

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2020
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NAME OF PROVIDER OR SUPPLIER REST HAVEN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 120 WEST MAIN ALBION, IL 62806
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S 000	Initial Comments Complaints: 2055899/IL125205 2055777/IL125074 2052464/IL121554 2052795/IL121921 2051784/IL120810 2056799/IL126241 2056847/IL126297	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
10/07/20

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S9999	<p>Continued From page 1</p> <p>Section 300.1010 Medical Care Policies</p> <p>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 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. Restorative measures shall include, at a minimum, the following procedures:</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>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview, record review, and observations the facility failed to 1) implement interventions of turning and positioning and moisture management to prevent the development of pressure ulcers, 2) consistently measure, describe and provide location of pressure ulcers and 3) failed to obtain treatment orders for worsening pressure ulcers, failed 4) to effectively identify, assess, treat, document, and report decline in wounds to physician, for 2 residents (R11 and R12) reviewed for pressure wounds.</p> <p>These failures resulted in R11 developing an 8cm x 3cm blackened area to the left inner buttock and reddened area to the testicles on 3-15-2020. R11's pressure ulcers continued to get progressively worse and R11 developed new areas as follows: left inner buttock Stage III is 4.8 cm X 2.8 cm, right buttock is unstageable 8.0 cm</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>X 5.0 cm., on 5-21-2020. R11 was admitted to the hospital on 6-24-20 for a 7 week stay, due in part to 2 Stage IV decubitus to the sacrum that required the debriding of a considerable amount of nonviable tissue. R11 also required an incision and drainage with extensive debridement of a 7 X 6 X 5 cm sacral decubitus and 6 X 5 X 3 cm sacral decubitus. Advanced ulcerations with necrosis and sepsis were also noted. R11 required a second debridement on 6-30-20 of the two sacral pressure wounds that included skin, subcutaneous tissue, and muscle: measuring 14 X 12 X 3 cm on the left wound and 15 X 14 X 4 cm on the mid-sacrum wound. R11 had a post-operative diagnosis of Sacral Pressure Wounds with Necrotic Tissue.</p> <p>Findings Include:</p> <p>1. R11's Discharge Plan/Recapitulation of Stay, from previous facility, dated 3/10/2020, documents the following in part: R11 has history of pressure ulcers, Stage II on buttock that was treated and is now healed. Resident is changed multiple times a day, R11 is incontinent of bowel and bladder with peri-care provided by staff. Section 13 b. Customary Routine: Get out of bed with the assistance of 2 staff members.</p> <p>R11's Initial Nursing Assessment, dated 3/11/2020 (date of Admission), documents the following: Diagnoses-Multiple Sclerosis, Hemiplegia, Seizure, and Urinary Incontinence. Activities of Daily Living is scored as must be bathed and requires help with dressing. R11 is assessed as being totally incontinent of Bowel and Bladder.</p> <p>The Braden Scale for Predicting Pressure Sore</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>Risk, dated 3/11/20, score is 13 indicating R11 is a Moderate Risk and requires a turning schedule, use foam for lateral positioning, pressure-reduction support surface, protect heels, manage moisture, nutrition, and friction and shear.</p> <p>R11's MDS (Minimum Data Set), dated 3/18/20, Section C - Cognition is scored a 14 out of 15 indicating that he is cognitively intact. Section G - Functional Status documents that turning from side to side in bed, transfer from bed to wheelchair, toileting and bathing requires 2 or more persons for physical assist. Resident does not walk in room or on unit. While in wheelchair or dressing R11 requires one person for physical assist. Section H- Urinary and Bowel Incontinence shows R11 is always incontinent of bowel and bladder. Section K - Nutritional Status documents a weight of 212 pounds. Section M - Risk of Pressure Ulcer documents that this resident is at risk for developing pressure injuries.