Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000186	A. BUILDING: ______ B. WING ______	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	4900 NORTH BERNARD CHICAGO, IL 60625

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S 000	Initial Comments Annual Licensure Survey 2188037/IL139752	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff protected a resident that was assessed for increased vulnerability for three residents (R45, R54, R91) in the sample of 72 reviewed for abuse. This failure resulted in R91's physical assault on R45 and R54 which required transfer to the hospital for R45 for an injury of contusion of right shoulder and required emergent transfer to the hospital for R54 for laceration to the right eyebrow measuring one centimeter (cm) in length and four cm in depth that required two sutures.

Findings include:

R91's Admission Record documents, in part, that R91 is a 67-year-old with diagnoses of unspecified dementia with behavioral disturbance, restlessness and agitation, and aphasia following cerebral infarction.

R91's Trauma Screening, dated 9/17/21, documents, in part, that R91 has "factors that increase (R91's) vulnerability (... confusion, disorientation, poor insight/poor judgement, poor communication skills ... frailty/weakness)." However, in this same screening, R91 is assessed as having "history or presence of dysfunctional behavior (e. g. [for example], provoking, aggressive, manipulative, derogatory, disrespectful ... and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space."

R91's MDS, dated 9/15/21, documented that the

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staff assessment for mental status was conducted for R91 and that R91 has short- and long-term memory problems with cognitive skills for daily decision making as "modified independence."

R91's Care Plan, dated 9/16/21, which was presented to this surveyor on 11/10/21 by V22 (Social Services Director, SSD), after V2 (Director of Nursing, DON) had provided R91's requested complete care plan, documents, in part: "(R91) displays conflictual, difficult behavior with other persons related to: Poor or ineffective coping skills and general intolerance and limited ability to deal with frustration. Behavior symptoms are manifested by: Complaints/concerns about other residents and physical contact with staff. Approaches: Teach and remind (R91) to communicate (R91's) feelings, including anger and frustration through means other than hitting, touching."

On 9/16/21 at 3:51 pm, V21 (Licensed Practical Nurse, LPN) documented, in part, in R91's incident note, "Writer noted (R91) in the hallway making physical contact towards (R45, R54) with a cane."

Census documents for the date of 9/16/21 indicated that R45 and R91 were roommates with R54 residing in the next neighboring room.

On 11/8/21 at 1:18 pm, V16 (RN) stated that on 9/16/21, during her morning medication pass, V16 was in the hallway and stated, "I (V16) am the witness." V16 stated that she (V16) observed R45 and R54 outside of R45's room where R91 hit R45 and R54 with R91's black cane. V16 stated that she (V16) witnessed in the hallway R91 hit R45 in the back of the head. V16 stated

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that V16 called out for help, and as she (V16) was "getting to (R91), (R91) was swinging to hit (R54) again." V16 stated, "(R45) ran away and was trying to shield himself." V16 then stated that at this time, R54 was observed in the hallway, facing the wall and holding onto the safety rail attached to the hallway wall with hands, and that R91 hit R54 from behind with R91's cane. V16 stated that V16 didn't notice that R54 was bleeding from the face until R54 turned around from facing the wall. V16 stated staff "helped (R54) into a chair (in the hallway) because (R54) couldn't walk and was so weak." V16 stated that R45, R54 and R91 were separated, sent to hospitals and that staff didn't know what happened between these three residents prior to observing them in the hallway. When asked about R91's previous behaviors, V16 stated, "I (V16) don't know (R91) that much. (R91) was on another floor. (R91) relatively new to second floor when this happened."

On 11/08/21 at 3:17 pm, V21 (LPN) stated that on 9/16/21, she (V21) was at the second-floor nurse's station when V21 heard V16 "shout so I (V21) ran." V21 stated, "I (V21) saw (R91) striking (R45). I (V21) saw (R91's) cane go up and strike at (R45)." V21 stated that staff separated R91 from R45, and "As we (staff) backed out (R91) away from (R45), I (V21) saw (R91's) arm with cane swing and connected with (R54)." V21 also stated that R54 was standing in the hallway, facing the wall, and holding onto the safety bar.

R45's Admission Record documents, in part, that R45 is 51 years old with medical diagnoses of Schizoaffective disorder, Parkinson's disease and weakness.

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R45's Trauma Screening, dated 3/9/21, documents, in part, that R45 has "factors that increase (R45's) vulnerability (... confusion, disorientation, poor insight/poor judgement, poor communication skills ... frailty/weakness)" and that R45 has no "history or presence of dysfunctional behavior (e. g. [for example], provoking, aggressive, manipulative, derogatory, disrespectful ... and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space."

