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| F 314 | Continued From page 15<br>R2 to be discharged to home.<br><br>3. Record review of R3's January 2007 POS shows that R3 has a diagnoses, in part, of Anxiety and Dementia.<br>Record review of R3's MDS of 1-2-07 shows that R3 requires extensive assistance for transfer, dressing, hygiene, bathing and toilet use.<br>R3's most current Braden Scale for Predicting Ulcer Risk shows that R3 scored a 17 which is moderate risk.<br>R3's Care Plan of 10-13-05 stated he is at high risk for skin breakdown. Care Plan approach includes, in part, turn and reposition every 2 hours.<br>R3 was observed on 1-18-07 from 9:45AM to 1:52PM to be sitting up in a wheelchair. R3 was put to bed at 1:52PM so a skin assessment could be done. Skin assessment showed R3 had deep creases at the back of thighs and and R3's buttocks were deep red.<br>Interview with E5, CNA reflected that R3 was toileted at about 11AM and it took about 2 minutes. E5 confirmed that this was the only time R3 was repositioned since 9:45AM.<br>E2 stated at 3:15PM that R3's red buttocks was a stage 1 pressure sore and does not blanch. E2 stated they would get a Physician order for treatment. | F 314 | | |
| F9999 | FINAL OBSERVATIONS<br><br>300.1010 h)<br>300.1210 a)<br>300.1210 b)2)<br>300.1210 b)3)<br>300.1210 b)6)<br>300.3220 f) | F9999 | | |

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| F9999 | Continued From page 16<br>300.3240 a)<br><br>300.1010 Medical Care Policies<br><br>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.<br><br>300.1210 General Requirements for Nursing and Personal Care<br><br>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. 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.<br><br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>3) Objective observations of changes in a resident ' s condition, including mental and emotional changes, as a means for analyzing | F9999 | | |

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| F9999 | Continued From page 17<br>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.<br><br>6) 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.<br><br>300.3220 Medical and Personal Care Program<br><br>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility ' s Director of Nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders (Section 2-104(b) of the Act)<br><br>300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident (Section 2-107 of the Act).<br><br>These requirements are not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure that 3 of 3 residents in the sample, R1, R2 and R3, received | F9999 | | |

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treatment to prevent the development of pressure sores. This resulted in harm to R1 and R2. R1 developed multiple stage 2 pressure sores. R2 developed a stage 4 pressure sore while in the facility. The facility failed to ensure that R2 received treatment to promote the healing of the pressure sore resulting in a decline in condition, and R2 developed sepsis and an infection of the stage 4 pressure sore with tunneling and osteomyelitis of the wound requiring surgical debridement.

Findings include:

1. Record review of R1's January 2007 Physician Order Sheet (POS) shows that R1 has a diagnosis, in part, of Dementia.

R1's Braden Scale for Predicting Pressure Ulcer Risk of 8-4-06 shows that R1 scored a 13 which is high risk.

R1's Minimum Data Set (MDS) of 10-17-06 shows that R1 has cognitive impairment, no behaviors, is totally dependent on staff for transfers, hygiene, bathing, toilet use. MDS shows R1 requires extensive assistance of 2 for bed mobility and is incontinent of bowel and bladder.

R1's Care Plan of 7-18-06 states that R1 is at high skin risk. Care Plan approach includes, in part, to turn and reposition every 2 hours - helps but cannot on her own.

On 1-18-07 at 9:45AM, R1 was observed to be up in a wheelchair with a mechanical lift sling under R1. R1 was observed sitting in the wheelchair from 9:45AM to 12:05PM without being repositioned. At 11:55PM E4, Certified Nurse Aide (CNA) took R1 from her room to the Dining Room. At 12 noon, E4 went back to the dining room and brought R1 back to her room.

