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S 000	Initial Comments Complaint #1821004/ IL100302 Statement of Licensure Violations	S 000		
S9999	Final Observations 1 of 2 Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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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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. Restorative measures shall include, at a minimum, the following procedures:
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.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

1. Based on interview and record review, the facility failed to notify the physician with a change of condition, obtain a STAT lab draw, report abnormal laboratory results, and to transfer to the emergency room for one of one resident (R7) reviewed for physician notification in the sample of 52.

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S9999	Continued From page 2 2. Based on interview and record review the facility failed to ensure a physician ordered laboratory value was obtained in a timely manner for one of one resident (R7) reviewed for laboratory values in the sample of 52. These failures resulted in R7 being hospitalized with the diagnosis of Anemia and Septic Shock. Findings include: 1. The facility's Change of Condition Reporting policy, dated 2/2013, documents, "The facility will notify the resident's physician and the resident's representative whenever: There is significant change in the resident's health, mental or psychosocial status; There is a change in the resident's condition that although not significant is prudent to report using good nursing judgment; The resident is to be transferred or discharged." The facility's Laboratory Agreement, dated 4/8/2015, documents, "The laboratory company will provide STAT (life threatening situation) service for clinical lab services 24 hours per day, 365 days per year. Laboratory STAT testing will be reported within five hours of laboratory notification." The facility's Lab/X-ray orders policy, dated 11/1998, documents, "Radiological and diagnostic testing will be available 24 hours per day, seven days a week." The facility's Obtaining Lab Specimens policy, dated 11/1998, documents, "Document the collection of the specimen and the resulting findings in the nurse's notes, as well as physician and family notification of any abnormal results."	S9999		

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R7's Nurse's notes, dated 2/9/18 at 2:00 a.m., document, "R7 has been shaky and weak the past couple of nights. Color pale. Strong smelling urine and seems increasingly confused."

R7's Nurse's notes, dated 2/9/18 at 6:45 a.m., document, "R7's son requested a STAT Hemoglobin and Hematocrit. Dr notified. Orders written. STAT lab called into laboratory company."

On 2/22/18 at 9:45 a.m., V8 (Certified Nursing Assistant) stated, "We (V8 and V13 (Certified Nursing Assistant) reported to (V9 Licensed Practical Nurse) that (R7) wasn't acting herself before breakfast, then three additional times. (V9) kept telling us (R7) probably needs a blood transfusion. After breakfast, (R7) had a black tarry stool. We reported that to (V9). Later that morning, (R7) was dry heaving when we took her to the bathroom, and we reported that to (V9)."

On 2/22/18 at 12:05 p.m., V13 stated, "Right away in the morning (2/9/18), (R7) is normally pretty independent and she couldn't stand or barely sit up on her own. We assisted her to the toilet and cleaned her up. I reported this to (V9) and (V9) said, 'Yeah the 3rd shift nurse told me she needs a transfusion. She's fine.' A little later (R7's) call light was on and I smelled something. So I told (R7) we needed to go to the restroom. Her skin color was yellow, and she was incontinent of black tarry stools all over in her clothing. She's never incontinent. I reported this to (V9) again, and (V9) told me, 'Yeah she needs a transfusion.' (R7) was weak all day, and didn't want to come out of her room. She is normally out and about social with activities and meals, and she wasn't herself."

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S9999	Continued From page 4 On 2/22/18 at 12:55 p.m., V4 (Certified Nursing Assistant) stated, "(R7) wasn't feeling well. She didn't look good, and she had black tarry stools. Myself and (V13) told (V9) twice that day (2/9/18) that something was wrong with (R7) but (V9) never would do anything." R7's Nurse's notes, dated 2/9/18, document at 8:45 p.m. "Received call from laboratory, R7's Hemoglobin of 3.7;" at 8:55 p.m. 911 called; at 9:04 p.m. R7 left the facility by ambulance." R7's Laboratory report, dated 2/9/18, documents that a Hemoglobin and Hematocrit level were drawn on 2/9/18 at 5:27 p.m., received at 7:17 p.m., and the critical values of the Hematocrit of 14.9 (normal 35-46) and Hemoglobin of 3.7 (normal 12-15.5) were reported to the facility by fax at 9:43 p.m. R7's Nurse's notes, dated 2/9/18, have no documentation of R7's physician being notified after 6:45 a.m. with R7's change of condition symptoms, the delay in STAT lab draw, the abnormal laboratory results, nor when R7 was transferred to the emergency room. On 2/22/18 at 10:30 a.m., V9 confirmed that R7 symptoms of black tarry stools, weak and slow were reported to her by other staff members, and that she did not report these symptoms to the physician. V9 also confirmed that R7 had an order for a STAT Hemoglobin and Hematocrit that was ordered in the morning. However, when V9 left the facility at 2:15 p.m. the lab had still not been drawn, and that V9 did not notify the physician of the delay in the lab draw time. R7's Emergency Department to Hospital Admission, dated 2/9/18, documents that R7's	S9999		

