaluation and Management Summary, dated 11/5/2019, documents Stage 4 pressure wound of the left, upper ischium. Pressure 3.00 cubic centimeters with 100% thick adherent devitalized necrotic tissue measuring 1.5 x 2 x 0.1 cm. Unstageable (due to necrosis) of the left, lower ischium. Pressure 3.00 cubic centimeters with 100% thick adherent devitalized necrotic tissue measuring 2 x 1.5 x 0.1 cm. Both areas requiring surgical excisional debridement of 3.0 cubic centimeters of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 0.3 cm. R30's Wound Evaluations and Management Summaries, dated 12/3/19, 12/10/19, 1/14/20, 2/4/20 and 3/10/20 documented V56, Wound Physician continued to see R30 for weekly surgical excisional debridement. R30's Wound Evaluation and Management Summary, dated 3/10/2020, documents stage 4 pressure wound to the left, lower ischium measuring 1.5 x 1 x 0.2 cm requiring surgical excisional debridement of 0.15 cubic centimeters of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 0.3 cm. On 3/16/2020 at 3:51 PM, V56, Wound Physician, stated, The area started out as a shearing, sitting for extended periods

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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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) of time without being position would have caused the wound to progress to a stage 4 quickly. The facility is a good home. They have lost some staff and that may be causing them some issues. He (R30) should be in the bed and repositioned in the bed. 2. R49's MDS, dated [DATE], documents R49 is totally dependent on 2 staff for bed mobility, transfers, dressing, toilet use and is always incontinent of bowel and bladder. This MDS further documents Formal and Clinical Assessment indicates R49 is at risk for pressure ulcers development. R49's Pressure Ulcer Risk Assessment, dated 1/17/2020, documents R49 is at high risk for pressure ulcer development. R49's Care Plan with goal date 4/3/2020, documents, Resident has a Stage 4 pressure ulcer to coccyx identified in-house 8/26/19. Turn and reposition every 2 hours and as needed, Float heels while in bed. R49's Wound Management Consultation Notes, dated 3/10/2020, documents, Stage 4 Pressure Wound coccyx 3 x 1.5 x 1 cm moderate serous exudate. 60% granulation, 40% necrotic. Wound Progress: No change. Plan of Care: Off load wound. Reposition per fac (facility) protocol. Dressing treatment plan: [REDACTED]. Collagen powder once daily. Mupirocin once daily. Factors complicating wound healing: Diabetes Mellitus 2. On 3/10/2020 from 10:27 AM until 1:31 PM, R49 was in bed on her right side without the benefit of repositioning based on 15-minute observation intervals. On 3/12/2020 at 10:05 AM, V27 and V22, both CNAs, provided incontinent care to R49 in bed, R49 had an incontinence of bowel episode. R49 had a dressing on her coccyx dated 3/11/20 that was loose, adhering on one side, was soiled and discolored with fecal material. On 3/12/20 at 10:20 AM, V23, LPN and V24, RN provided wound care to R49 in bed. V24 removed the loose dressing off the wound. V23 cleansed the wound which measures approximately 1.25 inches by 1 inch with 50 percent pink granulation. V23 applied dressing to the wound. 3. R53's Care Plan on Skin Integrity Changes dated related to PURA (Pressure Ulcer Risk Assessment), dated 10/12/19, at risk for pressure ulcer, Requires assistance for transfers, ambulate, turn and reposition, incontinent of bowel and bladder at times, appetite and fluid intake fair, receives routine [MEDICAL CONDITION], has [DIAGNOSES REDACTED]. Interventions: 2/14/20 Float heels while in bed. Reposition and turn every 2 hours and as needed. On 3/11/20 from 10:21 AM until 1:14 PM, R53 was in bed on her back without the benefit of repositioning based on 15 minute or less observation intervals with no offloading of her heels while in bed. The Facility Policy on Repositioning dated 12/1/2016 documents, Standards: It will be the standard of the facility to provide evaluation of the residents' needs, to aid in the development of a care plan for repositioning as needed, to promote comfort for all bed-comfort or chair-bound residents, to attempt to prevent skin breakdown, promote circulation and prevent pressure relief for residents. Guidelines: 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. 2. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. 4. On 03/10/20 from 9:24 AM until 12:30 PM, R65 was lying in bed on her left side without her pressure relieving offloading boots on her bilateral feet. On 3/12/2020 at 4:00 PM, V24, RN and V34, LPN were performing wound care to R65's right hip and during care, the right leg was kept covered. When completed, V24, RN stated that they were going to do the right heel treatment at that time. When R65's blanket was removed, there were no pressure relieving offloading boots on R65's feet. V24, RN, looked at the R65's treatment administration record and stated that she doesn't know how or when the open area to the right hip started but then she and V34, LPN continued to apply a dressing to the right lateral wound. R65's physician's orders [REDACTED]. It does not document a treatment for [REDACTED]. It continues to document, Dressing treatment plan. Primary dressings. Alginate calcium apply once daily for 30 days; Foam silicone boarder apply once daily for 30 days; Silver [MEDICATION NAME] apply once daily for 30 days. R65's Care Plan, dated 09/30/2019, documents,(Pressure relief and off loading) boots in place at all times for prevention. It continues, See (Treatment administration record) for current treatment orders On 03/16/2020 at 2:40 PM, V31, Restorative Certified Nurse Assistant (CNA) and V40, CNA both stated that R65's boots disappear all the time and that they are usually in the laundry. Both V31 and V40 continued to state that they were not aware of the open area to R65's hip. 5. R89's Admission Nursing Assessment, dated 1/29/2020, documents R89's heels were blanchable (blanching of the skin occurs when the skin becomes white or pale in appearance). R89's Pressure Ulcer Risk Assessment, dated 1/29/2020, documents R89 is at high risk for pressure ulcers and requires assistance to turn/reposition. R89's Care Plan, dated 3/11/2020, documents, Problems: SDTI (suspected deep tissue injury) Location: right heel 2/17/2020; left heel 2/17/2020. Current ulcer/s will show improvement and no new ulcers will develop. It continues, Provide pressure redistribution as appropriate: float heels, heel protectors. R89's physician's orders [REDACTED]. The Facility's Weekly Pressure Ulcer Report dated 3/2/2020-3/8/2020, documents R89 has DTI (Deep Tissue Injury) to the right (total surface area 16) and left heel (total surface area 8), both were identified 2/17/2020. On 3/10/2020 at 1:00 PM, R89 was seen by V6, Wound Physician. R89's heel protectors were observed in R89's chair. R89 was lying in bed. V8, LPN, lifted R89's heels off the bed in order to perform R89's treatment to R89's bilateral heels. At this time, V6 stated, They attempted to float (R89's) heels with a pillow, but they did not do it properly. On 3/11/20, at 1:56 PM, V2, Director of Nursing (DON), stated, (R89's) heels (pressure ulcers) were acquired in house due to pressure. (R89) is supposed to wear the boots (heel protectors).
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to provide safe transfers, supervision and insure all wheelchairs have all components in place for 4 of 9 residents (R30, R102, R115, R335) reviewed for accidents in a sample of 50. Findings include: 1. R30's Care Plan, dated 12/23/2019 to Present, documents at risk for falls, weakness, environmental changes. R30's Minimum Data Set (MDS), dated [DATE], documents total dependence on 2 staff physical assist for transfer. R30's Fall Assessment, dated 10/12/2019, documents requires assistance for mobility, transfer, ambulation, unsteady gait, altered awareness of immediate physical environment, impulsive, lack of understanding of one's physical and cognitive limitations. High fall risk. On 3/10/2020 at 9:11 AM, V51, Certified Nurse Aide (CNA), and V52, CNA, were transferring R30 from his reclining high back wheelchair to his bed with a full mechanical lift. R30 was sitting in the reclining wheelchair with wheelchair unlocked. V51 and V52 attached the sling to the mechanical lift. V51, operating the controls, raised R30 up out of the wheelchair and transferred R30 over to and lowered him down onto the bed. V51 and V52 did not perform a safety check for the sling straps after raising him above the wheelchair. R30's reclining high back wheelchair remained unlocked during the transfer. 