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ASTA CARE CENTER OF BLOOMINGTN	**1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701**

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F 325	Continued From page 35 significant weight loss. E2 stated the prior Dietary Supervisor, who was recently terminated, was responsible for monitoring weights and reporting them to the Physician. E2 stated, after the Dietary Supervisors termination, they determined weight changes were not being reported to the Physician as they should have been. On 1/23/12 at 1:35 p.m., E6 (Care Plan Coordinator) stated all dietary/nutritional concerns were to be given to the Dietary Supervisor, who in turn, forwarded them to the Registered Dietitian. E6 stated she has "noted some concerns" about weight issues not being reported as they should.	F 325		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)4)A)5) 300.1220b)2)3) 300.3220f) 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	F9999		

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F9999	Continued From page 36 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 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 notification. 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	F9999		

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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

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.

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

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F9999	Continued From page 38 made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical	F9999		

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F9999	Continued From page 39 impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3220 Medical Care 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) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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These Regulations were not met by:

1) Based on observation, interview and record review, the facility failed to have current policies and procedures regarding Pressure Sore Prevention and Treatment that provided staff with a working knowledge of how to properly assess and monitor pressure ulcers once they develop. Staff were not provided ongoing continuing education related to pressure sore prevention and treatment, resulting in a delay in the treatment of a pressure ulcer, which developed into a Stage III wound, for one resident (R8) reviewed for pressure ulcers. R8 developed a Stage III pressure ulcer on the Left Buttock after admission, which required debridement. The facility failed to ensure policies and procedures were in place to ensure residents who experienced a significant weight loss, received necessary services to improve their nutritional status, for one (R8) resident reviewed for weight loss.

Findings include:

An Admission and Discharge Summary dated 9/16/11, documents R8 was admitted on 9/09/11 with the diagnoses of Dementia and Organic Brain Syndrome. Nursing Progress notes, dated 9/09/11, indicate R8's skin was free of pressure ulcers upon admission. R8's Braden Scale (for

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predicting pressure ulcer risk) of 9/09/11 identified R8 as being at moderate risk (score of 14) for pressure ulcer development. R8's Minimum Data Set dated 9/15/11, indicates R8 required limited assistance of one staff person for bed mobility and transfers, extensive assistance upon staff for personal hygiene, at risk for pressure ulcer development, occasionally incontinent of urine and continent of bowel. R8's 9/19/11 Plan of Care does not identify the potential for skin breakdown as an area of concern for R8. A Telephone Order on 9/21/11, indicates R8 was put into a wheelchair with a soft waist restraint and on 9/30/11 changed to a highback reclining chair with a lap tray.

R8's Minimum Data Set dated 12/09/11, indicates R8 required an increase to extensive assistance of one staff person for bed mobility and transfers, remained at risk for pressure ulcer development, and had become frequently incontinent of urine and occasionally incontinent of bowel. R8's 12/15/11 Plan of Care does not identify the potential for skin breakdown as an area of concern for R8.

On 12/07/11, E6 (Care Plan Coordinator) completed a follow-up Braden Scale (for predicting pressure ulcer development) on R8, and scored R8 at a "mild risk (score of 15)" for pressure ulcer development, despite R8's physical decline and increasing need of staff assistance for bed mobility and transfers. This score of 15 on the Braden Scale of 12/07/11, was an upgrade from the score of 14 on 9/09/11, from Moderate Risk to Mild Risk.

On 1/23/11 at 1:35 p.m., E6 (Care Plan

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Coordinator) stated she determines a resident's need for Care Planning of Pressure Ulcer Prevention by the resident's Braden Score, clinical assessment, and if the Minimum Data Set identifies a resident as being at risk for pressure ulcers. E6 stated R8's admitting Minimum Data Set did identify R8 as being at risk for the development of pressure ulcers and that she should have proceeded to Care Planning to decrease R8's risk of pressure ulcer development. E8 stated R8 did not have any pressure ulcer prevention interventions in place, upon admission and through December 2011.

A Body Check Form dated 12/28/11 at 9:40 a.m., by E8 (Certified Nursing Assistant), documents R8 had an open area on his buttock. The nurse, E4 (Licensed Practical Nurse) signed the Body Check Form which documented R8's newly found open area.