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| F9999 | Continued From page 19<br>E4 and E5 stated they were going to give incontinent care.<br>At 12:05PM R1 was transferred from the wheelchair to her bed by a mechanical lift. R1 had been incontinent of bowel and bladder. R1's disposable incontinent brief was saturated with urine and R1 had a strong, foul urine odor. The back of R1's thighs were deep creased and red. R1 had feces up in the labia and buttocks. R1 was observed to grimace when washed. R1's buttocks were bright red and very creased. R1 had a stage 2 pressure sore on her right inner buttock. R1 had a stage 2 pressure sore on the coccyx and multiple pinpoint stage 2 pressure sores on the left buttock. R1's right upper back of thigh had a stage 2 pressure sore. R1 was observed urinating again when being cleaned. E4 and E5 confirmed pressure sores and stated they were new.<br>E4 and E5 stated that R1 was transferred from bed into the wheelchair by mechanical lift at 8:15AM that morning. Both confirmed that R1 had not been out of the wheelchair until 12:05PM.<br>At 1:40PM, E3, Licensed Practical Nurse (LPN), and E2, Director of Nursing, observed R1's pressure sores. Both stated that they were new. E3 measured the pressure sores. The right upper thigh was measured as 1 cm x .2cm. The right buttock measured .3x .2 cm. The coccyx measured 1.2 x .3 cm. Left buttocks were not measured. E3 confirmed multiple pinpoint stage 2 pressure sores.<br>Nurses note of 1-18-07 at 2:30PM shows that R1's Physician and family were notified of above areas. Nurses note at 3:15PM shows that R1 had a new order for vitamin C and zinc sulfate daily and treatment of Silvadene to above pressure sores. | F9999 | | |

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2. Record review of R2's April 2005, Physician Order Sheet, POS, shows that R2 was a 70 year old male newly admitted to the facility on 4-19-05. R2 had a diagnoses, in part, of Depression and Failure to Thrive. R2 was receiving a tube feeding and a regular diet.

Nurses notes of 4-19-05 state that R2 had a full body check with no indication of pressure sores. Nursing Admission Assessment form of 4-19-05 confirms that R2 did not have pressure sores on admission to the facility. Admission assessment identifies R2 as alert and oriented to place, self and others and is cooperative and is on a regular diet and tube feeding.

R2's Minimum Data Set of 4-16-05 and 7-20-05 shows that R2 had modified cognitive independence with difficulty in new situations only. MDS shows that R2 required extensive assistance of 2 staff for transfer and bathing and extensive of 1 for bed mobility, dressing and hygiene. MDS shows that R2 was incontinent of bowel and had a urinary catheter. MDS identifies R2 as having no behaviors.

R2's NORTON PLUS PRESSURE ULCER SCALE assessment of 4-24-05 and 7-21-05 show that R2 was at high risk for development of pressure sores.

R2's Care Plan of 4-24-05 states that R2 has a suprapubic catheter, is incontinent of bowel and is at high risk for skin breakdown. R2's Care Plan note of of 6-22-05 states, "Boil 2 cm x 1 cm on Right buttock." Care Plan note of 7-5-05 states Right buttock - 3.0 x 2.4x .2cm red outer area. .6 x .3 x ? dark necrotic center. "Previous boil area that R2 continues to have pressure on by sitting." Care Plan note of 8-18-05 states, "Very social person now does not like to lay down after meals-needs to keep pressure off buttocks.

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| F9999 | Continued From page 21<br>Non compliant per own choice." (This note was written after R2's pressure sore had declined to a stage 4. There are no Care Plan interventions for noncompliance other than to "Remind of importance of pressure relief." This approach was not added to Care Plan until 9-2-05.)<br>Physician order of 6-1-05 states to discontinue Megace, discontinue tube feedings and discontinue order for Failure to Thrive.<br>Physician order of 6-9-05 states to refer for peg tube removal.<br>Physician order of 6-20-05 states, "Extra egg/meat at meals."<br>Physician order of 6-22-05 states, "Cleans Rt buttock with normal saline daily. Apply Dermagran to area. No dressing at this time. Zinc Sulfate 220 mg every AM. Vit C 500 mg BID (twice a day). MVI (Multiple Vitamin) with Iron Q (every) day.<br>Nurses note of 6-16-05 "June Goal Documentation" states current weight 194 lbs. Peg tube remains without feedings and to be removed last week of June. Feeds self at least 75 to 100% of food and fluid intake. No open red areas noted."<br>Dietary Note of 6-21-05 states that R2's diet was changed to a regular diet with extra egg or meat at breakfast. R2's Care Plan also stated that R2 was to get an extra egg or meat at breakfast. (Facility failed to follow Physician order for an extra egg and/or meat at all meals.)<br>R2's Weight records show that R2 was admitted to the facility weighing 179 lbs. and was up to 194 lbs on on 6-3-05 and weighed 186 lbs on June 19th.<br>Nurses of 6-22-05 identifies R2 as having a boil to right buttocks with treatment orders.<br>Nurses note of 7-5-05 states that Z1 examined Rt buttocks and noted 3.0 x 2.4 x .2 cm | F9999 | | |

