

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2014
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NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5 300.3240a)</p> <p>Section 300.1010 Medical Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to implement preventative measures and follow physician's orders for pressure ulcer treatment to prevent new wounds from developing and promote healing of existing wounds, failed to notify the physician of resident refusal of preventative measures, failed to provide wound and incontinence care to prevent infection of wounds, and failed to reassess and update the treatment plan for changes in wounds and when new wounds were noted for two (R2 and R1) residents reviewed for pressure ulcers. This failure resulted in R2 developing an unstageable pressure ulcer on the right heel and R1 developing an unstageable infected pressure ulcer on the coccyx/sacrum.</p> <p>The findings include:</p> <p>1) The face sheet admission record showed that R2 was originally admitted to the facility on 3/31/2010. The POS (Physician Order Sheet) dated 3/2014 showed R2's diagnoses that include peripheral neuropathy, prostate cancer, spinal fusion, depression, glaucoma Parkinsonism, deep vein thrombosis and mood disorder. The " Infectious Disease and Wound Specialist " progress notes dated 3/14/2013 showed that R2 was assessed with a stage 4 chronic pressure ulcer on the left ischium since 2010. The progress notes also showed that R2's right heel wound had healed on 8/16/2012. The left ischium wound measurements were 0.3 cm for length, 0.4 for width, and 1.9 cm for depth. The plan was to protect right heel with heel suspension orthotic boot and to lubricate the skin. The Braden Scale pressure sore skin</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>assessment dated 2/14/2014 showed that R2 was a high risk for pressure ulcer. The " Wound Care Specialist Evaluation " dated 2/20/2014 showed that R2 has the following pressure ulcers with interventions and assessment as follows:</p> <ul style="list-style-type: none"> - A stage 4 pressure ulcer of the left ischium. The ulcer was described with light serous exudate and measurements were 0.2 cm. in length; 0.8 cm. in width; 1.2 cm. in depth; undermining at 1.1 cm. at 7 o ' clock. - An Unstageable pressure ulcer described as necrotic on the right heel. The pressure ulcer measurements were 0.4 cm in length; 0.3 cm. in width; and a not measurable depth. The right heel unstageable pressure ulcer was acquired at the facility on 2/19/2014. - The Plan Intervention for the pressure ulcers were pressure reduction in chair and in bed and float heels to off load pressure. - R2 was assessed as oriented times 3 (person, place and situation) with mood and affect to be calm and cooperative. <p>The POS (Physician order Sheet) dated 3/2014 showed treatment orders dated 2/20/2014 as follows:</p> <p>1) " Cleanse left ischium stage 4 with normal saline, apply Aquacel Alginate dressing then cover with dry dressing and change daily (scheduled for 11:00P.M.-7 A.M. shift) and as needed. "</p> <p>2) " Paint right heel with Betadine then cover with dry dressing daily (scheduled for 11P.M.-7:00 A.M. shift) and change as needed. "</p> <p>On 3/10/2014 at 3:00 P.M., 3:15 P.M., 4:30 P.M., 5:05 P.M. and 5:30 P.M., R2 was lying on his left side facing window. R2 remained on the same position during these observations. Upon prompting, E6 (Wound Treatment Nurse), E31</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>(Licensed Practical Nurse) and E27 (Nurse Aid) assisted to do skin check for R2 at 5:30 P.M. R2 was without heel suspension or a heel protector to off-load pressure from the heels. E27 and E31 stated they were not aware that R2 was supposed to have heel suspension boots or heel protector.</p> <p>R2 was also noted with a disposable brief and an incontinent cloth pad and a sheet on a low air low mattress. R2 was urine soaked. The absorbent padding from the brief had turned into a gel like consistency due to heavy saturation of urine. It was also noted that the urine had leaked through the brief onto the incontinent cloth pad. Redness and excoriation to the scrotal area was also noted. R2 was observed with soft stool smeared throughout the rectal /buttocks, scrotal and groin area. There was no dressing on the left ischium pressure ulcer. There was also stool around the opening of the pressure ulcer on left ischium. E27 (Nurse Aid) stated that there was no dressing in placed on R2' s left ischium pressure ulcer when E27 changed R2's incontinent brief at 2:00pm and at 4:00 P.M. E27 stated that she had informed an unidentified staff at 2:00 P.M. when E27 found out that there was no dressing on the left ischium pressure ulcer. E27 also added that she should have increased the frequency of changing R2's incontinent brief to keep him clean and dry. E31, (the nurse in charge of R2 from day and evening shift of 3/10/2014) had stated that he was not aware that R2 ' s dressing was off. E6 stated that she does not do the daily dressing change and only does the dressing change once a week to evaluate the existing and new wounds.