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S9999	Continued From page 5 reason for admission was Septic Shock and Anemia due to Gastrointestinal blood loss. R7's Hospital History and Physical, dated 2/10/18, documents, "R7 presents with low hemoglobin and worsening confusion." The History and Physical also documents, "R7 was brought to the emergency room and her Hemoglobin was 4.1 with hypotension and urinalysis with a possible urinary tract infection. R7 got short of breath and hypoxemic and was started on BIPAP and admitted to the intensive care unit for evaluation and treatment." Also documented was, "Principle problem: Severe Anemia with hemocult positive stool. Transfusing packed red blood cells." On 2/22/18 at 1:30 p.m., R7 stated, " I was very sick the day I went into the hospital. I don't remember anything that day I just know I was very sick." On 2/21/18 at 12:15 p.m., V1 (Administrator) stated, "During that day (2/9/18) that morning a STAT lab was ordered for (R7) and her condition was changing throughout the day. It was reported to (V9) that (R7) was weaker and having black tarry stools. (V9) should have done something about this. Had she taken care of (R7) correctly she would have notified the physician and sent (R7) out earlier instead of the second shift nurse sending her out." V1 also stated, "(V9) should have notified the physician of (R7's) change in condition and that her laboratory values had not been drawn. (V15 Registered Nurse) should have notified the physician when she received the critical lab result and when she sent (R7) to the emergency room." On 2/22/18 at 1:15 p.m., V2 (Director of Nursing) stated that a STAT lab value should be drawn	S9999		

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within two to four hours, and if it doesn't get done in that time frame the nurses should call the laboratory again and see where the phlebotomist is. V2 also stated that the nurses can draw the lab value themselves and take it to the laboratory or send the resident to the emergency room.

On 2/22/18 at 11:30 a.m., V7 (Medical Director) stated, "I was notified at 2:00 a.m. and 6:45 a.m. regarding (R7's) change in condition, and I ordered a STAT Hemoglobin and Hematocrit with the last phone call at 6:45 a.m. A STAT lab should be drawn within a few hours not almost twelve hours later. If a STAT lab draw is delayed I would have them transferred to the emergency room to have the lab drawn. I should be notified that the laboratory is delayed, and I wasn't. If the nurse would have notified me of the new symptoms of black tarry stools I would have insisted (R7) be transferred to the emergency room much earlier than 9:00 p.m. I should have been notified of these changes and again I wasn't. I also wasn't notified of her critical laboratory value or that she was sent to the emergency room."

(A)

2 of 2 Licensure Violations
300.610a)
300.1210a)b)c)
300.1210d)2)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. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the

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S9999	Continued From page 7 administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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:	S9999		

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S9999	Continued From page 8 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced by: 1. Based on observation, interview and record review, the facility failed to develop and implement a care plan to address a resident's skin condition for one of four residents (R4) reviewed for care plans, in a sample of 52. 2. Based on observation, interview and record review, the facility failed to assess a resident's skin condition (R3 and R4), failed to administer a physician-ordered skin treatment (R3), failed to monitor a resident's skin condition (R3 and R4)	S9999		

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and failed to develop a care plan for an at-risk resident (R4). Two (R3 and (R4) of three residents reviewed for pressure ulcers in a sample of fifty two

These failures resulted in R3 developing multiple avoidable Stage 2 pressure ulcers and R4 developing avoidable pressure ulcers, including two unstageable pressure ulcers and a stage 2 pressure ulcer.