2. R102's Care Plan, dated 11/18/2019 to current, documents Fall risk related to environmental changes, weakness, left arm fracture. Cognitive deficits related to Alzheimer's Dementia. Assist to toilet as necessary to lessen possibility of resident attempting to get up without assistance. Monitor by keeping resident in practical visible areas as necessary (near nurses station, bring to activity programs). R102's MDS, dated [DATE], documents R102 needs extensive assistance. Requiring 1 person to provide physical weight bearing assist. R102's Fall Risk Assessment, dated 8/1/2019, documents urgency or frequency, unsteady gait, Requires assistance or supervision for mobility, transfer, or ambulation, visual or auditory impairment affecting mobility, high fall risk. On 3/9/2020 at 9:10 AM, a [MEDICAL CONDITION] eye monster sign was noted on R102's wheelchair and on her name plate outside of her room. On 3/9/2020 at 1:02 PM, R102 was sitting in her room in the wheelchair, calling for help. R102 transferred herself to the toilet, R102 was sitting partially on the toilet and leaning with her head on the toilet paper roll. R102 reached back and pulled the call light. At 1:16 PM, V11, Registered Nurse (RN), entered the room and told resident to stay there and she would get some help. V11 left the room leaving the resident sitting partially on the toilet, leaning with head on the toilet paper roll. At 1:18 PM, V12, CNA, entered the room and applied the gait belt. At 1:23 PM, V12 left the room leaving R102 sitting on toilet with head on toilet paper roll. At 1:26 PM, V12 returned to the room. After completing incontinent care, V12 assisted R102 into her wheelchair. V12 held onto the R102's pants and body during the transfer and did not utilize the gait belt that was around R102's waist. On 3/9/2020 at 2:00 PM, V50, CNA, stated (R102) is on the fall program. She is not to be left in her room unattended. When you are on the program you have the eye sign on the door and on the wheelchair. That tells you they are at risk for falls. On 3/16/2020 at 2:25 PM, V53, Physical Therapist, stated If a resident requires assistance, you are to apply the gait belt and utilize the gait belt during the transfer. If a resident is in a vulnerable position, you do not leave the resident You stay with them and call for help. On 3/16/2020 at 2:40 PM, V55, CNA, stated, If a resident requires assistance with transfer we apply a gait belt. Stay with the resident if they are

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) not safe. When doing the transfer we grab onto the gait belt and transfer the resident. The Facility's [MEDICAL CONDITION] Eye Program, not dated, documents, Residents that are at a fall risk and deemed unsafe to be left alone, unsupervised, while up in their wheelchairs will be placed on the [MEDICAL CONDITION] Eye Program. These residents are to be in common areas and in line of sight supervision while up in wheelchair. Residents identified to be designated for the [MEDICAL CONDITION] Eye Program will be made known to staff by attached sign on their wheelchair with a [MEDICAL CONDITION] Eye monster. A sign will be placed next to their name on the doorway. This information will also be written in their Care Plan. 3. On 03/12/20 at 9:45 AM, V33, CNA, operated a full mechanical lift, V32, CNA, supported R115 as R115 was transferred from chair to bed. R115's reclining chair was not locked and the mechanical lift pad straps were not checked for safety prior to moving R115 from the reclining chair to bed. R115's physician's orders [REDACTED]. R115's MDS, dated [DATE], documents R115 is totally dependent upon staff to move her from chair to bed and to perform incontinent care. R115's Care plan, dated 11/8/2019, documents, (Full mechanical) lift to transfer. On 03/16/2020 at 2:52 PM, V31, Restorative CNA, V40, CNA, and V41, CNA, all stated that they would check the straps to the mechanical lift pad, prior to moving a resident from the wheelchair to the bed, they also agreed that they would lock the wheelchair prior to transferring the resident from the wheelchair to the bed. The full mechanical lift manual, dated 2005, documents, e. Hook the hanging strips of sling with the hanging bar. If a chain is used, make sure the S hooks are away from the patient. Lock rear coasters. It continues, g. .Lock brakes of both lifter and commode (or wheelchair). 