</p> <p>After the incontinence care, E6 with assistance from E31 and E27 had proceeded with pressure ulcer dressing change. During this observation, the unstageable pressure ulcer on the right heel</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>had a dry dressing with a label date of " 3/7 " (this was 2 days prior to date of observation on 3-10). Observation of wound care indicated that infection control was not maintained. Cross contamination from dirty to clean and clean to dirty was noted. E6 had prepared the wound supplies onto the treatment tray and failed to observed possible cross contamination during the preparation. E6 had also used same gloves to open multiple single pack of dressing supplies and the application of these supplies for pressure ulcer treatment. E27 also had failed to wash hands after removal of soiled gloves and prior to donning new pair when she provided the incontinence care prior to dressing change. R2 was not maintained to be clean and dry from bowel and bladder incontinence to prevent cross contamination and development of wound infection.</p> <p>The TAR (Treatment Administration Record) dated 3/2014 documented that the treatment for the left ischium was not signed as given on 3/9/2014. The right heel treatment was also not signed as given on 3/9/2014, but was signed on 3/8/2014. This was contradictory to the observation made on 3/10/2014 that the right heel dressing had a date labeled 3/7/2014 as the last dressing changed.</p> <p>On 3/13/2014 at 11:30 A.M., E33 (Licensed Practical Nurse- the nurse assigned on 3/8 and 3/9/2014 for 11 P.M.-7 A.M. shift) stated during interview that she does not remember if she changed the dressing on the left ischium on 3/9/2014. However, E33 had stated that it is the facility's practice and policy to sign the TAR when treatment was given. E33 also added that she did not change R2's right heel pressure ulcer</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>dressing on 3/8 and 3/9/2014. E33 also added that though, she had signed the TAR on 3/8/2014 that the right heel dressing was changed, E33 stated that she made a mistake and thought that she was signing the left ischium dressing. This was an indication that physician orders for treatment of pressure ulcers were not followed. R2 right heel dressing was not changed for 2 days and left ischium dressing was not changed for 1 day.</p> <p>On 3/10/2014 at 10:15 A.M. and at 12:45 P.M., R2 was seated in his wheelchair that has a foam cushion. R2 was also noted to be wearing shoes while up in a chair.</p> <p>On 3/11/2014 at 9:30 A.M. and at 11:30 A.M., R2 was observed sitting in his wheelchair with the same foam cushion. Again R2 was wearing shoes that were in contact with his heels. R2 stated that it was his preference to be up at 5:00 A.M. daily, but staff put him back to bed after lunch around 1 to 2:00 P.M. R2 also added that he just sits in his wheelchair for duration of 8-9 hours. R2 also added that staff does not lift him up from his wheelchair while he was seated. This was an 8-9 hours prolonged sitting with a resident who is a high risk of pressure ulcer and had an existing stage 4 pressure ulcer on the ischium area without pressure relief.</p> <p>On 3/11/2014 at 1:30 P.M., R2 was in bed. R2 was not wearing a heel suspension nor were his heels off loaded from pressure. E23 (Licensed practical Nurse) and E32 (Nurse Aid) was in R2's room and stated that they were not aware that R2's heels was supposed to have his heels offloaded nor was aware of the heel suspension. E32 added that R2 was not being reposition while seated in his wheelchair because R2 uses a mechanical lift for transfer.</p> <p>On 3/11/2014 at 12:30 P.M., Z1 (Wound physician specialist) during interview stated that</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>R2 should be turned and repositioned at a minimum of at least every 2 hours to off load pressure from the identified pressure ulcers and other parts of bony prominence. Z1 also added that prolonged sitting was not appropriate for R2 and that an air or gel cushion was the appropriate pressure relieving device for seat cushion. Z1 also added that R2's pressure dressing should have been intact at all times and change as ordered, otherwise infection could happen. Z1 also added that R2 should be off from pressure on his heels and therefore shoes was not recommended but instead a heel protector and heel suspension while in bed was appropriate measures.</p> <p>The " Wound Care Specialist Evaluation " dated 3/13/2014, (a note from Z1) showed that R2 was calm and cooperative. The notes showed that it was reiterated to R2 the importance of limited sitting but R2 refuses. It was also noted that R2 was only up this time that the foam cushion was changed to gel cushion for R2 to use while seated in his wheelchair.