FINDINGS INCLUDE:
The facility policy, Baseline Care Plan, dated (revised) 10/2017 directs staff, "To ensure a plan of care is available for all residents until their comprehensive interdisciplinary care plan is completed, a 'Baseline care Plan' will be initiated within 48 hours of admission and will include the instructions needed to provide effective and person centered care and is developed based on relevant diagnoses, medical conditions and other physical or psychosocial needs. Personalize the baseline care plan so it reflects as accurately as possible the resident's conditions and care needs. Make changes, updates , additions or deletions to the Baseline Care Plan as needed based on changes of condition, new information regarding care needs, new physician orders, ect. until the Comprehensive Interdisciplinary Care Plan is completed."

The facility policy, Skin Care: Pressure Ulcer/Wound Management, dated (revised) 10/04 directs staff,"To promote healing of pressure ulcers, stasis ulcers and other wounds, (the facility) will use standardized protocols or follow physician's specific orders for wound care. Optimal wound management will include: Assessment of skin and wound. Use of standardized protocols. Regular reassessment to

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monitor effectiveness of interventions. The nurse will: Do a complete skin assessment of each new guest upon admission to identify any wounds. Document the size and description of the wound in the nurse's notes. Initiate a wound documentation form, identifying the type of wound, the size, the location and the status of the wound. Obtain orders for (an) appropriate treatment. Implement appropriate pressure ulcer prevention protocols per policy. Complete skin assessments on all guests weekly after showers or as assigned to check for new skin integrity impairment. Document results in the nurse's notes. Perform treatments as ordered. Make changes to the resident's care plan as necessary to include risk of skin integrity impairment, current skin condition, preventative measures taken and treatments."

1. R3's Physician Transfer Order Report documents that R3 was transferred to the facility from a local hospital on 2/12/18 after surgery from a Closed Fracture of the Right Distal Femur. R3's other diagnoses include: Cellulitus of the Left Lower Extremity and Obesity. Included in this same document is an order for Clotrimazole-Betamethasone Cream (anti-fungal) Apply twice daily for excoriation over buttocks.

R3's facility Admission Nursing Assessment, dated 2/12/18, under General Skin Condition, directs staff to, "In the diagram below please indicate all body marks such as old/recent scars (surgical and other), bruises, discoloring, abrasions, pressure ulcers or any questionable markings. Indicate decub (decubitus) size, depth, color and drainage." No bruises, discolorations, abrasions or decubitus ulcers are documented on R3's skin assessment.

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R3's Physician Order Sheets, dated 2/12/18 include the following orders: Lotrisone Cream apply BID (twice daily) at 9:00 A.M. and 6:00 P.M. over excoriated buttocks, and Weekly Skin Assessment on Mondays.

R3's Treatment Administration Record, dated 2/12/18 does not document the physician ordered treatment or that the facility staff completed the treatment as ordered on 2/12/18, 2/13/18, 2/14/18 or the morning of 2/15/18. This same Treatment Record does not document (R3) being assessed for Weekly Skin Assessments on 2/12/18 or 2/19/18.

R3's (untimed) Nurse's Progress Notes, dated 2/15/18 document, "(3) Stage 2 areas with excoriation of whole buttocks. Bruising of buttocks and abdomen, also of right leg from fall at home."

R3's facility Wound Documentation (3 documents) dated 2/12/18 documents, #1. Pressure wound to left buttocks, Stage 2, 1.5 CM (centimeter) X 0.5 CM, scant sero-sanguinous exudate with redness to the peri-wound area. #2. Pressure wound to left buttocks, Stage 2, 1 CM X 1 CM, scant sero-sanguineous exudate, with episodic pain and redness to peri-wound area. #3. Pressure wound to right buttock, Stage 2, 1 CM X 1 CM, scant to moderate sero-sanguineous exudate with redness to peri-wound area.

On 2/20/18 at 1:40 P.M., V15/Registered Nurse stated, "I got in Report from the hospital that (R3)'s bottom was excoriated. I did not look at (R3)'s bottom once (R3) got here on 2/12/18. I didn't have enough help and it would have taken three of us to roll (R3). (R3)'s a big lady. There wasn't any orders for a treatment to (R3)'s bottom