On 1/24/12 at 10:40 a.m., E8 (Certified Nursing Assistant) stated she noticed a "nickel sized" open pink area on his lower buttock. E8 stated she told E4 (Licensed Practical Nurse) about the open area on 12/28/11, after she noticed it.

On 1/23/12 at 1:10 p.m., E4 (Licensed Practical Nurse) confirmed E8 (Certified Nursing Assistant) did inform him of a new open area on R8's buttock on 12/28/11. However, Nursing Notes and a Physician's Order, both dated 12/30/11, document treatment orders for R8's open buttock wound were received and started on 12/30/11. E4 confirmed that he did notify Z2 (Physician) of R8's newly developed buttock wound, but not until 12/30/11, two days after the wound developed.

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F9999	Continued From page 43 On 1/23/11 at 2:43 p.m., E3 stated her role as the Wound Nurse, includes monitoring and measuring wounds, looking at dietary concerns, cushions and supplements. E3 (Wound Nurse) stated that E4 (Licensed Practical Nurse) did notify her, on 12/30/11, that R8 had developed a pressure area on his buttock. E3 did not have any documentation related to the wound size or appearance and indicated she only "looked at the wound" and did not measure it. E3 described R8's left buttock pressure ulcer as approximately nickel sized and pink, on 12/30/11. E3 confirmed that the only pressure ulcer intervention implemented for R8,on 12/30/11, was a Hydrocolloid Alginate Dressing over the wound. E3 stated she did not evaluate R8's bed mattress or wheelchair cushion at that time and "should have implemented additional measures, like a gel cushion for the wheelchair and air mattress." E3 stated R8 never received the gel cushion or air mattress that Z1 ordered, as they did not arrive before R8 expired on 1/07/12. E3 stated she was abruptly put in the position of wound nurse "several months ago" and has not had any special training on pressure ulcer prevention and wound management. On 2/06/12 at 12:25 p.m., E2 (Director of Nursing) stated the facility was not following any specific policy on wound treatment/management. On 12/07/11, E6 (Care Plan Coordinator) completed a follow-up Braden Scale (for predicting pressure ulcer development) on R8, and scored R8 at a "mild risk (score of 15)" for pressure ulcer development, despite R8's physical decline and increasing need of staff	F9999		

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assistance for bed mobility and transfers. This score of 15 on the Braden Scale of 12/07/11, was an upgrade from the score of 14 on 9/09/11, from Moderate Risk to Mild Risk.

On 1/23/11 at 1:35 p.m., E6 (Care Plan Coordinator) stated she determines a resident's need for Care Planning of Pressure Ulcer Prevention by the resident's Braden Score, clinical assessment, and if the Minimum Data Set identifies a resident as being at risk for pressure ulcers. E6 stated R8's admitting Minimum Data Set did identify R8 as being at risk for the development of pressure ulcers and that she should have proceeded to Care Planning to decrease R8's risk of pressure ulcer development. E6 was uncertain as to why she scored E8's 12/07/11 Braden Scale as a 15 (Mild Risk) when the resident had experienced such a significant decline in November 2011. E8 stated R8 did not have any pressure ulcer prevention interventions in place, upon admission and through December 2011.

A Wound Care Specialist Note, dated 1/03/12, by Z1 (Wound Consultant/Physician) documents R8 as having a "pressure" wound, "unstageable (due to necrosis) of the left buttock of unknown days duration." The Wound Care Specialist Note describes the wound as being 3.5 centimeters by 3.5 centimeters and requiring "surgical excisional debridement of subcutaneous tissue." The Wound Care Specialist Note further indicates, "Length of visit more than 35 minutes of which greater than 50% spent in counseling and/or coordination of care. Reason: Patient's wounds required extensive discussion with PCP (Primary