</p> <p>The most recent care plan available dated 7/5/2013 and revised 2/24/2014 showed that R2 has an actual impairment to skin integrity with chronic stage 4 pressure ulcer on the left ischium. It was also indicated that R2 refused to see Z1 on 1/3/2014. The care plan interventions included the following:</p> <ul style="list-style-type: none"> -keep skin clean and dry -skin check daily - float heels while in bed, use heel protectors when in bed - turn and reposition every 2 hours and as needed -administer treatments as ordered <p>The care plan interventions were not followed as above. Furthermore, the care plan showed no interventions with regards to R2's prolong sitting and R2's refusal to see Z1 on 1/3/2014. There</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>was no assessment to determine possible causes of the refusal.</p> <p>Z1's documentation on the " Wound Care Specialist Evaluation " dated 12/12/2013, 1/9/2014, 1/23/2014, 2/6/2014, 2/20/2014 2/27/2014 showed that R2 was " calm and cooperative. "</p> <p>The " Daily Skin Assessment /Wound Status" for February 6, 2014 to February 27, 2014 did not identify R2's right heel unstageable pressure ulcer. This ulcer was never identified on the daily skin assessment form, however a treatment order was in place as of 2-20-14. Z1 had documented on 2/20/2014 that R2 had a facility acquired unstageable pressure ulcer on the right heel on 2/19/2014. The documentation on the " Daily Skin Assessment " had failed to identify and monitor R2's development of new pressure ulcer that had progressed to an unstageable.</p> <p>R2's MDS (Minimum Data Set) dated 3/14/2013 and 2/7/2014 documents that R2 was without negative behavior, mood disturbances or signs and symptoms of delirium. R2 was also assessed with extensive and total assistance for bed mobility and transfers.</p> <p>2. R1 is a 45 year old individual that was re-admitted to facility on 03/04/13 after hospitalization related to placement of feeding g-tube due to resident declined nutritional status and refusing to eat. While at hospital Methicillin Resistant Staphylococcus Aurous (MRSA) was identified in R1's wounds and R1 was started on intravenous antibiotic therapy treatment and continued at the facility. According to re-admission orders dated 03/04/14, R1 has diagnosis of End stage Renal disease with dialysis, history of Hypertension, Coronary Artery disease, Anemia, Failure to thrive, Rheumatic arthritis, anorexia, Osteomyelitis, Diabetes type II, status post Cerebral Vascular accident and</p>	S9999		

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S9999	Continued From page 9 MRSA in sacral wound and receiving Vancomycin antibiotic treatment for infection to infuse through PICC line. R1 is receiving nutrition through newly placed g-tube feeding tube. Hospital records for R1, on 2-21-14, document that R1 was admitted on 2-21-14 from the facility with open wounds of both heels measuring 2 centimeters by 2 centimeters with depth to the subcutaneous tissue. R1 was also noted with an open wound at the left lateral malleolus and sacrum. The heel wound was noted to be draining pus and later noted to be positive for infection. Hospital record documents under history, " The patient was found to have several decubiti, the most significant which appears to be that of the left heel that looks to be grossly infected as evidenced by gross purulence being expressed. " Wound cultures from the hospital dated 2-22-14 indicate that R1's wounds on the sacrum and heels were positive for MRSA. On 03/11/14 from 12:40pm to 1:05pm. a phone interview was conducted with Z1 (Wound Care Doctor). Z1 stated she had been working with R1's pressure ulcers on the feet on and off since October of last year. Z1 stated that R1 had recently been in hospital and had pressure ulcer on coccyx debrided and was noted to have Methicillin Resistant Staphylococcus Aurous and Osteomyelitis in sacral pressure ulcer and started on intravenous antibiotic therapy for this at hospital which was continued at facility. Z1 stated that special low air loss mattress was ordered to help healing process because it redistributes weight and helps relieve pressure, specifically to pressure on sacral area. Z1 stated that resident wearing and adult incontinent brief could negatively affect healing process to sacral area because it would keep moisture and soiling to stay against skin causing irritation and friction. R1 stated that multiple layers on low air loss mattress	S9999		

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S9999	<p>Continued From page 10</p> <p>could affect effectiveness because it decreased the benefits of the redistribution or air flow to sacral area. Z1 stated that with the low air loss mattress would be more effective if it only had thin draw sheet between resident and fitted sheet on mattress. Z1 stated that if soiling such as urine or feces was on dressing and or wound for extended periods could cause increased issues with infection because it could contaminate area. Z1 stated dressing should be change immediately after any visibly soiling and extra care should be taken to ensure feces doesn ' t contaminate area. Z1 stated she would expect facility to notify her or the primary care physician if resident was refusing treatments and she had only been made aware of R1 refusal of treatment on 03/10/14 by E6 (wound care nurse). Z1 stated that for best practice with turning and repositioning resident to help wound healing for pressure ulcer on sacral area that resident should be turned and repositioned