4. R335's MDS documents R335's cognitive skills are severely impaired. R335's Admission Record, dated 3/16/2020, documents R335 has a [DIAGNOSES REDACTED]. R335's Care Plan, dated 3/9/2020, documents R335 is at risk for falls and has a potential for [MEDICAL CONDITION]. Interventions include, Frequent monitoring of resident to ensure safe positioning and needs are met. On 3/10/2020 at 8:30 AM, R335 was in her high back wheelchair in her room. The wheelchair had foot pedals. R335 was slouched down in the wheelchair. R335's right leg was not on the pedal, instead it was hanging off to the right side of the wheelchair. R335's right arm was also hanging off to the side of the wheelchair. There was no arm rest / bracket connect from the seat of the chair on the right side of the wheelchair. On 3/10/2020 at 10:30 AM, R335 was in her wheelchair, in the same position as earlier, with her right leg and right arm hanging off the the right side of the wheelchair. V35, CNA, re-adjusted R335's right leg, placing it on the pedal, and applied the arm rest to the right side of R335's wheelchair. On 3/12/2020 at 12:45 PM, multiple staff were seen rushing to R335's room. An unidentified staff member stated, We thought she was on the floor. She keeps sliding down in the chair.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide complete incontinent care for 5 of 8 residents (R49, R102, R115, R123, R127) observed for incontinence care in the sample of 50. Findings include: 1. R49's Minimum Data Set (MDS), dated [DATE], documents R49 is totally dependent on staff to carry out daily tasks including transfers, dressing, toileting and is always incontinent of bowel and bladder. R49's Care Plan, dated 1/3/2020, documents,Pads/briefs uses. Skin will remain intact without signs of irritation. Interventions: Check for incontinence, change if wet/soiled. Use pre-moistened wipes for cleansing. Apply moisture barrier. On 3/12/2020 at 10:05 AM, V27 and V22, Certified Nursing Aides (CNAs), provided incontinence care for R49 in bed. V22 used disposable wipes and cleansed the groin area, across the vagina. V22 and V27 turned R49 to her left and cleansed the rectal area. R49 had a small amount of bowel incontinence and V22 cleansed the Perineal area, the inner and outer buttocks. V22 did not adequately spread the labia to access between the labial folds and urethral opening for thorough cleansing. V22 did not cleanse the inner thighs. 2. R127's MDS, dated [DATE], documents R127 requires 25 to 50 percent staff assist to be able to carry out daily tasks including transfers, dressing and toilet use, is always incontinent of bowel, and has an indwelling urinary catheter. R127's Care Plan, dated 1/29/20, documents, Indwelling catheter for [DIAGNOSES REDACTED]. On 3/10/2020 at 2:25 PM, V21, CNA, provided incontinence care and Catheter care for R127 in bed. V21 used disposable wipes to clean R127. V21 wiped the head of the penis once with one circular stroke then discarded the wipe. V21 wiped the right and left groin, wiped the catheter tubing from insertion site outwards once. V21 assisted R127 to turn to his left. R127 had a small amount of bowel incontinence. V21 wiped the rectal area using 2 wipes. V21 did not wipe the inner thighs and inner buttocks. On 3/10/2020 at 2:36 PM, V21 stated V24, Registered Nurse (RN), is in charge of giving staff in-service training on patient care including incontinence care and catheter care. 3. On 03/12/20 at 9:45 AM, V33, CNA, cleansed R115's bilateral groins and center labia without changing wipes, or turning/folding for clean side of wipe. V33, CNA, rolled R115 over on to her right side and using a cleansing wipe, cleansed the rectum and did not cleanse the buttocks. R115's physician's orders [REDACTED]. R115's MDS, dated [DATE] documents R115 is totally dependent upon staff to perform incontinent care, and is occasionally incontinent of urine and