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S9999	Continued From page 12 on admission." On 2/20/18 at 1:50 P.M. V18/ Licensed Practical Nurse (LPN) stated, "I took an order from the doctor on February fifteenth for (R3)'s buttocks. (R3) had three pressure ulcers. I didn't write a telephone order for the treatment." On 2/20/18 at 1:55 P.M. V3/Wound Nurse stated, "I saw (R3)'s buttocks on February fifteenth, (R3) had three stage two pressure sores." On 2/21/18 at 8:30 A.M., V2/Director of Nurses verified that R3's Treatment Administration Record did not document the physician ordered treatment as being administered or weekly skin assessments as being performed. On 2/21/18 at 12:35 P.M., V1/Administrator stated, "A nurse would be expected to complete a skin assessment on admission, document the findings, obtain a doctor's order for a treatment and document that treatment on the treatment administration record." On 2/22/18 at 11:20 A.M., V7/Physician stated, "Untreated, macerated skin over a pressure area can lead to the development of a pressure wound." 2. R4's Physician Order Transfer Report documents that R4 was admitted to the facility on 11/20/17 after a Surgical Repair of a Traumatic Rupture of the Right Quadriceps Tendon. This same document includes the following physician's orders for treatment: Non-weight bearing to right lower extremity. May do touch down weight bearing on right side to maintain balance if needed. Change dressing on post op (operative) day 3 to telfa/tegaderm. May shower with this	S9999		

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	IL6012587	A. BUILDING: _____ B. WING _____	C 02/22/2018

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S9999	Continued From page 13 dressing on. Do not bend the knee. Brace on and locked in extension. R4's facility (un-signed) Admission Nursing Assessment, dated 11/20/17 at 4:00 P.M. includes the following documentation under Skin General Condition, "pale, dry, warm." This same document instructs the user, "In the diagrams below please indicate all body marks such as old/recent scars (surgical and other), bruises, discoloring, abrasions, pressure ulcers or any questionable markings. Indicate decub (decubitus) size, depth, color and drainage." The anterior view of the diagram includes, "Pacemaker scar (upper left chest), IV (intravenous) site X2 (left lower arm) and Surgical repair site (right knee). The posterior view of the diagram is blank. The diagram does not include any areas noted for decubitus ulcers. A "right leg brace" is documented under "Supportive Devices Used." R4's Pressure Ulcer Risk Assessment, dated 11/20/17 documents that R4's skin risk as a "17." "A score of 9-15 = Mod (moderate) risk. Implement appropriate Preventative Protocols-See reverse side of form." This same form (reverse side) directs staff, "Check all appropriate interventions and indicates (by check mark), Turn and reposition at frequent intervals/ as necessary. Utilize pressure redistribution mattress and w/c (wheel chair) cushion. Monitor areas of pressure under splints/ braces." R4's Treatment Administration Record (TAR) dated 11/20/17 includes the following physician's order: Weekly skin assessment. Document moisture, color, temp (temperature), integrity, turgor on shower day or as scheduled.	S9999		

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S9999	Continued From page 14 R4's Physical Therapy Evaluation and Plan of Treatment, dated 11/21/17 documents under Assessment Summary, "(R4) is a pleasant and cooperative 90 year old who presents to this facility s/p (status post) quadriceps tendon repair. (R4) presents with NWB (non weight bearing) status and with an immobilizer and presents with deficits in RLE (right lower extremity) strength, bed mobility and balance. (R4) (is) at a w/c (wheel chair) level and unable to ambulate secondary to NWB status. Due to documented physical impairments and associated functional deficits, (R4) is at risk for DVT (deep vein thrombosis), falls, further decline in function, immobility, muscle atrophy and pressure sores." R4's Minimum Data Set (MDS) Assessment, dated 11/29/17 documents under Activities of Daily Living (ADLs) that R4 requires, "extensive assist of 2 staff members for bed mobility and transfers." This same assessment documents R4's Risk of Pressure Ulcers as, "(This resident) is at risk of developing pressure ulcers. And, "(This resident) does (not) currently have one or more unhealed pressure ulcers at Stage 1 or higher." R4's Care Area Assessment: Pressure Ulcer, dated 12/11/17 and signed by V3/Licensed Practical Nurse/Wound Nurse, documents, "At risk for pressure ulcer due to functional limitations requiring staff assistance for mobility, position changes. Proceed to Care Plan."	S9999		
	R4's facility Treatment Administration Record, dated December 2017 documents facility staff only performed a "Weekly Skin Assessment" on R4's skin on 12/9/17 and 12/23/17 by staff initializing as complete. There is no documentation of moisture, color, temperature,			