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F9999	Continued From page 45 Care Physician) and/or nursing staff regarding prognosis." On 1/24/12 at 4:00 p.m., Z1 (Wound Consultant/Physician) stated R8's left buttock wound was pressure related and was dry, hard, dead tissue with granulation around the edges, when he first assessed it on 1/03/12. Z1 stated R8's pressure ulcer was a Stage III or "could have been a" Stage IV. Z1 stated he would not expect a wound to quickly decline from pink and nickel sized on 12/28/11 to the condition the wound was in on 1/03/12, unless the wound "wasn't addressed by the staff" at the facility. Z1 stated, when R8's health started to decline, "putting (R8) on a low air loss mattress could have possibly prevented the development of a pressure sore." Z1 further stated R8's Braden Score was not accurately assessed in December 2011 and that an accurate Braden Assessment would have triggered an increased risk in pressure ulcer development and "ideally" new pressure ulcer prevention interventions would be created, such as a change in the resident's mattress. On 1/24/11 at 1:00 p.m., E2 (Director of Nursing) provided requested policies and procedures regarding pressure ulcer prevention and treatment. E2 provided an undated policy with pressure ulcer prevention methods that are not up to date with the current standards of practice, some of which were simply crossed out. The Prevention and Treatment of Decubitus Ulcers Policy also identifies two assessment tools that staff are to utilize, the Pressure Ulcer Potential Assessment Sheet and the Integument Watch Sheet.	F9999		

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On 1/26/12 at 11:40 a.m., E2 (Director of Nursing and Previous Wound Nurse) stated she was not certain what the assessment tools identified in the Prevention and Treatment of Decubitus Ulcers Policy were. E2 provided additional policies on Skin Assessment and Skin Risk Protocol, which were faxed on 1/24/12 at 12:17 p.m., from another facility in their corporation. E2 stated it is the protocol of the facility to measure and document the details of a pressure ulcer, on the day it is identified. E2 confirmed R8's wounds were not measured until, Z1 (Wound Consultant/Physician) evaluated the resident on 1/03/12, seven days after the onset of the pressure ulcer. E2 stated she took the Director of Nursing position in August 2011 and she has not coordinated an inservice for staff on pressure ulcer prevention and wound treatment since taking that position. E2 was unable to determine when the last training was for herself, or nursing staff, on pressure ulcer prevention and wound treatment.

On 1/26/12 at 11:42 a.m., E6 (Care Plan Coordinator) stated the two assessment tools identified in the Prevention and Treatment of Decubitus Ulcers Policy, may be an "unutilized flow sheet", but was uncertain as to the details of the assessment tools and confirmed they were not in use.

A 9/09/11 Admission Resident-Data Collection documents R8 was 5 feet 5 inches tall and 160 pounds. A Plan of Care dated 9/19/11, documents R8 had the potential for impaired nutritional status and weight loss due to dementia and depression.

The Weight Log lists R8's weight at 155 pounds

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for September 2011, 156.9 pounds for October 2011 and 147 pounds for November 2011. Weekly weights initiated in November 2011 lists R8's weight at 167.75 pounds for week one, 147 pounds for week two, 141.5 pounds for week three (a 11.5% decrease from the admission weight), and 154.25 pounds for week four. The Weight Log lists R8's December 2011 weight as 142 pounds and January weight at 129.5 pounds (a 10% decrease). From R8's admission on 9/09/11 to January 2012, R8 lost 30.5 pounds (a 24% decrease).

On 1/24/12 at 10:40 a.m., E8 (Certified Nursing Assistant) stated she routinely cared for R8. E8 stated R8 was able to ambulate to meals, with assistance of staff, when he was admitted. E8 stated R8 began declining in "mid October" and became more confined to his highback wheelchair and would lay down after all meals. E8 stated R8 became incontinent of bowel and bladder and wore adult briefs. E8 stated R8's weight loss was evident, and "you could see he was losing weight."

A Physician's Order Sheet dated 12/01/11 indicates that R8 was on a no added salt, mechanical soft diet, thin liquids with no dietary supplements or vitamins ordered. A Dietitian Recommendation dated 12/23/11, indicates there was correspondence with Z2 regarding a significant weight change and concerns over inadequate fluid intake. The Dietitian Recommendation documents that on 12/30/11, Z2 agreed with the recommendation to add one Healthshake twice per day between meals. This was the only documented nutritional intervention

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made for R8. On 1/26/12, at 2:45 p.m., E2 (Director of Nursing) confirmed that the only notification made to the physician regarding R8's weight loss was on 12/23/11, and the 11.5% weight loss in November 2011 was not reported to the physician.