bowel. R115's Care Plan, undated, documents, Monitor for incontinence. Change pads/briefs as needed. It continues, Provide hygiene after voiding/BM's to prevent skin breakdown. Apply moisture barriers. On 03/16/20 at 02:52 PM, V31, Restorative CNA, V40, CNA, and V41,CNA all stated that they would use a new disposable cleansing cloth after each after each wipe during incontinent care. They also stated that when performing incontinent care, that the buttocks are cleansed as well. 4. R123's MDS, dated [DATE], documents R123 is always incontinent of bowel movements and is totally dependent on staff for toileting needs. On 3/11/2020, V9, Licensed Practical Nurse (LPN) performed R123's dressing change to his buttocks with assist of V5, CNA. R123 had a small amount of feces in his rectal area. V9 completed the treatment to R123's buttocks. V5 and V9 confirmed they were done with R123's care and exited the room without cleaning the feces from R123's rectum. When questioned regarding the feces on R123's rectal area, V9 stated she did see a small amount. V5 stated, If there was some (feces), I didn't see it. 5. R102's Care Plan, dated 11/18/2019 to present, documents self care deficit. Staff assistance required with bathing hygiene dressing and grooming. Monitor for incontinence. Change pads/briefs as needed. Provide hygiene after voiding/bowel movements to prevent skin breakdown. R102's MDS, dated [DATE], documents requires extensive assist of 1 and occasionally incontinent. On 3/9/2020 at 1:18 PM, R102 was incontinent of a large amount of soft and loose stool. Stool was located on the toilet, outside of the undergarment, and on the back of both legs. V12, CNA, performed incontinent care. V12 cleansed R102's buttocks and legs, but did not cleanse the front peri area including the groin and did not open R102's labia and cleanse the area. On 3/16/2020 at 2:35 PM V24, RN, stated, I just did an in-service with the staff and would expect them to cleanse all areas of incontinence. The Facility's Perineal/Incontinence Care policy and procedure, dated 9/1/17, documents, Standard: It will be the standard of the facility to provide cleanliness and comfort to the resident to prevent infections and irritation, and to observe the resident's skin condition and provide appropriate care and services required to maintain functional levels while providing Perineal/incontinence care. The Policy continues to document, 4. Provide Perineal/incontinence care in accordance with physician orders [REDACTED].
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to offer hydration and serve meals for 6 of 10 residents (R6, R11, R77, R102, R108, R127) reviewed for nutrition and hydration in the sample of 50. Findings include: 1. R127's Minimum Data Set (MDS), dated [DATE], documents R127 requires 25 to 50 percent staff assist to be able to carry out daily tasks including transfers, dressing and eating. R127's [DIAGNOSES REDACTED]. R127's Care Plan, dated 1/29/2020, documents, Requires assistance with activities of daily living (ADLs) due to increase weakness. Interventions: Allow adequate time to eat, provide cues, encouragement, and assistance. R127's Care Plan, dated 3/1/2020, documents, 3/1/2020 Resident under the care of (Hospice) Diagnosis: [REDACTED]. Continue with water flushes and meds through gastrostomy tube (250 milliliters every 4 hours). Diet as tolerated. On 3/10/20 between 8:01 AM through 9:39 AM observation intervals of 15 minutes, R127 was in bed, awake. There was no breakfast tray brought to his room. There was no water within reach. On

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	145651	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE REHAB & HEALTHCARE	3490 HUMBERT ROAD ALTON, IL 62002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) 3/10/20 from 12:03 PM until 1:31 PM at 15 minute observation interval checks, R127 was in bed and there was no lunch tray noted in his room. On 3/10/2020 at 2:25 PM, V21, Certified Nurse Aide (CNA), provided incontinence care and indwelling urinary catheter care for R127 in bed. V21 did not offer a drink to R127 before or after the procedure. V21 emptied R127's urine collection bag. There was 200 milliliters of dark amber urine collected. On 3/10/20 at 