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| F9999 | Continued From page 22<br>red outer area with .6 x 1.3x <.1 black center tissue and ordered to debride with Santal and then use Xenaderm until healed.<br>Physician Progress Note of 7-5-05 identifies the above wound as a decubitus.<br>R2 has a Physician order of 7-28-05 stating may consult with Wound Clinic for wound care.<br>R2's PRESSURE SORE RECORD shows that facility first identified R2's sore on right buttocks as a pressure sore on 7-3-05 (It had previously been assessed as a boil.) Note identifies the sore measuring 3 x 2.4 x .2 cm. With .6 X 1.3 cm dark necrotic tissue. Note identifies the pressure sore was acquired in house and unstageable.<br>Note of 7-19-05 identifies pressure sore being 1.5 x .5 depth and 3.0 x 3.0 with minimum to moderate drainage and necrotic tissue. "Stage 2 ?"<br>Note of 7-28- 05 identifies the pressure sore as being a stage 4 measuring 2.4 x 3.0 with 3.0 tunnel with moderate to large drainage and gray slough. Order received to consult wound clinic.<br>Note of 8-4-05 states wound debrided and VAC applied.<br>Note of 8-26-05 states continue VAC change 3 times a week.<br>Note of 9-9-05 states identifies wound as stage 4 measuring 4.8 x 5.2 cm tunnel large with yellow slough. Change in size. Continue VAC. (R2 did not have a Physician order for a VAC at this time. Interview with E2, Director of Nursing, on 1-30-05 confirmed that R2 was not on a VAC at that time.)<br>Wound Care Instructions of 8-18-05 state to change tubing and dressing on Saturday and Monday. Wound Care will change on Thursday visit. Wound Clinic notes of 8-24-05 show that R2's dressing was changed at the clinic with no change in orders for dressing change. This | F9999 | | |

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would indicate that the facility would continue to change wound VAC dressing on Saturday and Monday.

Facility Treatment Administration Record for August 2005 shows that R2's tubing and dressing were changed on 8-24-05 at the Wound Clinic.

Nurses note of 8-24-05 at 10PM states changed dressing to wound related to being soiled with Bowel movement. Wound VAC in place. There is no documentation on R2's TREATMENT ADMINISTRATION RECORD of the dressing being changed.

Treatment Records showed that R2's dressing was changed on 8-26-05 due to being soiled. There is no documentation in nurses notes that R2's wound VAC dressing was changed due to being soiled. There is no documentation in the nurses note or on Treatment Record that R2's tubing and dressing were changed until R2 went back to the wound clinic on 8-31-05. Facility failed to follow orders to change the dressing on 8-27-05 and 8-29-05.

Nurses note of 8-31-05 states that R2 went to the Wound Clinic. Note states R1 was sent to the hospital and was admitted for wound debridement.

Z5's, (Wound Clinic Nurse) Wound Clinic note of 8-31-05 states, "Arrives in w/c (wheel chair) - Mechanical lift to bed with 2 assist. V.A.C. removed. Very strong odor from wound and peri -wound. Found V.A.C. applied with foam and trac pad placed directly over skin with stool and drainage collected under wound drape....V. A.C. settings noted to be on 0 mmhg. Seen by Z4. R2 c/o (complained of ) pain @ 7-8 level...Arrangements for admission to hospital..."

Z4's Hospital Progress Note of 8-31-05 states, "The Wound Vac was not properly attached or functioning when R2 appeared in the Wound

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Care Center today. It appears that the Wound Vac was disturbed some three to four days prior to this admission and there has been no Wound Vac activity over this wound. It appears that there is significant necrosis and necessity for debridement under general anesthesia.

Z8's hospital History & Physical note of 8-31-05 states R2 was admitted directly from the Wound Care Center after it was noted that he had worsening sacral decubitus...He has specific wound care instructions regarding a wound VAC, however, these instructions were not adequately implemented. As a result, the patient's wound deteriorated. Upon evaluation by the physician at the Wound Care Center, R2 was found to have worsening decubitus along with necrotic debris and foul-smelling discharge. He also has secondary cellulitis. MRI of the pelvis done on 8-22-05 showed inflammation, but no evidence of Osteomyelitis.

Z9, Surgeon, Hospital Consultation Report of 9-1-05 states that the wound is very clean and there is nothing to be debrided... R2 does not ambulate and it is imperative that he be kept off of this to give it any chance of healing. He provably also needs attention to nutrition and that has been ordered.