</p> <p>On 8/26/20 at 10:00AM, V6 (Registered Nurse/RN) stated that R11 had no areas to his buttock only a small area to his heel on admission to this facility. R11 went to the hospital, on 6/24 related to issues with his catheter, and the hospital discovered on a CAT scan that R11 had 2 large decubitus areas on his buttock. R11 returned to the facility around the first of August with 2 Stage 4 decubiti. R11 was not turned at night after he was admitted to this facility and he was allowed to lay in feces and urine. The night nurse (V21) would not help the Certified Nurse Aide. V6 stated that V1 (Administrator) was notified of the condition of R11 and the care at night.</p> <p>On 8/24/20 at 2:00 PM, V11 (Registered Nurse)</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>stated that R11 did not have pressure wounds when he was admitted to this facility. After he was admitted, every morning when V11 came to work R11 would be laying in feces and urine. The nighttime staff would allow R11 to lay in feces and urine. R11 is incontinent. His buttock would be red and excoriated. We reported this to V1 (Administrator) but the situation of R11 being turned on nights did not improve.</p> <p>On 8/24/20 at 2:30 PM, V2 (Registered Nurse/RN) stated that R11 did not have pressure wounds when he was admitted.</p> <p>On 8/24/20 at 11:05 AM, V7 (Certified Nurse Aide/CNA) stated that when she would come to work in the morning that R11 was always lying in feces and urine. V7 stated she complained to V1, but V1 did not address the issues. V7 stated that after R11 was admitted to this facility his buttock quickly deteriorated due to the feces, urine and not being changed at night.</p> <p>On 9/1/20 at 9:47AM, V17 (Registered Nurse/RN) stated on the night shift there is only one nurse and one CNA (Certified Nurse Aide) and has been that way since the beginning of March 2020.</p> <p>On 9/1/20 at 2:55 PM, V19 (Certified Nurse Aide) stated she was working nights when R11 was admitted. She stated that R11 did not have a pressure ulcer when he was admitted to this facility but was incontinent of urine and feces. V19 stated she was unable to turn him at night because the night nurse (V21, RN) would not help her turn the residents. V19 stated that she repeatedly talked to V1 about the night nurse not helping but this did not help. V19 stated that R11's pressure wound developed because he was not cleaned and turned as he should have</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>been. V19 stated the resident is a big resident and too big for her to turn by herself. V19 stated because she was unable to turn R11 he developed necrotic areas and 2 pressure ulcers. V19 stated this continued for about 4 weeks until the night nurse quit.</p> <p>On 9/8/20 at 2:30PM, V13 (Certified Nurse Aide/CNA) stated that when she worked the day shift, R11 would be saturated with urine and feces from his head to his toes when she arrived at his room. R11's bed sheets in the morning were always wet with dried brown urine and the ring around the urine was always a darker brown. She went on to say that his feces were often dried to his skin. V13 stated that occasionally she worked nights with V21. V13 stated that she told V1 that V21 would not help turn and clean R11 when he soiled himself. After V13 talked to V21 she continued to refuse to help with R11's care. V13 stated that R11 is a 2 person assist due to his size, because he has MS (Multiple Sclerosis), and because he is unable to help turn himself.</p> <p>On 9/8/20 at 10:00AM, V6 (Registered Nurse) stated that she worked days and, in the morning, R11 had dried urine and feces under him. He had a brown ring from his shoulders to his mid-thigh area. V6 stated this occurred when V21 did not help the night CNA turn, reposition, or change the soiled bed sheets under R11. V6 stated it takes 2 staff members to turn and reposition R11. R11 is unable to turn himself or even help to turn himself. V6 stated V1 did not respond to V6's complaint of V21's refusal to help turn residents at night.</p> <p>On 9/8/20 at 1:00PM, V1 (Administrator) stated that V21 worked from 3/9/20 to 5/27/20. V1 then confirmed V21 worked 5 days a week on the</p>	S9999		