On 2/01/12 at 10:56 a.m., Z8 (Registered Dietitian) stated that any big discrepancy in weights, such as the 167.75 pound weight and 154.25 pound weight in November, should have prompted the staff to do a re-weight to determine accuracy. Z8 stated any significant weight change needs to be reported to the physician and dietitian. Z8 stated R8's weight of 141.5 during the third week of November 2011, was a significant decrease and should have been reported to her and the physician. Z8 stated, had she been aware of R8's weight loss to 141.5 pounds in November, she would have started R8 on a dietary supplement at that time, rather than in December. Z8 stated a significant weight loss would have put R8 at greater risk of pressure ulcer development.

The interventions/approaches identified on the 9/13/11 Plan of Care include Multivitamin daily and to monitor/record weight weekly for four weeks. There is no documentation to support R8 was provided a Multivitamin.

On 1/23/12 at 2:10 p.m., E2 (Director of Nursing) stated the Physician should be notified of any significant weight loss. E2 stated the prior Dietary Supervisor, who was recently terminated, was responsible for monitoring weights and reporting them to the Physician. E2 stated, after the Dietary Supervisors termination, they determined weight

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changes were not being reported to the Physician as they should have been.

On 1/24/12 at 10:40 a.m., E8 (Certified Nursing Assistant) stated R8's weight loss was evident, and "you could see he was losing weight."

On 1/23/12 at 2:10p.m., E2 (Director of Nursing) stated the Physician should be notified of any significant weight loss. E2 stated the prior Dietary Supervisor, who was recently terminated, was responsible for monitoring weights and reporting them to the Physician. E2 stated, after the Dietary Supervisors termination, they determined weight changes were not being reported to the Physician as they should have been.

On 1/23/12 at 1:35 p.m., E6 (Care Plan Coordinator) stated all dietary/nutritional concerns were to be given to the Dietary Supervisor, who in turn, forwarded them to the Registered Dietitian. E6 stated she has "noted some concerns" about weight issues not being reported as they should.

On 1/24/11 at 1:00 p.m., E2 (Director of Nursing) provided requested policies and procedures regarding weight loss and nutrition. E2 provided policies on Monthly Weights, Weight Loss Interventions, Nutrition Intervention Program, Food Fortification and Supplementation and Dietary Supplements, which were faxed on 1/24/12 at 12:17 p.m., from another facility in their corporation, as they did not have any policies available in the facility.

The facility policy and procedure, titled "Monthly Weights", states "(4.) Residents with a significant weight change, 5% in one month, 7.5% in three

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months, and 10% in six months, will be re-weighed by the ____th of the month."

The facility policy and procedure, titled "Weight Loss Interventions", states "(1.) The Physician, Dietitian and appropriate family member will be notified of a resident's significant weight loss."

B. Based on observation, record review and interview, the facility failed to provide pressure ulcer treatment and dressing, as ordered by the physician, for one resident (R10) reviewed with a pressure ulcer.

Findings include:

Nursing Notes dated 1/20/12, document R10 has a unstageable coccyx pressure ulcer, measuring 4 centimeters by 0.5 centimeters, and a right heel pressure ulcer, measuring 3.5 centimeters by 3.5 centimeters. Wound Care Specialist documentation indicate R10's coccyx wound required surgical debridement on 1/03/12. A Physician's Order dated 1/10/12, instructs staff to apply Skin Prep to the right heel wound (change daily) and Santyl, dry protective dressing, and hypofix tape to the coccyx wound (change daily).

On 1/25/12 at 10:02 a.m., E5 (Licensed Practical Nurse) was going to change R10's coccyx and right heel dressing. Both of R10's pressure ulcers were not dressed and were open to air, upon entering the room. E5 stated she did not remove any old dressings that morning and did not know why R10's pressure ulcers were not dressed, as ordered by the physician.