R45's Minimum Data Set (MDS), dated 9/6/21, documented that R45's Brief Interview for Mental Status (BIMS) was not performed due to R45 is "rarely/never understood" and that R45 has short- and long-term memory problems with cognitive skills for daily decision making as "moderately impaired."

R45's Care Plan, dated 6/11/20, documents, in part: "(R45) demonstrates cognitive impairment related to unspecified symptoms and signs involving cognitive functions and awareness. Symptoms are manifested by: Impaired decision making, poor logic, and poor ability to understand cause and effect. Approaches: Assess suspected transient causal factors."

On 9/16/21 at 8:55 am, V16 (Registered Nurse, RN) documented, in part, in R45's incident note, "Writer noted (R45) walking in the hallway and (R91) making physical contact towards (R45) with a cane on the head twice ... On assessment, slight redness noted to right upper posterior head."

R45's emergency department records, dated 9/16/21, document, in part, that R45's reason for

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hospital visit is "hit by a cane at NH (nursing home)." R45's emergency department discharge instructions, dated 9/16/21, document, in part, that R45 had "contusion of right shoulder" and that "a contusion is a bruise that appears on your skin after an injury."

R54's Admission Record documents, in part, that R54 is 69 years old with medical diagnoses of cerebral infarction, major depressive disorder and weakness.

R54's Trauma Screening, dated 8/16/21, documents, in part, that R54 has "factors that increase (R54's) vulnerability (... confusion, disorientation, poor insight/poor judgement, poor communication skills ... frailty/weakness)" and that R54 has no "history or presence of dysfunctional behavior (e. g. [for example], provoking, aggressive, manipulative, derogatory, disrespectful ... and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space."

R54's MDS, dated 9/10/21, documented that R54's BIMS score is a 6 which indicates severe cognitive impairment.

R54's Care Plan, dated 9/16/21, documents, in part: "(R54) demonstrates cognitive impairment related to: Diagnosis of mental illness. Symptoms are manifested by: Impaired decision making, poor logic and poor ability to understand cause and effect. Approaches: Offer and lend (R54) wise judgement/guidance."

On 9/16/21 at 2:35 pm, V16 (Registered Nurse, RN) documented, in part, in R54's incident note, "(R54) standing in front of (R54's) room by the

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door holding on the rail when (R91) make(s) physical contact towards (R54). Residents were immediately separated. (R54) being assess, noted above right eyebrow with laceration measuring 0.7 x 1.0 x 0.5 (centimeters) with medium amount of blood. Noted (R54) slow to respond ... Called 911. (R54) reported with translator that (R91) hit (R54)."

R54's emergency hospital records, dated 9/16/21, document that with interpreting assistance by hospital staff, R54 stated that "approximately 1 hours prior to arrival (R54) was struck in the head by a cane of a fellow nursing home resident. (R54) also seems to endorse being struck in the back at some point with the same walking cane during the altercation" and that R54's "right eyebrow laceration, length 1 cm, depth 4 cm" was repaired and closed with 3 sutures.

In facility document, titled "Initial Report" and dated 9/20/21, faxed timely to the state agency, V2 (DON) documented that the physical altercation of R45, R54 and R91 occurred on 9/16/21 at 9:30 am. V2 documented, in part, "Nurse on duty reported that (R91) and (R45) and (R54) were involved in a physical altercation while in the unit hallway."

On 11/9/21 at 9:38 am, V22 (Social Services Director, SSD) stated that V22 was not in the facility on 9/16/21. V22 stated that "monitoring" and "keeping (residents) closer to nurse's station" are interventions for supervising residents, and nursing and social services staff are responsible for monitoring resident behaviors.

On 11/10/21 at 9:33 am, V22 (SSD) stated that there is "no specific time frame for rounds" for monitoring residents and that nurses will report

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back to him (V22) with any resident behaviors. V22 stated that V22 will assess a resident's vulnerability, as indicated in the trauma screening document, in the facility during quarterly evaluations, and whenever there is a physical altercation incident between residents, nurses will screen residents' mental and physical conditions.

On 11/9/21 at 3:28 pm, V2 (DON) was shown in R45 and R54's electronic medical records that there was no trauma screening performed on or after 9/16/21 (date of physical assault from R91) for R45 and R54. V2 stated, "That should have been done."

