STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 R1 ' s June 2013 TAR shows on 6/2/13 R1 developed a 2 x 2 CM black, dry eschar area on the left posterior foot below the big toe. R1 ' s 5/2/13 Pressure Ulcers care plan has a goal that pressure ulcers will be healed by next review (3 months). R1 ' s care plan has 5 approaches: assess for pain; administer treatment per physician order; bi weekly skin checks; bilateral heel protectors, remove for skin care only; & monitor for sign and symptoms of infection. R1 ' s June 2013 Physician Order Sheet shows current orders to " apply nickel size amount of Santyl ointment on moistened 2x2 gauze to bilateral heels and cover with Kerlix daily. " The left planter foot and the coccyx wound had orders to apply Aquacel Ag and cover. On 6/26/13 at 2:30 PM, E2 said R1 had been followed by the wound clinic since February. The osteomyelitis that developed in R1 ' s left heel made healing of the wound difficult.	F 314		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1010g)3) 300.1210c) 300.1210d)2)3)5) 300.1220b)3) 300.3240a)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 8	F9999		

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:

3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.)

Section 300.1210 General Requirements for Nursing and Personal Care

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 9 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 made by nursing staff and recorded in the resident's medical record. 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: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 10 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent residents at high risk for skin break down from developing pressure ulcers, failed to prevent these areas from worsening, failed to track wound characteristics, failed to apply the ordered treatment, and failed to ensure pressure relieving devices were present. These failures contributed to R1 and R2 developing unstageable pressure areas. This is for 2 of 3 residents (R1 & R2) reviewed for pressure ulcers in the sample of 4. The findings include:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 11	F9999		

1. R2 ' s 2/19/13 and 5/17/13 Minimum Data Set Assessment shows R2 is totally dependent on staff for bed mobility, transfers, dressing, and hygiene/bathing. R2 is at high risk for developing pressure ulcers.

On 6/26/13 at 10:30 AM, E2 (Director of Nursing) said skin assessments and wound documentation is done on the Treatment Administration Record (TAR) for each resident.

R2 ' s February 2013 TAR ' s show from 2/7 to 2/21, R2 developed skin breakdown going from intact skin to a stage II, 5 x 3 CM (centimeters) coccyx wound, and a 2 x 0.7 CM open area " to distal wound " . The 2/24 entry shows an open skin abrasion (no measurement) to right buttock under treatment with Santyl and foam dressing daily.

The manufacturer's specifications for Santyl ointment state that Santyl ointment is indicated for use in debriding (removal of dead tissue) chronic dermal ulcers. Santyl is an enzymatic debriding ointment. It possesses the ability to digest collagen in necrotic (dead) tissue. An erythema (redness) can occur in the surrounding tissue when Santyl ointment is not confined to the wound. Therefore, the ointment should be applied within the area of the wound. Use of Santyl should be terminated when debridement of necrotic tissue is complete.

R2 ' s March 2013 TAR shows between 3/7 and 3/28, R2 developed a stage I wound on the right buttock that progressed to two open areas on each buttock. No measurements were taken of the four wounds on the buttocks. R2 ' s coccyx developed a second open area. On 3/13/13 the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 12 coccyx wounds measured 1 x 2 CM and 2 x 1 CM. On 3/20/13 the coccyx wound was 3 x 2 CM and had a " small dark purple area by the coccyx, not open. " R2 ' s April 2013 TAR shows on 4/1 R2 had a 0.5 x 0.5 open area on the coccyx, pink in color and had no drainage. On 4/17 R2 had a purple area (no measurement) on the coccyx that was not open and was being treated with Santyl and covered with a foam dressing. Between 4/4 and 4/21 no measurements were taken of the " open areas to the coccyx and the left buttock. " R2 ' s May 2013 TAR shows an undated entry, " coccyx is red with black center and not open. Right thigh is open (2 x 1.5) using Santyl and foam dressing. " On 5/24 R2 continued to have " open areas to the buttock/coccyx and right hip. The black spot to the center of the buttock wound remains unchanged. " (no measurements) R2 ' s Physician Order Sheets (POS) show the same treatment order (Apply Santyl ointment and cover with a foam dressing) from 2/14/13 to 5/27/13. On 5/28/13 wound treatment orders were to cleanse with normal saline, apply Aquacel Ag (absorbent, antimicrobial pad that maintains a moist environment) and cover with a foam dressing. Change every 3 days and as needed to facilitate drainage. Turn and reposition patient every 2 hours and as needed. R2 ' s June 2013 TAR shows on 6/13 R2 had 3 open areas. " 1. Coccyx is necrotic, 3 x 3 CM. 2. Left buttock is stage II, 1 x 1 CM. 3. Right thigh has a large amount of drainage, 2 x 2 x 0.5 CM. " On 6//18 the coccyx wound increased in size to 6 x 5 CM.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13	F9999		