at least every two hours and should be more side to side and only occasionally place on back. Z1 stated that pillows could be used to be position resident from side to side but should use as few as possible and should be place above buttock to ensure no extra pressure on pressure sore on sacral area. Z1 stated example of turning and repositioning of left side, right side, middle, left side, right side, middle. Z1 stated that R1 should have pressure relieving boots on in bed and when up to help relieve pressure to pressure ulcers on heels and foot and could also float feet off bed by putting pillow under legs. Z1 stated that if resident had on foot protectors in bed should not have feet pressed against foot board as this could increase pressure and feet should not be placed on top of foot board as this would increase pressure to area. Z1 stated that she felt pressure areas could possibly be healed and at very least remain</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>stable.</p> <p>On 03/10/14 at 10:25 am, R1 was in room lying on back, had thick blue incontinence pad between low air loss mattress and resident and had on pressure relieving boots on but R1 was noted to have slid down in bed and feet were pressed against foot board.</p> <p>On 3/10/14 at 2:24 pm, R1 was in room receiving dialysis with E7 (dialysis nurse) and E15 (certified nurse's aide/dialysis technician) present in room. R1 was again noted to be on his back with thick blue incontinent pad between resident and low air loss mattress as well as sweat pants. R1 had on foot protectors but was slid down in bed and both feet were pressed against footboard. E15 stated R1 wears an adult incontinent brief while in bed. E7 or E15 made no attempt to reposition resident off back or slide up in bed to relieve pressure from footboard.</p> <p>On 03/10/14 at 3:45 pm, R1 was in room, in bed, lying on back, wearing sweat pants as well as thick blue incontinence pad between resident and low air loss mattress. R1 had on foot protector but feet/heels were lying on top of footboard.</p> <p>On 03/11/14 at 6:50am to 8:25 am wound care was observed. E6 (wound care nurse) performed treatment and was assisted by E19 (Certified Nurse's Assistant). Upon entering room R1 had heel protectors on but, feet were lying over foot board of bed. R1 was on low air loss mattress with upper part of body positioned to the right side with pillow underneath lower back and buttock. R1 had on sweat pants, adult incontinent brief and thick blue incontinent pad between him and low air loss mattress. During wound care E6 was noted to contaminate treatments to all areas on both feet by wiping same open area with same side of 4x4 gauze multiple times. E6 was observed to open the 4x4 gauze that came from the treatment cart, open these with gloved hands</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2014
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NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
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S9999	<p>Continued From page 12</p> <p>then use same gloved hands to clean wound areas thereby contaminating the wound. E6 did this with all wound areas. On multiple occasions E6 touch bedding, resident and residents clothing with gloved hands then touched area being used as her designated clean field and entire tray used for supplies of treatment, thereby contaminating entire clean dressing field. E6 also cut and placed packing for sacral area by cutting into ribbons and placing on tray that E6 had contaminated with ungloved hands and soiled gloves. When E6 went to do the treatment for area coccyx, dressing and resident was soiled with feces. E6 cleaned area and had to wipe area several times, used approximately half a box of cleaning wipes due to dried feces on and around dressing and anus. E6 or E19 were unable to tell when last time resident had been checked for incontinence. After soiled dressing was removed R1 noted to have feces in and around edge of bed of pressure area, thereby causing contaminations and area and increasing possible issues with infection. E6 again contaminated wound on coccyx by using same side of the 4x4 gauze. E6 used the same side of the gauze to wipe same area four times on same side of gauze. When E6 put on adherent wound covering pad and dressing tape was observed to have wrinkles along bottom of wound area which can cause pressure and allow open areas for feces to enter wound if incontinent. When E6 finished treatment R1 was positioned to right side and staff put on adult incontinence brief, thick blue incontinence pad and sweat pants between resident and low air loss mattress. E19 stated that since R1's return from the hospital he is total care and requires two people assist for most all activities of daily living.