Hospital Transfer Orders shows that R2 was readmitted to the facility on 9-3-05 with an order to clean ulcer with sterile water. Apply skin prep to periwound. Apply Silva Sorb into wound and gently pack into wound. Change dressing every 8 hours. Apply pressure redistribution mattress...Hold using wound VAC until seen again @ Wound Care Center ...

POS for September 2005 shows that R2 had an order for a regular diet.

Facility Treatment records for September 2005 show that nurses signed off as using Silvasorb 3

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| F9999 | Continued From page 25<br>times a day 3 times a day as ordered by the Physician from 9-2 thru 9-10 when R2 was admitted to the hospital. Yet there is an added note dated 9-10-05 stating "May use IntraSite gel for right gluteal wound until silvasorb with arrows showing this was the treatment used (not the Silvasorb). Interview with E2 on 1-30-05 at 9:55AM reflected that the facility never got the Silvasorb because Public Aide would not pay for it so they used the IntraSite gel instead. E2 stated they are the same thing. When asked why the nurses were signing off that they were using the Silva sorb, E2 did not respond. E2 later in the afternoon stated that the hospital had sent some silversorb gel and the facility used it until it ran out and used the IntraSite until they could get the silva sorb from the Pharmacy. E2 did not know how long the IntraSite was used.<br>Nurses Notes of 9-3-05 states Blood Pressure (BP) 122/70. No complaints noted. R2 continues on contact isolation for Methicillin Resistant Staff Aureus. Will continue to monitor...Appetite and fluids taken good.<br>Nurses Notes of 9-4-05 states appetite good and fluids taken well. Remains on isolation for wound.<br>BP 90/60 Temperature of 98.2.<br>Nurses Notes of 9-5-05 states R2 offers no complaints. Propels self around facility.<br>Nurses Notes of 9-6-05 states BP 126/70 and appointment for wound clinic scheduled for 9-12-05.<br>Nurses Notes of 9-7-05 states Dressing changed and red drainage on dressing...R2 complained of upset stomach and requested to go to bed after supper time. Treatment changed per order. Noted large amount of green drainage.<br>Nurses Note, "Goal Documentation" | F9999 | | |

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documented on 8-18-05 states weight is 174 lbs...feeds self regular diet ...appetite and fluid intake good...Wound to to L buttocks and he attends wound clinic for new treatment ...no sign or symptoms of infection...Nurses note at 9:35PM states R2 not feeling good this evening..." Writer was talking to R2 and he just fell asleep. (Weight records show that R2 weighed 165.5 lbs on 9-6-05 with previous weight of 174 lbs on 8-26-05. Physician Weight Notification Form shows that Physician was faxed a note on 9-10-05 concerning a significant weight loss of 6.7 % in 30 days and 14.9% is 90 days. Note states R2 is above Ideal Body Weight range. Note states R2 receives a regular diet with extra egg or meat. Yet diet order shows a regular diet.)

Nurses Note of 9-9-05 at 2AM state BP 82/56..Moderate amount of drainage, bloody and tan. Odor present. Nurses Note at 9AM states Called Physician in regards to increased pain from wound. Awaiting return call. (There is no indication that Physician was notified of drainage and odor of wound or decreased BP. Note at 3:30PM states new order for Ultram 50 mg. 4 times a day as needed. Note at 9:30PM states moderate amount of foul bloody drainage.

Nurses Notes of 9-10-05 at 2AM states temperature 94.8. Note at 9AM states complained of upset stomach. Refused AM medications. Note at 2PM state, "New order for IntraSite for gluteal wound Rt (right) until pharmacy can send silvasorb."...BP 78/45...R2 complained of a queasy stomach. 1 loose stool. Notified Physician and order to send to emergency room.

Hospital History and Physical of 9-10-05 shows that R2 was admitted to the hospital with Sepsis, Hypotension and infected Sacral decubiti ulcer

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| F9999 | Continued From page 27<br>stage 4.<br>Hospital Discharge Summary of 9-27-05 states Discharge Diagnoses include, in part, Osteomyelitis of right ischial tuberosity, Stage 4 decubitus ulcer of the right gluteal region tunneling wound that was infected, Sepsis Syndrome, Recurrent hypotension and Clostridium difficile colitis. Discharge Summary shows that R2 underwent debridement by Surgeon with bone biopsy.<br>Facility failed to follow their own Policy and Procedure for Physician Notification of Resident's Change of Condition. Policy states that attending Physician will be notified of a change in a resident's condition by licensed nursing personnel as warranted in a timely manner...Physician notification is to include but is not limited to significant change in/or unstable vital signs...5% weight loss in 30 days or 7.5% weight loss in 90 days.<br>Facility failed to follow their Policy and Procedure for Decubiti Care/Pressure areas in that facility failed to notify physician when R2's pressure sore showed signs in deterioration, such as large amount of green drainage, foul smelling drainage. The Policy and Procedure states that nursing is to notify dietary for nutritional support and monthly reviews by the dietitian. (R2 was readmitted to the facility on 9-2-05 with a physician order for a regular diet. There is no dietary assessment addressing R2's nutritional needs and increased needs for calories and protein to aid in healing the pressure sore. There is no dietary assessment of significant weight loss.)<br>Facility failed to ensure they followed their own policy and procedure for Decubitus Ulcer Program of Nutritional Intervention. Policy states that Nutritional intervention shall be utilized as | F9999 | | |