R2 ' s 6/10/13 results of a wound culture of the right thigh wound showed growth of proteus mirabilis and was treated with the antibiotic Bactrim DS, twice a day for 7 days.

On 6/26/13 at 10:25 AM, E5 (Licensed Practical Nurse- LPN) & Z1 (hospice LPN) changed the dressing to R2 ' s coccyx pressure ulcer. R2 ' s coccyx wound was approximately 5 x 4 CM with a large black necrotic tissue center surrounded by yellow slough. Z1 applied Santyl ointment and covered R2 ' s coccyx wound with a foam dressing. R2 ' s right lower buttock area had a white dressing covering it. Z1 said he had just completed the treatment of Aquacel Ag covered by a foam dressing on the right lower buttock pressure ulcer. R2 ' s 6/26/13 Treatment Administration Record (TAR) shows the current orders are to apply Duoderm to the right lower buttock area, change every 3 days and as needed. R2 ' s Physician Order Sheets (POS) show that this order was received on 6/14/13.

R2 ' s 6/26/13 Treatment Administration Record (TAR) shows the current orders are to cleanse the coccyx with wound cleanser, apply Santyl, and cover with foam dressing daily and as needed.

On 6/26/13 at 12:05, 1:00, 2:15, & 2:30 PM, R2 was sitting in a reclining wheelchair in the same position.

On 6/27/13 at 11:20 AM, Z2 (Regional Registered Nurse for the hospice) said Z1 put the wrong treatment on R2 ' s right lower buttock.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 14 Residents can be repositioned while sitting in reclining wheelchairs to redistribute pressure. On 6/26/13 at 10:25 AM, R2 ' s right foot had 3 dry dark scabs (dime size) on the top of and near the 2nd, 3rd, and 5th toes. R2 ' s left foot had a moist pink open area (nickel size) with a flap of thin skin at the base of the 1st toe. R2 had no scabbed areas on the left foot. Z1 said the areas on the right foot were being left open to air. The left foot was a new blister from today that opened. R2 ' s June 2013 TAR, Nurses Notes and hospice Nursing Visit Record do not mention the scabs on R2 ' s right foot. R2 ' s June 2013 POS show no orders for the right foot scabbed areas. R2 ' s 6/7/13 TAR entry states, " Scabbed area noted to top of left foot. " No measurements or other description was documented. R2 ' s TAR entries of 6/7, 6/11, 6/14, 6/21, & 6/25 do not mention the right foot wounds. On 6/26/13 at 12:35 PM, E4 (Certified Nursing Assistant) said R2 slides down in the bed and his toes press against the footboard. There are usually pillows at the foot of the bed, but not always. R2 ' s 2/26/13 Potential for Skin Impairment care plan states, R2 will maintain current intact skin integrity by next review date. Turn and reposition every 2 hours and as needed. The facility ' s 7/11/05 Pressure Ulcer Prevention policy states, Mechanical Loading and Support Surfaces: Bed-bound residents will be repositioned at least every two hours, chair-bound	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 15	F9999		

residents every hour. Devices such as pillows and foam wedges or bath blankets will be used to keep bony prominences from direct contact with each other, stabilize postural alignment, provide pressure relief when positioning in a chair, and to relieve pressure on the heels.