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S9999	<p>Continued From page 7 night shift.</p> <p>On 9/1/20 at 2:00PM when asked about the issue with V21 not turning and cleaning residents, V1 stated that she has not been able to get help for the night shift.</p> <p>Each of R11's multiple pressure ulcers are not consistently measured or described and the location of the pressure ulcers are not identified as follows:</p> <p>R11's Progress Notes, dated 3/15/20 documents: 8 cm X 3 cm Stage III to left inner buttock. He (R11) will be turned side to side every 2 hours. Lay down after lunch to relieve pressure.</p> <p>R11's Fax to V14 (Physician), dated 3/15/20, documents: "Resident has been noted to have loose watery bowel movement since admission on 3/11/20. Has blackened area 8 cm X 3 cm on Left inner buttock. Hard tissue noted to both side of buttock. Red areas to testicles. Zinc applied to buttock. Bag Balm applied to scrotum. Any new Order? Orders received from V14 for Zinc, resident side to side, Wedge placed behind him, lay down in the afternoon to relieve pressure."</p> <p>R11's Treatment Sheet and Skin Alteration Charting Record, dated 4/5/20, documents that on discovery the wound on R11's left inner buttock is Length 2 cm and width is 1 cm. Stage II, pink with bleeding.</p> <p>R11's Treatment Sheet and Skin Alteration Charting Record, dated 4/18/20, documents: Wound #1 is Stage II, Gluteal fold, 1 1/2 cm and Wound #2 buttock is 1/2 cm circle. Clean with NS (Normal Saline) and apply Duoderm. Zinc to buttock every shift till healed.</p>	S9999			

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S9999	<p>Continued From page 8</p> <p>R11's Progress Notes, dated 4/19/20, documents: Treatment to buttocks, area on Right buttock is 1/2 cm in diameter. Is a circle. Area cleansed with Normal Saline and Duoderm applied. Left buttock creased is 1 1/2 circle area cleansed with NS (Normal Saline) and Duoderm applied.</p> <p>R11's Progress Notes, dated 4/27/20, documents: Many areas on buttock will check with Doctor to see what kind of treatment will be ordered. There is no documentation of a response from V14 regarding changes related to the 'many areas on buttock on 4/27/20'. There is no documentation that the treatment was changed related to 'many areas on buttock on 4/27/20.</p> <p>R11's Progress Notes, dated 5/1/20, documents: Continue to monitor and treat bottom. Area on bottom continues to be open and draining blood. Area on bottom left cheek appears to have an infection.</p> <p>R11's Mapping Documentation, dated 5/2/20, documents Wound A- 3 cm X 3 cm Stage II, Wound B- Stage I, Wound C 2 cm X 1 cm Stage II, Wound D- 4 cm X 3 cm Stage II. There is no documentation of a response from V14 regarding changes noted on 5/2/20 to Wound A, Wound B, Wound C, Wound D. There is no documentation of the location of these pressure ulcers. There is no documentation that the treatment was changed.</p> <p>R11's Progress Notes, dated 5/14/20, documents: 2 X 2.5 open area noted to left buttock, cleaned area with Hibiclens and Duoderm applied, changed dressing and measure wound every 72 hours.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>R11's Progress Notes, dated 5/21/20, documents: Measured area on lower left buttock 2 cm X .5 cm, Duoderm applied, resident turned.</p> <p>R11's Progress Note, dated 5/21/20, Wound Consultant Nurse (V23) here for evaluation. Some necrotic tissue noted in crack with slight odor. R11's documentation from the Wound Consultant Nurse, dated 5/21/20, documents the Wound 1 is Buttock, Right Lower is Stage II 2.5 cm X 2.5 cm (This is the first documentation of this area), Wound 2 Buttock Left is Unstageable 10 cm X 14 cm (Progress Note dated 3-15-20 shows this area was first identified as a stage III 8x3 cm), and Wound 3 Buttock, Right is 12 cm X 3 cm.(Progress note dated 4-19-20 shows this area as ½ cm) Treatment ordered is Cleanse area, Apply Hydrocolloid and change every 3rd day.