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| F9999 | Continued From page 28<br>one means of treating decubitus ulcers. Purpose to provide and additional means of treatment to improve the healing process of residents with decubitus ulcers. Procedure includes, in part, A program of increased protein is developed by the Dietitian and approved and ordered by the physician. Decubitus nourishment's shall address the needs of the resident and the severity of the skin breakdown.<br>Dietary Note of 6-21-05 by the Dietary Manager, states that R2's diet was changed to extra egg or meat at breakfast. (Physician order of 6-20-05 shows that R2 was to get an extra egg or meat at all meals, not just at breakfast. Note of 7-21-05 states that R2 continues on a regular diet with extra egg or meat at breakfast. Note states that R2 eats 86% at breakfast, 80% at lunch and 75% at supper. Weight was 196.5 lbs in May, 188.5 lbs in June and 174 lbs in July. Interview with E1, Administrator and E2, Director of Nursing, on 1-30-07 confirmed that dietary notes and Care Plan identify that R2 was receiving only an extra egg or ounce of meat at breakfast.<br>Dietary Notes show that R2's Nutritional Needs were assessed by E6, Registered Dietitian, on 4-20-05. Assessment shows that R2 weighed 179 lbs and his Ideal Body Weight (IBW) was 178 lbs. with usual weight of 182.8 lbs. E6 assessed R2's calorie needs as being 1952 Calories a day, 81 grams of protein per day and 2551 cc's of fluids a day. (At that time R2 did not have a pressure sore.) Dietitian note of 8-18-05 identifies R2 as having a stage 3 pressure sore, yet there is no further assessment of R2's nutritional needs. Note identifies a weight loss and that R2 remains within his IBW range. Note states that R2 is on a regular diet with extra egg or meat at breakfast. Continue to encourage | F9999 | | |

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increase protein intake. (There are no further Dietary notes or Dietitian assessment on R2 addressing the Stage 4 pressure sore and increased needs for calories and protein.)

Interview with E6, Registered Dietitian, on 1-30-07 at 1:20PM, E6 stated that menus in 2005 when R2 was at the facility provided approximately 2200 to 2400 calories a day and 95 to 100 gram of Protein a day if resident ate 100%. E6 stated that Residents with pressure sores are assessed for needed increased calories and protein and that oral supplements , fortified milk, super cereal, sandwiches may be implemented. E6 stated that R2's Physician would order these supplements on recommendation of the Dietitian. E6 stated that a Resident with a Stage 4 pressure sore most definitely needs extra protein and calories to promote heal of the pressure sore. Sometimes they recommend Arginaid supplement. E6 stated a facility usually gets a hold of her when a resident has a stage 3 or stage 4 pressure sore so nutritional needs can be assessed and supplements ordered.

Interview with Z7, Facility Pharmacy Wound Nurse, on 1-26-07 at 3:50PM, reflected that the facility faxed an order for Silvasorb gel for R2 on 9-2-05 after the Pharmacy was closed. Z7 stated that the next day was Saturday and Sunday and that Monday was a holiday. Z7 stated the Pharmacy was unaware of the order until 9-6-05. Z7 stated that the Silvasorb gel was sent to the facility on the 9-6-05 later on in the day. Z7 stated that Silvasorb gel and IntraSite are not comparable products. Silvasorb helps fight infection and IntraSite does not.