The facility ' s undated Assessment and Treatment of Pressure Ulcers policy states, " When the Charge Nurse is aware of skin breakdown the area will be assessed using the following guidelines. Type of Ulcer; Ulcer Characteristics- location ..., staging, size ..., exudates ..., wound bed ..., description of wound edges and surrounding tissue ..., the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection ..., pain ...; The resident ' s physician and responsible party will be notified. Treatment orders will be obtained from the physician. The charge Nurse will ensure that all treatments and dressings are applied, dated and initialed. " " If a pressure ulcer fails to show progress toward healing within 2-4 weeks, the overall clinical condition will be reassessed and the physician and family will be notified. " " Based upon the assessment and the resident ' s clinical condition, choices and identified needs, basic care should include interventions to: redistribute pressure (such as repositioning, protecting heels, etc.) ... "

The facility ' s undated Stages of Pressure Ulcers policy fails to include the 2007 updated staging system from the National Pressure Ulcer Advisory Panel that includes a definition of deep tissue injury. Suspected Deep Tissue Injury is purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 16	F9999		

may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

2. R1 ' s 1/19/13 Minimum Data Set Assessment shows R1 needs extensive assistance of 2 staff for bed mobility, transfer, hygiene, and toilet use.

R1 ' s January 2013 Treatment Administration Record (TAR) shows on 1/12 R1 developed a blister to the left heel with clear fluid drainage. A foam dressing and heel protector was applied. On 1/25 R1 ' s right heel developed a blister that was intact. A foam dressing and heel protector was applied. No measurements were done.

R1 ' s February 2013 TAR ' s had no wound assessments. R1 was discharged to the hospital on 2/13 and was readmitted to the facility on 2/20/13. R1 ' s 2/20/13 Resident Admission Assessment shows Unstageable pressure areas to both heels. The left heel wound was 3.5 x 4.8 CM and dry. The right heel wound was 2.6 x 3.0 CM and dry. R1 had an open area noted between the gluteal folds. The coccyx wound was 3 x 2 CM and pink in color.

R1 ' s March 2013 TAR shows on 3/8 R1 ' s left heel wound was 8 x 7 CM with a moderate amount of drainage. R1 ' s right heel wound was 5 x 3 CM. R1 ' s coccyx wound was 0.5 x 0.5 CM.

R1 ' s 4/2/13 hospital Operative Report shows that R1 had both heels surgically debrided. The left heel had osteomyelitis.

R1 ' s May 2013 TAR shows on 5/21/13 R1 ' s coccyx wound was 2.5 x 3.5 CM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ROCKFORD	**707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 17 R1 ' s June 2013 TAR shows on 6/2/13 R1 developed a 2 x 2 CM black, dry eschar area on the left posterior foot below the big toe. R1 ' s 5/2/13 Pressure Ulcers care plan has a goal that pressure ulcers will be healed by next review (3 months). R1 ' s care plan has 5 approaches: assess for pain; administer treatment per physician order; bi weekly skin checks; bilateral heel protectors, remove for skin care only; & monitor for sign and symptoms of infection. R1 ' s June 2013 Physician Order Sheet shows current orders to " apply nickel size amount of Santyl ointment on moistened 2x2 gauze to bilateral heels and cover with Kerlix daily. " The left planter foot and the coccyx wound had orders to apply Aquacel Ag and cover. On 6/26/13 at 2:30 PM, E2 said R1 had been followed by the wound clinic since February. The osteomyelitis that developed in R1 ' s left heel made healing of the wound difficult. (B)	F9999		