</p> <p>On 3/11/14 at 10:45, R1 was in bed had pillow under lower back and buttock, thick blue</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>incontinent pad and sweat pants between pressure area on coccyx and low air loss mattress and feet were in protective boots but pushed against end of foot board. On 03/11/14 at 4:30pm, R1 was noted to be in room in bed. E20 (certified nurse aid) entered room and stated he had just been in to turn resident. E20 stated that since R1's return from hospital he is total care and requires two assist for most activities of daily living. E20 stated that before the last hospitalization he could help with some of his activities of daily living. E20 stated R1 was incontinent of bowel and bladder but not with bladder very often due to dialysis. R1 was turned toward left side with one pillow under back and another pillow under buttock. E20 stated that R1 had on adult incontinent briefs, sweat pants and thick blue incontinent pad on bed and that was how they usually changed him and kept him in bed. E20 indicated that R1 was turned and repositioned every two hours and schedule was right side, middle, left side, middle, right side, middle.</p> <p>During several observations, R1 was noted to lying on the special mattress with several layers between R1 and the mattress. R1 was also noted during these observations to have slid down in bed with both feet pressing against the foot board, creating pressure. These observations were noted on 3-10-14 at 10:25am, 3-10-14 at 2:24pm, 3-10-14 at 4:45pm, 3-11-14 at 6:50am, and 3-11-14 at 10:45am</p> <p>On 3/12/14 at 8:20 am, R1 was in room, in bed receiving dialysis. E7 (dialysis nurse) was present. R1 had pillow under right buttock and E7 stated that was to relieve pressure on bottom. R1 also had thick blue incontinence pad between him and low air loss mattress.</p> <p>On 03/12/14 at 8:45, E3 (Nurse) and E18 (CNA-Certified Nurse aid) and E19 (CNA) went to</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>check on R1. E19 stated that R1 was to be turned every two hours and was to be right side, middle, left side, middle, right side, middle. E19 confirmed this turning schedule. E19 stated they had turned and repositioned resident around 7:00am. Upon entering room, R1 was noted to have thick blue incontinent pad, adult incontinent brief and pillow under right buttock. E3 verified that R1 should not have all the padding between bottom and low air loss mattress and pillow should be placed above buttock area under lower back. R1 was repositioned on back by staff. At 9:00am all staff exited R1's room at no time did staff check incontinent brief for soiling and staff also did not ask R1 if he was incontinent and needed changing.</p> <p>According to R1's TAR (Treatment Administration Record) for month of March 2013, that was initiated on 3/4/14 with R1's readmission to the facility, indicates that on 03/09/14 and 03/10/14 that R1's treatment was not done due to resident refusal. On 03/08/14 there is no signature or initial to indicate ordered treatment was done for R1 on that day. No documentation could be found in R1's chart to indicate wound care doctor or primary care physician was notified of R1's treatment not being done on 3/8/14 or refusal on 03/09/14. TAR also indicates that on 3/8/14 daily skin check was not done and on 03/09/14 daily skin check was not done due to refusal.</p> <p>R1 was first noted with the unstageable pressure ulcer to the sacrum/coccyx on 2-11-14 by E6. E6 noted the wound as follows: " measures of 3.8cm x 3.5cm x 0.1cm wound bed with slough, some granulation noted, edges are attached, margins are uneven with moderate drainage. " Z1 however documented in the wound notes of 2-20-14 that this same area was, " (due to necrosis) of coccyx that is related to pressure and less than one day old ". Z1 went on to indicate</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>that this area was acquired in the hospital, however R1 was out less than 24 hours for treatment for a fall incident for 2-19-14. The facility was asked several times to produce the treatment records for February of 2014 and but none was provided during the survey. A treatment order was noted for 2-18-14 for R1 as follows: " Coccyx, cleanse with Normal Saline, pat dry, apply foam dressing, skin prep surrounding tissue, apply border gauze. Change daily." R1 was then sent to the hospital on 2-21-14 and at that time the coccyx/sacrum was positive for MRSA infection and required a debridement, which was performed secondary to infection.</p> <p>According to R1's TAR for January 2014, under heel protectors to be worn at all times while in bed there and off load bilateral heel while in bed is no indication this was done on the 6-2 shift on the 1/08/14, 01/09/14, 01/10/14, 01/18/14, 01/19/14, 01/30/14, on 2-10 shift on the 1/25/14, 01/26/14, on the 10-6 shift on the 1/29/14, 1/30/14, 1/31/14. The TAR Under these has hand written to chart if non-compliant and no corresponding charting could be found regarding refusal. Under skin checks daily (10-6) on 01/29/14 & 01/30/14) there is no indication these were done. According to the treatments areas for the left heel and right heel, there is no indication theses were done on 1/28/14, 1/29/14, 1/30/14, or 01/31/14. Facility was unable to provide TAR for R1 for February 2014 when requested. Facility also unable to provide documentation regarding refusal of care for the dates noted above when requested.</p> <p>(A)</p>	S9999		
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