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S9999	Continued From page 15 integrity or turgor. There is no staff documentation on 12/2/17 and 12/16/17 that R4's physician ordered skin assessment was completed. R4's (unsigned) 12/9/17 Shower Record/Skin Audit documents, "Reddened areas (pressure)." This same form documents, "Slightly red between cheeks" and has an arrow pointing to the coccyx/buttocks area. This form directs facility staff, "If New condition, Nurse must notify Physician and Responsible Party. Secure Treatment." The form gives no indication that the physician or responsible party were notified or that a treatment for the affected area was obtained. R4's Nurse's Progress Notes, dated 12/20/17 document, "12 pm Two open areas noted to (R4)'s buttocks. One on (R4)'s coccyx measuring 2 CM (centimeters) X 1.2 CM. The other open area on the left buttocks measuring 1.5 (CM) X 0.5 (CM). The facility Weekly Pressure Ulcer Report, dated 12/29/18 documents, "(R4) Stage 2 pressure ulcer to coccyx, identified on 12/20/17. Current measurements include: 1.5 (CM) X 1.5 (CM)." This same form documents (R4)'s pressure ulcer as, "House Acquired." R4's January 2018 Treatment Administration Record documents that no facility staff completed physician ordered weekly skin assessments for the entire month. The facility Weekly Pressure Ulcer Report, dated 1/5/18 documents, "(R4) Stage 2 pressure ulcer to coccyx, 2 CM X 2 CM.	S9999		

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The facility Weekly Pressure Ulcer Report, dated 1/19/18 documents, "(R4) Coccyx pressure ulcer as UTS (unstageable)."

R4's Nurse's Progress Notes, dated 1/21/18 at 6:00 P.M. document, "Open area noted 1 CM X 1 CM on (R4)'s right inner knee."

R4's Ortho (Orthopedic) Note, dated 1/24/18 documents, "(R4) has pressure ulcer on medial aspect of knee."

R4's Nurse's Progress Notes, dated 1/30/18 document, "New order received (for treatment) to right outer ankle. Cleanse with NS (Normal Saline), apply telfa and cover with border adhesive."

R4's Wound Documentation form, dated 1/26/18 documents,"Right knee 4 CM X 2 CM, 100% eschar (Unstageable) to wound bed. Pressure from brace."

R4's February 2018 Treatment Administration Record documents that no facility staff completed physician ordered weekly skin assessments through 2/20/18.

On 2/21/18 at 10:30 A.M., V14/Licensed Practical Nurse (LPN) removed the dressings from R4's skin and revealed a 1.5 CM (centimeter) X 1 CM, Stage 2 pressure wound to the right outer ankle with a yellow eschar center; a 2.5 CM X 1.75 CM, Unstageable pressure wound to the right inner knee with thick yellow eschar and a hard, black necrotic center. A foul odor and yellow drainage were noted when the dressing was removed; and a 2 CM X 0.5 CM, Stage 2 pressure wound to the coccyx that was pink with hard, white, rolled edges. The bandage was full of stool. At this

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S9999	Continued From page 17 same time, V14/LPN stated, "(R4)'s leg brace caused the wounds. I don't know where (R4)'s care plan is. (R4) doesn't have one." On 2/21/18 at 12:45 P.M., V2/Director of Nurses (DON) stated, "We knew that brace (of R4)'s was gona be a problem. It didn't fit (R4) well when they put it on (R4). It kept bothering (R4). They (staff) were supposed to be looking at (R4)'s skin everyday. They (staff) should have charted it in (R4)'s TAR. I would call that area on (R4)'s right ankle a stage 2 pressure ulcer. The wound nurse said it was an abrasion, but it's not." At that time, V2/DON verified that R4's treatment administration records were incomplete. On 2/22/18 at 9:50 A.M., V3/Wound Nurse stated, "(R4) was admitted (to the facility) in November and should have been repositioning from side to side due to (R4) being at risk for skin breakdown. (R4) also should have weekly skin checks done by a nurse and the results should be documented on the back of the treatment record. (R4) was found with a stage two open area on (R4)'s buttocks on December twentieth during cares. At one point the wound deteriorated until it was unstageable. I don't know who found that area on (R4)'s buttocks on (December) ninth. If we had known, there are interventions we could have started to prevent it from getting worse. (R4) does not have a care plan for (R4)'s pressure ulcers. (R4) should have one to tell the staff what to do for (R4)'s wounds." (B)	S9999		