2:35 PM, V21, CNA, stated R127 did not go to the dining room for breakfast and lunch and she did not bring a breakfast or lunch tray to R127 in his room. V21 stated as far as she knew he was on tube feeding. On 3/16/2020 at 8:15 AM, V2, Director of Nursing (DON), stated that R127 has poor appetite and had admitting [DIAGNOSES REDACTED]. V2 stated R127 was vomiting and had increasing residuals, hospice was consulted and he was admitted to hospice. On 3/16/2020 at 2:45 PM, V15, Assistant Director of Nursing (ADON), stated even if R127 has very poor appetite he should still be served his meal and offered other options or alternative and encouraged to eat. 2. R6's MDS, dated [DATE], documents R6 is alert, oriented to person, place, time and situation and needs 50 to 75 percent assist from staff to carry out daily tasks. On 3/09/20 at 8:51 AM, R6 stated the staff are not passing water specially in the evening shift. 3. R77's MDS, dated [DATE], documents R77 has no cognitive impairment, oriented to person, place, time and situation. On 3/10/20 02:09 PM, R77 stated the staff used to pass water, now they don't anymore. 4. On 03/12/20 at 10:10 AM, V30, Restorative CNA, and V31, Restorative CNA, did not offer hydration to R11 after care was provided. R11's Admission record, dated 02/01/2020, documents [DIAGNOSES REDACTED]. R11's Care plan, undated, documents, Encourage fluids to soften stool. 5. On 03/12/20 at 10:40 AM, V30 and V31, did not offer hydration to R108 after care was provided. R108's physician's orders [REDACTED]. R108's Care Plan, undated, documents, Problems: Constipation Status: Active (current). Interventions: Encourage fluids to soften stool. Status: Active (current). 6. R102's Physician order [REDACTED]. On 3/9/2020 at 1:18 PM, R102 was incontinent of large amount of soft and loose stool. V12, CNA, performed incontinent care, V12 assisted R102 into her wheelchair, gathered the trash, washed her hands and then left the room. V12 did not offer R102 any fluids. On 3/10/2020 at 1:44 PM, R102 stated, They don't give me any (water), can't get it. They won't let me stay in here (room). The Facility Policy on Nutrition and Hydration Assistance, dated 11/1/16, documents, Standard: It will be the standard that this facility will provide the level of assistance required to the residents while maintaining their highest practicable level of function and personal preferences. Staff will help to ensure residents receive adequate assistance and provision of services for nourishment and hydration. The Policy further documents, Guidelines: 8. The resident's ability to perform Activities of Daily Living (ADLs) including eating, should be considered when assisting the resident with dining needs. ADLs may vary from day to day or during the course of the day, so this should also be taken into account as well. Staff should provide the level of assistance required to ensure the resident is able to receive his/her daily nutritional or hydration needs while maintaining the highest practicable level of function.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer insulin as prescribed by the physician for 3 of 4 residents (R83, R92, R130,) reviewed for medications in the sample of 50. Findings include: 1. R83's Physician order [REDACTED]. Insulin [MEDICATION NAME] 100 units/ml [MEDICATION NAME]. Inject 35 units subcutaneously 3 times a day before meals hold if blood sugar is less than 100. May follow (Facility) Hypoglycemic Protocol Fingersticks: (blood glucose monitoring) before meals and at bedtime. R83's MAR, dated 2/2020, documents R83 did not receive [MEDICATION NAME] before lunch on 2/13 and 2/14, and did not receive both [MEDICATION NAME] and Basaglar evening dose on 2/4, 216, 218, 2/23, 2/24/2020 per physician orders. R83's Care Plan, dated 2/18/2020, documents, Insulin Dependent Diabetes Mellitus. Goals: Will experience no complications from hypo or hyperglycemic reactions. Interventions: (blood glucose monitoring) per facility protocol and/or Physician orders. Administer medications as ordered. On 3/10/2020 at 11:01 AM, V36, Licensed practical Nurse (LPN), stated R83 does not have any sliding scale insulin and she has no problem giving R83 his scheduled insulin or doing his blood sugar fingerstick monitoring. On 3/16/2020 at 2:46 PM, V15, Assistant Director of Nursing, (ADON), stated the nurses are expected to follow orders for (fingerstick blood glucose monitoring), frequency, and documenting the results as well as when insulin is administered in the MAR. V15 also stated it is very important in identifying highs and lows, and the physician depends on those (fingerstick blood glucose monitoring) results to manage the residents' condition. 