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F9999	Continued From page 51 On 1/25/12 at 10:50 a.m., E11 (Restorative Aide) and E12 (Restorative Aide) stated they got R10 up from bed at approximately 7:30 a.m., on 1/25/12 and noted R10's coccyx and right heel wounds did not have dressings on them. The Treatment Administration Sheet documented E5 completed R10's wound treatments on 1/24/12. On 1/25/12 at 10:30 a.m., E5 stated she did not complete R10's wound treatment on 1/24/12, but just "signed it as being completed" because the "hospice nurse told me he'd do the dressing change." On 1/25/12 at 11:12 a.m., Z5 (Hospice Nurse) stated he did not change R10's dressing on 1/24/12, as E5 told him she would perform the wound treatment that day. (B) 300.1210b)3)4) 300.1210d)2)4)A)5) 300.3240)a Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 52 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: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.	F9999		

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F9999	Continued From page 53 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. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment 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.	F9999		

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F9999	Continued From page 54 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review and interview, the facility failed to provided adequate personal hygiene to two of five residents reviewed (R14, R17) which required staff assistance for bathing and incontinence care. This failure resulted in R14 developing a yeast infection of the penis and experiencing pain when being cleansed. Findings include: 1. An Admission Summary dated 3/07/11, indicates R14 has the diagnoses of Organic Personality Disorder, Alzheimers Disease and Cerebral Vascular Accident. A Minimum Data Set dated 1/29/12, documents R14 requires the total assistance of staff for bathing/hygiene and is incontinent of bowel and bladder. A Plan of Care dated 1/24/12, indicates staff are to keep R14's skin clean and dry and that R14 requires assistance with Activities of Daily Living, such as dressing/grooming. Nursing Notes dated 1/29/12, indicate R14 was sent to the Emergency Room for agitation and increased thirst. Hospital Emergency Room	F9999		

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documentation, dated 1/29/12, indicates R14 arrived with an elevated blood sugar reading. Emergency Room documentation also indicates, "Penis is uncircumcised, scrotum red...painful to pull back the skin to place (catheter)." An Emergency Room note, by Z11 (Physician) states, "(R14) did have some yeast in the (urine) specimen but he also is uncircumcised and he had quite a bit of yeast-like material under the foreskin."

On 2/06/12 at 1:15 p.m., Z9 (Emergency Room Registered Nurse) stated R14 presented to the Hospital (on 1/29/12) with an altered level of consciousness and an elevated blood sugar reading. Z9 stated, when R14's adult incontinence brief was removed, the scrotum was red and irritated where the penis had been laying and when the foreskin was retracted, there was a large amount of white, dried crust under the foreskin. Z9 stated R14's penis had to be cleansed prior to inserting the indwelling urinary catheter, as they were unable to insert it otherwise. Z9 indicated R14 did verbalized pain, when his penis was being cleansed. Z9 stated R14's socks were "literally stuck to his feet" and they "obviously had not been changed" in some time.

On 2/06/12 at 3:15 p.m., Z11 (Emergency Room Physician) stated when R14 arrived to the Emergency Room on 1/29/12, R14 had "lots of yeast on the shaft of his penis, which would have been related to having poor hygiene." Z11 stated R14's socks appeared to have been on his feet "for several days."

On 2/07/12 at 8:30 a.m., Z10 (Family) stated she

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F9999	Continued From page 56 observed Emergency Room staff, on 1/29/12, cut R14's socks off of his feet because they were "stuck" to him. Z10 stated R14's penis had "crust" and "white film" on it. Z10 stated she observed R14 "crying in pain" when the Emergency Room staff had to cleanse the penis in order to insert an indwelling urinary catheter. Z10 stated, after residing at the facility for seven years, she would not allow R14 to return and had R14 transferred to another facility. 2. A Physician's Order Sheet dated 2/12/12, documents R17 has the diagnoses of Schizoaffective Disorder, Urinary Retention, and has an Indwelling Urinary Catheter. A Minimum Data Set dated 1/30/12, indicates R17 requires extensive assistance of staff for bathing/hygiene and incontinence care. A Plan of Care dated 1/10/12, directs staff to provide "peri care with soap and water and dry thoroughly every shift", "assess skin daily during cares and notify nurse of any new issues (related to) skin", and "peri care to include: cleanse urinary opening with soap and water at least __ x daily." On 2/06/12 at 10:50 a.m., E14 (Certified Nursing Assistant) retracted R17's foreskin to observe for cleanliness. The underside of R17's foreskin was stuck to the tip of the penis when retracted and R17 cried out "it hurts." Directly below the head of R17's penis, the skin was red and excoriated. E14 stated she observed the excoriation on R17's penis earlier that morning, however, indicated she had not informed the nurse caring for R17 that day. (B)	F9999		

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