On 11/10/21 at 3:15 pm, V33 (Attending Physician) stated that she (V33) has recently saw R54 in person and uses a translator to communicate with R54. V33 stated, "(R54) is a vulnerable resident." When V33 was asked about any long-term care resident suffering physical harm, like R54's incident of being struck by R91, V33 stated, "No physical harm should happen, and residents are to be frequently monitored." When V33 was asked about residents having the right to not have any abuse or harm, not even one time like R54, V33 stated, "That's right. Staff need to monitor behaviors if there's more than normal confusion." When V33 was asked if staff are expected to prevent physical harm from resident to resident, V33 stated, "Of course. Staff need to give medications and do rounds more."

Facility document, titled "Final Report" and dated 9/20/21, that was faxed to the state agency documented, in part, the conclusion from the incident between R45, R54 and R91 on 9/16/21 at 9:30 am: "Conclusion: An investigation was completed which determined that (R91) made

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physical contact with (R45) and (R54). According to staff who were present at the time of the incident, (R54) entered room of (R91) and (R45) which agitated (R91)."

On 11/9/21, V2 (DON) was asked for the facility's resident rights policy, and V2 provided this surveyor with a document, titled "Residents' Rights for People in Long Term Care Facilities" and dated November 2018, which documents, in part: " ... Your rights to safety: You must not be abused, neglected or exploited by anyone ... physically ... Your facility must provide services to keep your physical and mental health, at their highest practical levels."

Facility policy, titled "Abuse Prevention Program" and dated January 2019, documented, in part: "Policy: It is the policy of this facility to prohibit and prevent resident abuse ... in the facility. The following procedures shall be implemented when an employee or agent becomes aware of abuse ... of a resident ... Procedure: If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions ... VII. Prevention: The facility desires to prevent abuse ... against a resident by establishing a resident-sensitive and resident-secure environment ... As part of the social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse ... or who have needs and behaviors that might lead to conflict ... Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis ... Abuse and Crime Reporting: Policy: ... 4. Physical abuse:

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Hitting."

(B)

Statement of Licensure Findings:

300.610a)
300.1210b)
300.1210c)
300.1210d)5)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 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

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care needs of the resident.

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:

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a low air loss mattress was functionally operating and failed to set the low air loss mattress at the appropriate resident weight and pressure settings which affected one (R129) of two residents reviewed for pressure ulcers in a sample of 72. These failures caused R129's stage 4 sacral pressure ulcer to decline and increase in size.

Findings include:

R129 is a 72-year-old resident with diagnoses of Alzheimer's disease, attention for tracheostomy, reduced mobility and need for assistance with

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personal care.

R129's Minimum Data Set (MDS), dated 10/14/21, documented that R129's Brief Interview for Mental Status (BIMS) was not performed due to R129 is "rarely/never understood" and that R129 has short- and long-term memory problems with cognitive skills for daily decision making as "moderately impaired." R129's same MDS documents that R129 requires two persons physical assist due to total dependence for bed mobility, transfer, dressing, toilet use, bathing and personal hygiene, and R129's skin and ulcer/injury treatments include a pressure reducing device for the bed.

On 11/08/21 11:45 am, R129 was observed in bed on a low air loss (LAL) mattress system. The LAL mattress pump at the foot of the bed was observed with the weight dial set at approximately 220 pounds with the arrow pointing midway between the 200- and 250-pound markers. The static button indicator light was on with a yellow light lit next to the static button. R129 was observed with a tracheostomy, not actively moving any extremities and not responsive to this surveyor's questions.

On 11/8/21 at 1:55 pm, this surveyor phoned V42 (R129's Power of Attorney, POA) and inquired about R129's care in the facility. V42 stated that she (V42) recently had concerns about R129's sacral pressure ulcer worsening, and after requesting to see R129's sacral wound, V42 wanted R129 sent to the hospital. V42 stated that R129 stayed two weeks in the hospital and had to have a surgery to debride the sacral wound.

On 10/15/21 at 2:22 pm, V37 (Licensed Practical Nurse, LPN) documented, in part, "(V42, Power

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of Attorney, POA) came to visit (R129) at 1 pm and requested evaluation at hospital for non-healing sacral wound. Wound care done by (V24, Wound Care Coordinator) this am. (V42) spoke with (V24). Nurse practitioner aware of (V42's) request with order to send (R129) to (hospital) emergency room."

R129's census documents that R129 was hospitalized from 10/15/21 to 10/31/21.

On 11/9/21 at 11:52 am, R129 was observed in bed on the same LAL mattress system. The LAL mattress pump at the foot of the bed was observed with the weight dial at the same setting of approximately 220 pounds, and the static button indicator light was on with a yellow light lit next to the static button.