2. R130's MAR, dated February 2020, documents [MEDICATION NAME] inject 20 units subcutaneously nightly. This MAR indicated [REDACTED]. On 3/12/2020, V1, Administrator, and V2, Director of Nurses (DON), both agreed the MAR indicated [REDACTED]. Surveyor: Embrey, Takenya 3. R92's POS, dated 3/2020, documents orders for Humalog Insulin subcutaneously with meals (8 AM, 12 PM, 6 PM)inject per sliding scale , less than 139 = 0 units; 140-750 2 units; 176-200=3 units; 201-250 = 5 units; 251-299 =7 units; greater than 299 call the doctor; Humalog Insulin subcutaneously at bedtime (8 PM) inject per sliding scale, less than 139 = 0 units; 140-175=1 unit; 176-200=2 units; 201-250=3 units; 251-299=4 units; greater than 299 call doctor. R92's POS documents the following Diagnosis: [REDACTED]. R92's MAR, dated March 2020, has no documentation that R92's Fingerstick Glucose Monitoring was performed on 3/1/2020 at 8:00 PM and R92 received Humalog per sliding at 8:00 PM on 3/1/2020, 3/3/2020, 3/5/2020, 3/6/2020, 3/7/2020, 3/8/2020. The back of the MAR indicated [REDACTED]. On 3/10/2020 at 11:20 AM, R92 stated, No, I don't get any insulin at night. They don't stick my finger at night unless they are running late. On 3/10/2020 at 1:40 PM, V49, LPN, stated, The fingersticks with the results and how much insulin is given, if any, is on the MAR. If its not given, the reason should be documented on the back of MAR.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform blood glucose monitoring for residents requiring sliding scale insulin for two of three residents (R53 and R83) reviewed for insulin in sample of 50. Findings include: Sliding scale refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges. 1. R83's Physician order [REDACTED]. Insulin [MEDICATION NAME] 100 units/ml [MEDICATION NAME]. Inject 35 units subcutaneously 3 times a day before meals hold if blood sugar is less than 100. May follow (Facility) Hypoglycemic Protocol Fingersticks: blood glucose checks before meals and at bedtime. R83's Medication Administration Record [REDACTED]. R83's MAR, dated 3/2020, documents blood glucose monitoring was never done at bedtime at all. R83's Care Plan dated 2/18/2020 documents, Insulin Dependent Diabetes Mellitus. Goals: Will experience no complications from hypo or hyperglycemic reactions. Interventions: Blood glucose checks per facility protocol and/or Physician orders. Administer medications as ordered. On 3/10/2020 at 11:01 AM, V36, Licensed Practical Nurse (LPN) stated R83 does not have any sliding scale insulin and she has no problem giving R83 his scheduled insulin or doing his blood sugar fingerstick monitoring. 2. R53's POS, dated 3/2020, documents, [DIAGNOSES REDACTED]. [MEDICATION NAME] R 100 unit/ml Fingerstick Blood Sugar (FSBS) before meals and at bedtime with coverage per sliding scale subcutaneously. Blood glucose checks before meals and at bedtime. R53's MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. On 3/16/2020 at 2:46 PM, V15, Assistant Director of Nursing (ADON), stated the nurses are expected to follow orders for blood glucose monitoring and frequency and documenting the results as well as when insulin is administered in the MAR, it is very important in identifying highs and lows, and the physician depends on those blood glucose checks results to manage the residents' condition. The Facility Policy on Diabetes Hypo/[MEDICAL CONDITION], dated 12/1/16, documents, Standard: It will be the standard of this facility to provide appropriate care to residents with diabetes mellitus. Nursing measures and physician orders [REDACTED]. Guidelines: 1. Residents diagnosed with [REDACTED]. The Policy further documents,5. Staff will provide glucose monitoring medication administration, laboratory testing and diet pre physician order.