</p> <p>R11's Physician's Telephone Order, dated 5/24/20, Duoderm to blackened under skin, unopened 3 X 4 cm (Blister like) change PRN until wound consultant supplies arrive cleanse Gluteal crease with Hibiclens- Apply Udder Balm and ABD dressing PRN.</p> <p>R11's Weekly Wound Assessment Form for Right Lower Buttock, dated 6/1/20, documents: 6/1/20 Right Lower Buttock 5 cm X 5 cm. Left buttock to crack cleanse with Hibiclens, Apply Anasept to dark brown Necrotic tissue, Sprinkle with collagen Particles and Cover with ABD (Army Battle Dressing).</p> <p>R11's Progress Notes, dated 6/4/20, New measurement for wounds. The right buttock 5 cm X 5 cm with 5 cm depth. New dressing applied at this time. The right buttock crack measures 15 cm X 2.5 cm with 7.75 cm depth. New dressing</p>	S9999		

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S9999	<p>Continued From page 10 applied.</p> <p>R11's Weekly Wound Assessment form for Right Lower Buttock, dated 6/12/20, documents: 2.5 cm X 2.5 cm X .2 cm, clean with Hibiclens apply Hydrocolloid.</p> <p>R11's Documentation from the Wound Consultant Nurse (V23), dated 6/12/20, Wound 1 is Buttock Left is Unstageable 5.5 cm X 4.0 cm and is 100% Eschar with purulent drainage, Wound 2 Buttock, Left Inner Stage III is 4.8 cm X 2.8 cm, Wound 3 Right Buttock is Unstageable 8.0 cm X 5.0 cm. Treatment is Wound 1 Calcium Alginate. Treatment Wound 2 Collagen change daily. Treatment to Wound 3 is Sorbact to debride necrotic tissue.</p> <p>R11's Progress Notes, dated 6/19/20, dressing changed still has necrotic tissue in coccyx and on buttock.</p> <p>R11's Progress Notes, dated 6/24/20, documents: Due to blood coming from penis and unsuccessful attempts at catheterization and scant output of less than 150 cc per shift for 24 hours. Will transfer to Hospital.</p> <p>On 8/24/20 at 10:55 AM, V1 (Administrator) stated that R11 was sent to the Emergency Room on 6/24/20 related to issues with a catheter. V1 added that due to extensive Pressure Wounds R11 did not return until 8/6/20.</p> <p>R11's Emergency Room Records, dated 6/24/20, documents that (R11) presented to the emergency room for concerns regarding decreased Urinary Output and Hematuria. The patient has had an indwelling cath (catheter) for approximately 3 weeks due to incontinence and a</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>decubitus ulcer. A CT (Computed Tomography) of Abdomen was ordered and a cutaneous ulcerative defect with gas located within the posterior buttock region. Orders received to admit (R11).</p> <p>R11's Hospital - Reason for Consult, dated 6/25/20, documents that (R11) presented with advanced decubitus of the sacral region. CT scanning confirms the decubitus. Assessment: Stage IV decubitus the sacrum. I (V18/Surgeon) debrided a considerable amount of nonviable tissue from the decubitus region at the bedside. Procedure performed: Incision and drainage with extensive debridement of 7 X 6 X 5 cm sacral decubitus and 6 X 5 X 3 cm sacral decubitus. Indication: Advanced ulcerations with necrosis and sepsis.</p> <p>R11's Hospital Surgical Report - V22 (Surgeon) documented the following. (R11) was returned to the Operating Room, on 6/30/20, for further debridement of sacral pressure wounds with necrotic tissue. Post-operative Diagnosis: Sacral Pressure Wounds with Necrotic Tissue. Procedure Performed: Debridement of two sacral pressure wounds including skin, subcutaneous tissue, and muscle: measuring 14 X 12 X 3 cm on the left wound and 15 X 14 X 4 cm on the mid-sacrum wound.</p> <p>R11's Nursing Assessment, upon readmission to facility from hospital dated 8/6/20, documents the diagnoses: Multiple Sclerosis, Stage 4 Decubitus Ulcers with (Negative-Pressure Wound Therapy), and Post Sepsis with Septic Shock. R11 has Supra-Pubic Catheter.</p> <p>On 9/11/20 at 12:00 PM, V14 (Physician) stated that R11 was in an acute bed and a swing bed for</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>7 weeks related to the stabilization of R11 related to sepsis, his pressure wound surgeries, and related to inserting a supra pubic catheter. V14 stated, due to R11 laying in feces and urine and not being turned at night, contributed to the development and the worsening of the pressure ulcers.