On 11/9/21 at 11:55 am, V37 (LPN) was called into R129's room by this surveyor to review R129's LAL mattress pump settings. Both V37 and this surveyor viewed the LAL pump setting together for R129 with the weight of 220 pounds, and the static button indicator light on with a yellow light. When V37 was asked about the static mode button being on, V37 stated, "I (V37) really don't know what static mode is." V37 then pressed the static mode button off, and the yellow indicator light went off. V37 stated that she (V37) checks to make sure all of the light indicators are "on" on the LAL pumps and will review the LAL mattress settings on her (V37) rounds at least three times a shift. V37 stated that CNA's (certified nursing assistants) and wound care nurses will check the LAL mattress settings too.

R129's monthly weight report from May to November 2021 documents R129's weight range of 112.4 pounds to 121.6 pounds which is

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significantly lower than the observed weight setting on R129's LAL mattress pump.

On 11/9/21 at 3:30 pm, V24 (Wound Care Coordinator) and this surveyor reviewed R129's LAL pump settings together, and both observed the weight dial setting adjusted to approximately 180 pounds with the arrow midway in between 150-to-200-pound markings. V24 stated that when the LAL mattress is set up, housekeeping or maintenance personnel are responsible for setting the weight on the LAL pump according to the resident's actual weight. V24 stated that floor nurses are responsible for checking the LAL pump settings. When this surveyor asked V24 about the yellow light indicator next to the static button, V24 stated, "I (V24) am not sure what that means." This surveyor asked what the static mode is used for on a LAL mattress, and V24 stated, "I (V24) am not sure." When asked about the static mode button yellow indicator light being lit up, V24 stated, "The light is always on. I (V24) don't know about the static mode." V24 stated that if there was low pressure in the LAL mattress, then the low-pressure indicator light would turn red and make a beeping sound. When asked if there have been any recent concerns with R129's air loss mattress malfunctioning, V24 stated, "Yes. It was alarming and blinking with the red light lit up. We were trying to figure out where the air loss was coming from. I (V24) removed the tubing connection from pump, and there wasn't much air coming from the tube. I (V24) put my hand over the connection from the pump, and the pump was not giving out enough air (to keep mattress inflated). I (V24) reported it to V3 (QA/Infection Prevention Nurse)." V24 stated that he (V24) expects the nursing staff to turn and reposition resident every two hours and to maintain a LAL mattress.

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S9999	Continued From page 14 On 11/10/21 at 9:23 am, V24 provided this surveyor with the manufacturer guidelines for R129's LAL mattress and stated that he (V24) read the guidelines. V24 stated that R129's LAL will promote weight distribution, and that when the static mode is on, this disconnects the alternating pressure from going inside the mattress. R129's Order Summary Report documents active orders as of 11/9/21 which include "low air loss mattress." R129's Care Plan, dated 10/14/21, documents, in part that R129 "has alteration in skin integrity and is at risk for additional skin issues related to: Dementia/Alzheimer's, Incontinence, Decreased Mobility, Comorbidities, Stage IV sacrum. Interventions: 4. Pressure reducing/relieving mattress as needed, low air loss." On 9/29/21 at 1:23 pm, V35 (Wound Physician) documented in the wound evaluation and management summary that R129's stage 4 sacral pressure "wound size (L, length, by W, width, by D, depth): 3 x 2 x 1 cm (centimeters), surface area: 6.00 cm squared, granulation tissue: 85 % (percent)." On 10/5/21 at 1:31 pm, V35 documented in the wound evaluation and management summary that R129's stage 4 sacral pressure "wound size (L x W x D): 4.4 x 5.2 x 1 cm, surface area: 22.88 cm squared, thick adherent devitalized necrotic tissue: 50 %. Additional wound detail: Per nursing report, there was an issue with air loss mattress which further exacerbated the wound." R129's facility provided hospital records (from hospital stay 10/15/21 to 10/31/21) were reviewed	S9999		

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and documented that R129 was sent from the facility on 10/15/21 due to "sacral wound worsening" and that R129 had a surgical "debridement 10/21/21: Sharp excisional debridement of stage IV sacral decubitus ulcer 12 x 7 x 3 cm including skin, subcutaneous tissue and bone."