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Based on observation, interview and record review, the facility failed to perform hand hygiene between glove changes and failed to follow isolation protocols using standards of practice for 5 of 32 residents (R27, R89, R111, R115, R127) reviewed for infection control practices in the sample of 50. Findings include: 1. On 3/10/2020 at 2:25 PM, V21, Certified Nurse Aide (CNA), provided incontinence care and Catheter care for R127 in bed. V21 donned gloves without washing hands. R127 had a small amount of bowel incontinence. V21 failed to wash hands before putting on gloves before starting care and failed to change gloves after cleaning R127's bowel incontinence. 2. R27's Nurse's Notes dated 2/19/2020 documents, On contact isolation for VRE [MEDICAL CONDITION] of the urine. R27's Urine Culture Report dated 3/8/2020 documents >100,000 colonies forming unit /milliliter [MEDICATION NAME] Resistant [MEDICATION NAME] (VRE) and 10,000 - 100,000/ml [MEDICAL CONDITION] (MRSA). On 3/10/20, R27 moved from his room to another room on 300. On 3/10/20 at 10:44 AM, V25, Housekeeping Staff, entered R27's old room to clean. V25 wore gloves, wiped surfaces with rags sprayed with sanitizing solution, swept floor and used mop to mop floor dipped in bucket. V25 exited R27's room done at 10:47 AM after 3 minutes. V25 brought her cart to the janitor's closet. At no time did V25 wear a gown. On 3/10/20 at 2:20 PM, V26, Housekeeping Supervisor stated she expected her staff to wear gowns, gloves, and masks when cleaning isolation rooms, uses Virex cleaning solution in dispenser bottles. On 3/11/20 at 1:00 PM, R27 and his belongings were moved to another hall. After he moved into the room, there was no signage on the door to see the nurse before entering the room and there was no PPE supply by the door to R27's new room until 3/12/2020 after 8:15 AM. 3. On 03/12/20 at 9:45 AM, V32, Certified Nurse's Aide, CNA and V33, CNA, did not perform hand hygiene or change gloves after they transferred R115 to her bed and prior to providing incontinent care. V32, with the same gloved hands, retrieved an incontinent brief and disposable wipes to perform incontinent care on R115. V33 continued to open wipes with same gloved hands, V33 cleansed down (front to back) both groins and center labia without changing wipes or turning/folding to the clean side of the wipe. R115 was then rolled on to her right side, and V33 use a cleansing wipe, cleansed the rectum and did not cleanse the buttocks. V33 then removed the soiled incontinent brief and placed a clean incontinent brief underneath R115 without the benefit of hand hygiene or glove change. The facility's policy, Hand Washing/Hand Hygiene, dated 03/2018, documents, h. Before moving from a contaminated body site to a clean body site during resident care. It continues, After removing gloves. 4. R89's Care Plan Report documents R89 is contact Transmission based precautions related to having [MEDICATION NAME] Resistant [MEDICATION NAME] (VRE) infection. The Care Plan documented to use appropriate precautions to prevent the spread of the infection. On 3/9/2020, at 1:02 PM, V3, Social Services, and V4, Administrative Assistant, were in R89's room, digging through the two biohazard bins, attempting to locate R89's glasses. V3 and V4 had gloves and masks on but did not have isolation gowns on. On 3/10/2020, at 10:38 AM, V15, Assistant Director of Nursing (ADON)/Infection Control, stated, (R89) has VRE in her blood and is on contact precautions. If I were looking for something in the biohazard container, I would put everything on (including gown) to protect myself in every way possible. There could be something in there you're not expecting. 5. R111's Care Plan, dated 2/22/2020, does not document [MEDICAL CONDITION] (C. diff) infection or education provided. R111's Lab Report, dated 2/25/2020, documents R11 was positive for [DIAGNOSES REDACTED] infection. R111's Physician Orders, dated 2/25/2020, documents R111 should be placed on Contact Isolation Precautions related to positive [DIAGNOSES REDACTED] in his stool. On 3/10/2020 at 2:31 PM, V36, R111's wife, was sitting on R111's bed in the isolation room with no protective equipment on. On 3/10/2020 at 2:31 PM, R111 stated, Don't worry about putting that stuff (gown and gloves) on. Nobody else does. On 3/10/2020 at 2:44 PM V36 stated that she has not been educated on putting on gowns and gloves before entering or when in R111's room. On 3/11/2020 at 10:08 AM V37, Registered Nurse, entered R111's isolation room, wearing no gown or gloves. V37 was observed touching surfaces in the isolation room. V37 exited the room. V37 did not perform hand hygiene prior to leaving the room. On 3/11/2020 at 9:43 AM R111 stated, I am still having those liquid stools. The last one I had was last night. On 3/17/2020 at 2:35 PM V24, RN, stated, Prior to going into any isolation room you are to perform hand hygiene, apply gloves, gowns, and mask, if required, no exception. The Nurses on the hall provide the documentation to the residents and the family. If it (education for isolation protocol) was performed that would be documented on the education sheet in the chart or in the nurse's notes. R111's Resident/Family Education Record was blank and contained no documentation R111's family was educated on isolation protocols.