Z3, Wound Clinic Physician, stated on 1-29-07 at 11:05AM, that turning and repositioning is very important in preventing and aiding in healing

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pressure sores. Z3 would expect R2 to be assessed for and provided extra calories and protein to aid in heal the pressure sore. Z3 stated if facility did not provide adequate nutrition he would have problems with development and healing of the pressure sore. Z3 stated that if R2 had adequate turning and positioning, normal albumin and protein stores and pressure relieving devices, it should have prevented the development of the pressure sore. (R2's albumin and total protein levels were within normal limits according to laboratory report of 4-2-05 with Total Protein being 6.4 G/DL (normal 6.4-8.0) and albumin was 3.6 G/DL (normal 3.3-4.5). Laboratory tests of 8-31-05 showed Total Protein down to 6.0 and albumin of 2.3.) Z3 stated that facility staff would have been trained on the use of the VAC before implementation. Z3 stated it makes no sense that feces was under the wound VAC dressing and that the setting was at 0. It should have been set at 125.

Z2, Physician Consultant for Illinois Department of Public Health, stated on 1-28-07 that if facility identified R2 as having a boil and then stated it turned into a pressure sore it was probably a pressure sore underneath the skin that was a stage 3 that hadn't opened up. Z2 stated that a boil would not turn into a pressure sore.

Interviews with staff did not confirm note written on R2's Care Plan that R2 would refuse to lay down after meals or reposition. Interview with E2 on 1-18-07, E2 stated that R2 was a very nice gentleman. He was depressed when he first was admitted to the facility. "Very cooperative with us." E9, CNA, stated on 1-18-07 that when R2 first came to the facility he was quiet and weak in the beginning. Once he was at the facility for awhile, he was a joy to be around. Was

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cooperative. Not combative. He was in a wheelchair and transferred with a sit to stand lift. In an interview with E8, CNA, on 1-26-07 at 4:30PM, E8 stated that R2 was in a wheelchair and required assistance of 2 for transfer. E8 stated she got along well with R2 and he never was resistive to laying down. He liked to stay in bed and we would have to encourage him to get up. He was very easy going. Never a problem. He was a pleasure.

During interview with Z4, Wound Physician, on 2-1-07 at 10:50AM, Z4 stated that with R2's total protein and albumin being normal when he was admitted to the facility, that if R2 received adequate nutrition and if R2 was on a repositioning program and had pressure sore relieving devices, then R2 should not have developed a pressure sore while in the facility. Z4 stated that the pressure sore was incorrectly assessed as a boil. A boil would not turn into a pressure sore. R2's pressure sore was avoidable. Z4 stated if the wound VAC had feces under the dressing and not set properly, then that would contribute to the decline in the pressure sore. Also if R2 was not getting adequate nutrition, it would contribute to the decline in the pressure sore and R2's protein stores. R2 needed increased calories and protein to aid in healing the pressure sore. Z4 confirmed that Silvasorb and IntraSite do not act the same and would be expected to be notified if the facility did not have the Silvasorb. When Z4 was asked about R2's September Nurses Notes identifying foul smelling drainage, low blood pressure and temperature of 94.5, Z4 stated it's classic symptoms of septic shock. Z4 stated the fact that R2's stage 4 pressure sore is now healed tells you everything. "This is neglect of the wound and neglect of care. Gross chronic neglect."

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| F9999 | Continued From page 32<br>Interview with R2 on 1-17-07 at 12:50AM, reflected that R2 transferred to another nursing home facility after hospitalization in September 2005. R2 states he was admitted to the facility in April 2005 with no pressure sores when he was admitted. R2 stated staff would get him up for breakfast and not lay him down until after lunch. He didn't have a good cushion for his wheelchair or bed like he does at his current nursing home. R2 stated they didn't reposition him like they do at his current nursing home which caused the development of the pressure sore. They thought it was a boil and the pressure sore was not treated properly. R2 stated his pressure sore is now healed and that he plans to go home. R2 stated, "I feel like I've lost over a year of my life due to the care I got at that facility."<br>Z6, Director of Nursing where R2 currently resides, stated on 1-29-07 that R2 was never resistive to turning and repositioning or staying off his buttocks. Z6 confirmed that R2's Stage 4 pressure sore is healed and ultimate goal is for R2 to be discharged to home.<br><br>3. Record review of R3's January 2007 POS shows that R3 has a diagnoses, in part, of Anxiety and Dementia.<br>Record review of R3's MDS of 1-2-07 shows that R3 requires extensive assistance for transfer, dressing, hygiene, bathing and toilet use.<br>R3's most current Braden Scale for Predicting Ulcer Risk shows that R3 scored a 17 which is moderate risk.<br>R3's Care Plan of 10-13-05 stated he is at high risk for skin breakdown. Care Plan approach includes, in part, turn and reposition every 2 hours.<br>R3 was observed on 1-18-07 from 9:45AM to | F9999 | | |