On 11/10/21 at 10:18 am, V28 (Wound Care Nurse) stated that R129's pressure ulcer interventions for the sacral wound included the LAL mattress. V28 stated that "it (LAL mattress) is the first intervention to help in terms of healing a wound and helps with relieving pressure off wound. If a resident is dependent on ADL's (activities of daily living), even staying 2 hours in one position can trigger a skin alteration." V28 was asked about how a LAL mattress is set up, and V28 stated, "(It's) based on the weight of the resident. We (nurses) check the weights in (electronic medical record) and turn the knob to the weight of resident." V28 stated that the resident's current weight needs to correlate on the LAL pump setting, and "If the weight setting is too high, and the resident is not heavy enough for that weight setting, then it would be a hard mattress. Then the intervention might not be appropriate. Weight setting is there for a reason to set up directly to the resident's weight."

On 11/10/21 at 1:44 pm, V2 (DON) stated that the purpose for using a LAL mattress is for wound healing and prevention and to decrease or prevent moisture on the skin. V2 stated that the settings of LAL mattresses are done by the wound care nurse and floor nurses and that the floor nurses will check settings every shift to make sure the settings are correct. When V2 was asked what kind of settings should be used for a LAL mattress, V2 stated, "I (V2) am not

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sure. Housekeeping staff will put in the settings when they set up the LAL mattress. Housekeepers will ask the nurse for the weight, and housekeeper will set up LAL mattress with weight of the patient."

On 11/10/21 at 2:44 pm, V30 (Housekeeping Director) stated that V30 is responsible for setting up the LAL mattress and putting the weight setting on the LAL pump. V30 stated, "Nurses or wound care nurse gives me (V30) the weight. I (V30) put whatever they (nurses) tell me (V30). Then I (V30) turn the dial to the weight." V30 stated that she (V30) will check the LAL mattress if she (V30) gets a report of any malfunctioning. When asked if she (V30) responded to any report of R129's LAL mattress malfunctioning, V30 stated that she (V30) did respond to check R129's LAL pump because "the lights were not working."

On 11/10/21 at 2:56 pm, V40 (Housekeeper) stated that she (V40) recalled replacing R129's malfunction LAL mattress.

On 11/10/21 at 12:45 pm, V35 (Wound Physician) stated that she (V35) is treating R129 for the sacral pressure wound and sees R129 weekly. V35 stated that she (V35) performs weekly measurements of R129's sacral wound and recently have been updating R129's family with a video call during the weekly measurements and assessments she (V35) performs. When V35 was asked about her (V35) documentation on 10/5/21 about R129's deterioration in the sacral wound from nursing report of an issue with the LAL mattress, V35 stated, "I (V35) was notified on my (V35) exam that day. Nurse (V24) said that day or the day before (R129's LAL was not working correctly). I (V35) noticed it. From what I

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S9999	Continued From page 17 (V35) could see, it felt like the mattress was not inflated even when raised up the pressure." V35 stated that the purpose of a LAL mattress is "to directly off load the wound to provide circulation floor to the wound." V35 stated that someone with a high skin moisture level, like R129, could cause a delay in wound healing. "But the benefit of having a LAL mattress outweighs (R129's) risk factors." Facility provided undated manufacturer's guideline, titled "8 inches Alternating Pressure Mattress Replacement System with Low Air Loss, User Manual," documents, in part: "Introduction: Pressure injuries are defined as localized injuries of the skin and/or underlying tissue over a bony prominence as a result of pressure or pressure in combination with shear. Support surfaces or specialized mattress systems are used ... to prevent and treat pressure injuries. The (8 inches Alternating Pressure Mattress Replacement System with Low Air Loss) is intended for: 1) Pressure redistribution for individuals with but not limited to the following conditions: At risk or present pressure injuries ... Product Features: ... 2) Therapy control unit: Analog system. This analog control unit includes an easy to use pressure dial that is adjustable to the patient's weight ... Static button is available to discontinue alternation therapy ... Product Function: ... Analog Pressure Dial: Adjust the dial to correspond to the patients' appropriate weight setting ... Static Pressure Button: Press the static pressure button to discontinue alternating therapy ... Operation: ... Step 4: The control unit is preset in alternating mode and its cycle time is set at 10 minutes/60Hz (Hertz). Press the Static button to set it in static mode, and the Static indicator will come on. The static mode will begin within 5 minutes. Press the Static button again to	S9999		

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S9999	Continued From page 18 switch back to alternating mode." Undated facility policy, titled "Preventative Skin Care," documents, in part: "Guideline: It is the intent of the facility that the facility provide preventative skin care ... and free from pressure sores. All residents will be provided a preventative pressure reducing mattress. Equipment: ... 3. Air mattress ... Procedure: ... 5. Air mattresses ... may be used on those residents identified as being high risk for potential breakdown." (B)	S9999		