</p> <p>On 9/9/20 at 12:00PM, V23 (RN/Clinical Specialist) stated that she is not a wound nurse but is a provider of Medical Durable Equipment and only told V1 what dressings are available for R11. V23 stated she was told by the facility that R11 was admitted to the facility with the wounds intact. V23 went on to say that all residents in nursing homes get pressure wounds. Regarding the Stage 3 wound identified on 3/15/20 as a Stage III, V23 stated that wounds that are necrotic should be staged as Unstageable because you cannot see the depth and the underlying condition of the wound. V23 stated that she did see R11 on 5/21/20 and 6/12/20.</p> <p>On 8/24/20 at 2:00 PM, V2 and V11 (Both Registered Nurses) performed a dressing change due to R11 being incontinent of stool. Two Stage 4 Decubiti noted to buttocks. Nurses cleaned the wounds applied dressings and reapplied Negative Pressure Wound Therapy. An attempt was made to interview R11 at this time and R11 was slow to respond and did not answer questions appropriately. R11's MDS dated 8-11-2020, after return from hospitalization, identifies a BIMS score of 7 (Severely impaired cognitively.)</p> <p>The facility's computerized Time Card documents that V21 worked from 3/9/20 to 5/27/20, 5 days a week, arriving around 10:00PM and leaving around 6:00AM.</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>The facility's Pressure Injury Protocols: Clinical Interventions for All Stages documents to Maintain Skin Condition- If the resident is incontinent, cleanse the skin per facility guideline following each incontinent episode. Minimize excess moisture on the skin.</p> <p>The facility's Incontinent Peri/Buttocks Care Policy documents the Purpose: To maintain cleanliness of perineal/buttock area, decrease offensive body odor to aid in prevention of urinary tract infection and skin breakdown. Procedure should be done each time resident is noted to be incontinent if they are unable to perform task themselves.</p> <p>The facility's Standing Orders, For Decubitus Care, dated 2/1/11, documents the following: 1. Turn and reposition every 2 hours, Moisturizer to unbroken areas. 3. On "Shear Ulcer" (superficial wounds Stage II) apply DUODERM. Replace as needed but at least weekly until healed. 4. For Stage III or IV irrigate with Normal Saline then apply Saline soaked dressing. Change as often as necessary to maintain moist wound environment. Notify Physician.</p> <p>2. On 8/24/20 at 11:30 AM, V11 (Registered Nurse) stated R12 had an open area on his right buttock when he was admitted and they were cleansing the wound with an antibacterial soap and applying a Hydrocolloid dressing every 3 days and as needed. V11 stated the wound on R12's right buttocks was very small and almost healed when he was admitted. V11 stated on 8/22/20 they found a new wound on R12's coccyx and started cleansing the area on R12's coccyx with normal saline and applying a Hydrocolloid dressing to the wound per their Standing Orders. On 8/26/20, V11 and V8 (Certified Nurse's Aide)</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>both stated R12's wound to his coccyx wasn't there on 8/20/20. V11 stated they were applying a barrier ointment to the scrotum, but the area has gotten worse because R12 is incontinent of bowel and scoots continuously when he's up in his wheel chair. V11 also stated there have been many mornings when she's come to work and R12 would be soaked in urine and have bowel movement on him and that was why his skin continues to break down.</p> <p>On 8/24/20 at 12:45, V1 (Administrator) stated R12 was given a terminal diagnosis by his Oncologist but R12's family didn't want him on hospice. V1 stated the wound on R12's right buttocks was worse than what the former facility said it was and the area on his scrotum was there because R12 scoots back and forth in his wheel chair because he has Restless Leg Syndrome. On 9/8/20 at 4:00 PM, V1 stated the nurses use the standing orders of irrigating the wound with Normal Saline and apply Hydrocolloid dressing for wound care.</p> <p>On 8/24/20 at 11:30 AM, R12 was observed being turned on his right side by V8 and V11. Once turned, R12 had been incontinent of bowel. R12's coccyx was observed being measured and it was 4 centimeters (cm) x 4 cm in diameter. R12's wound on his coccyx was very red around the perimeter of the wound, was bleeding, and there was some blackened tissue around the edge of the wound and this wound had a foul odor. V11 measured the wound on R12's scrotum and the wound measured 12 cm x 6 cm. The tissue on R12's scrotum was black with a hardened, raised area, and the wound had a very bad odor. When R12 was being measured, he was yelling out, "It hurts!" There was no pressure relieving mattress on R12's bed.</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>R12's Face Sheet documents R12 has a diagnosis of Renal Failure, Type II Diabetes Mellitus, Congestive Heart Failure, Ventral Hernia, Hyperlipidemia, Colon Cancer with Resection, Hypertension, Anxiety, Stage II Pressure Ulcer to Scrotum.</p> <p>R12's Plan of Care dated 7/22/20 documents R12 is at risk for skin breakdown and to apply skin barrier to scrotum and Zinc to buttocks. Turn and reposition every 2 hours; Plan of Care does not have other preventative measures to prevent wounds. On 8/26/20 the following was added to R12's Care Plan after the wounds were brought to V1's attention; Apply Zinc Oxide or Balm to scrotal area every shift and use a scrotal cushion to lift scrotum from firm surfaces; Turn and reposition every 2 hours. Start Juven for 28 days to promote wound healing.</p> <p>R12's Braden Scale dated 7/20/20 (date of admission) documents R12's score was 16, indicating R12 was at risk for skin breakdown. R12's Weekly Wound Assessment dated 7/20/20 documents R12 had a wound on his right buttocks that measured 1 cm x 1 cm x 0 cm and on 8/14/20, the same wound measured 1 cm x ¾ cm x 0 cm and under Wound Status documents; Improving. The Weekly Wound Assessment dated 8/22/20 documents R12 has a new Stage II wound on his coccyx that measured 3.2 cm x 1.2 cm x .5cm with minimal drainage. Treatment was to apply hydrocolloid dressing to the wound every 3 days and as needed per the facilities Standing Orders. V14 (Physician) was not notified that the wound on R12's coccyx was worsening and had an odor.</p> <p>R12's Treatment record dated August 2020</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>documents; Apply barrier ointment to buttocks every shift and PRN to 1cm x 1 cm on Right buttock, then on 8/23/20, R12's treatment sheet documents; Area on coccyx, one time per day, cleanse area with normal saline and apply a Hydrocolloid dressing every 3 days and as needed; open area on scrotum; 1 time per shift, Apply barrier ointment to scrotum.</p> <p>R12's Progress Notes dated 8/24/20 document, "Resident noted to have 4cm x 4cm open area to coccyx, necrotic. Area will be cleansed with normal saline and a new Hydrocolloid dressing will be applied. Review of R12's Progress notes has no documentation that V14 was notified of the coccyx being necrotic and worsening. R12's Progress Notes dated 8/26/20 document that an air mattress was placed on R12's bed.</p> <p>The facility's fax form sent to V14, dated 8/25/20 (after surveyor asked for wound measurements on R12 on 8/24/20) documents under "Remarks"; "Update on R12: Has an area on scrotum about 8-10 cm in length- 2cm wide. Is dark blue in color, Almost looks like a large varicose vein-Also has 2 areas -Stage II- Bag balm is being applied. Do you think a Foley would help since we're are forcing fluids and he is constantly incontinent."</p> <p>Record Review showed there were no measurements for the wound on R12's scrotum until this surveyor asked for wound measurements on 8/24/20. Record Review also showed there were no new orders received from V14 and no further preventative measures added to R12's Care Plan. The facility's "Standing Orders" documents under; For Decubitus Care: 1. Turn and reposition every 2 hours, 2. Moisturizer to broken areas, 3. On "shear Ulcers" (Superficial wounds Stage II) Apply Duoderm.</p>	S9999		

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S9999	Continued From page 17 Replace as needed but at least weekly until healed, 4. For Stage III or IV irrigate with Normal Saline then apply Saline soaked dressing. Change as often as necessary to maintain moist wound environment. Notify Physician. (A)	S9999		
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