Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: ______ B. WING ______	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	**614 NORTH SUMMIT** **COLLINSVILLE, IL 62234**

(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) COMPLETE DATE
S 000	Initial Comments Complaint 1949555/IL118789 Complaint 1949355/IL118568	S 000		
S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1010h) 300.1210b) 300.1210d)2)5) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 01/27/20

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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. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

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S9999	Continued From page 2 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) This Requirement is not met as evidenced by: Based on observation, interview and record review the facility did not notify timely the Physician or the responsible party of two new unstageable pressure ulcers, for 1 of 1 resident (R16) reviewed for change of condition. Facility failed to follow Physician orders for treatments, repositioning, and offloading pressure for 2 of 2 residents (R1,and R18) in the sample of 23. This failure resulted in R16 acquiring two unstageable pressure ulcers, being untreated by staff for 21 days and (R18's) stage 4 pressure ulcers.	S9999		

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Findings include:

R16's Cumulative Diagnosis Sheet, undated, documents his diagnoses as: Epilepsy, Hypertension, Schizophrenia, Right-sided Weakness, and Fall Risk.

R16's Braden Score for Preventing Pressure Ulcer Risk dated 11/18/19 documents a score of 11, indicating he is at high risk of developing pressure ulcers. No other updates to the skin risk assessment were documented.

R16's Nursing Admission Assessment dated 11/18/19 documents: Excoriation to coccyx. The body diagram does not document any areas of concern except his gastrostomy tube site.

On 12/26/19 at 5:22 AM V19, Certified Nursing Assistant (CNA) turned R16 onto his right side to perform incontinent care. R16 had two unstageable pressure ulcers to his right and left inner buttocks, with both wound beds covered with yellow slough. There was a moderate amount of drainage on his soiled adult diaper and a small amount of drainage on his bed sheet where the pressure ulcers were touching. There was no dressing covering either of the pressure ulcers. V19 confirmed that there was no old dressing contained in the soiled adult diaper. The skin surrounding the pressure ulcers had deep wrinkles that remained during care. V19 stated staff were putting protective cream on R16's buttocks and coccyx. She applied Aloe Vesta Antifungal Cream, over and around the pressure ulcers. The Pharmacy label on the bottle, documented the instructions to apply to buttocks and sacrum twice daily. The directions on the bottle document to use this medication for 2 weeks, if no improvement, notify the Doctor. R16

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also had dressings on his left outer knee and left ankle dated 12/23/19, 3 days ago.

On 12/26/19 at 10:00 AM V3, Licensed Practical Nurse (LPN) measured the unstageable pressure ulcer on right buttock as 2.5 centimeters (cm) by 1.5 cm, and the unstageable pressure ulcer on his left buttock as 3 cm by 1 cm. V3 stated, "It's not healing; it's worse than when he came back from the hospital, because it was just a rash. I don't think the Aloe Cream is doing the trick. He needs to be seen by the Wound Doctor." V3 stated, she last looked at R16's skin on 12/13/19 when she last worked and stated the wound on the right buttock was not getting better. V3, LPN, stated the area to the right buttock had been two smaller wounds, but now was one big wound. V3, LPN, acknowledged R16's dressings on his left ankle and left heel dated, 12/23/19 (three days ago) and stated she did take care of R16 on 12/24/19, but did not get a chance to do his dressing changes. V3 stated, "I don't even know what's under those dressings."

R16's Hospital Comprehensive Wound Report dated 12/03/19 documents the following wounds: Left Medial Heel- Stage II Pressure Ulcer 2.5 cm by 3.5 cm; Left Hip Deep Tissue Pressure Ulcer 4 cm by 4 cm; Left Heel- Deep Tissue Pressure Ulcer 2 cm by 2 cm; and Coccyx- Friction, Description: unapproximated macerated: 0.2 cm by 0.2cm by 0.1 cm. V3's measurements done today (12-26-2019) are 2.5 cm by 1.5 cm unstageable pressure ulcer on the right buttock and 3.0 cm by 1.0 cm unstageable pressure ulcer on left buttock. No wound measurements or assessments for any of R16's pressure ulcers to his left knee, left hip, left ankle or left heel were found in his facility medical record.

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R16's Discharge Hospital Report - Wounds, dated 12/04/19 documents that he had "peeling, flaking open skin to buttock surrounded by maceration from incontinence, with measurements: 0.2 centimeters (cm) by 0.2 cm by 0.1 cm

R16's Discharge Medication List dated 12/05/19 listed the following order: Mepilex dressings to all pressure areas- left upper foot (medial), left heel, left medial heel, left lateral ankle, right lateral ankle, and right hip.

R16's Nursing Admission Assessment dated 12/05/19 includes a body diagram for an admission skin assessment which has an arrow pointing to the left ankle and documents "wounds". No other areas were identified on the body diagram.

A Nurses Note dated 12/06/19 at 6:00 AM, documents that during incontinent care, R16 was found to have 2 small open areas to his coccyx, but there was no description of the wounds or measurements documented. No further documentation was found in R16's Medical Record regarding open areas to R16's coccyx, or of his Physician being notified for treatment orders.

The next acknowledgement of R16's pressure ulcers on his buttocks was documented in a Nurse's Note dated 12/19/19, "Breakdown noted to sacral area 2+ decub noted. Barrier cream applied. Will continue to monitor." No description of the pressure ulcers nor notification of MD for new treatment orders were documented on that date.

R16's Physician Order Sheet includes an order

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dated 12/09/19 documenting, "Refer to wound specialist." which was written and signed by V21, Family Nurse Practitioner, (FNP).

Review of R16's medical record on 12/27/19 indicate that V3 did not document finding the new pressure ulcers, a description of the pressure ulcers, and notification of the Physician or FNP and there were no new or updated orders for treatment of the unstageable pressure ulcers.

There was no facility skin assessment done on 12/14/19 when R16 returned from the hospital where he had been admitted on 12/10/19 with a diagnosis of pneumonia.

R16's Care Plan dated 10/01/19 documents he is at risk for skin breakdown per Braden Risk Assessment. Risk Score High. The goal documented, "Will have no skin breakdown thru admission review and care plan. Interventions include: Skin check by nurse weekly on 2-10 PM shift; Incontinent care and barrier cream after incontinence care as needed.; Report any new skin concerns to the Doctor for treatment and follow up; Prevent skin areas from prolonged contact, use pillows for positioning, float heels, assist to turn at least every 2 hours and prn. R16's care plan was updated on 12/26/19 with: "Resident noted to need wound treatments to both heels and skin treatment to hip areas. All these areas need to be assessed and MD to be notified and treatments to be put in place." The care plan does not identify that R16 has unstageable pressure ulcers on his buttocks, or pressure ulcers to his left knee and ankle.

R16's Treatment Administration Records (TAR) dated 11/01/19 through 11/30/19 and 12/01/19 to 12/31/19 document an order for Skin Check

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weekly on Tuesdays, but, there is no documentation that any skin checks were performed in the months of November or December. A Physician Order dated 12/14/19 documents, "Apply Aloe Vesta Antifungal Cream to sacrum every 12 hours." Another order on the TAR dated 12/14/19 documents: Apply 4X4 Mepilex dressing to ulcers on right hip, left heel, and right lateral ankle daily. Another order on the TAR was undated: Apply silver-sept to ulcers on left lateral ankle and left knee. Cover with Mepilex. Between the dates of 12/14/19 and 12/27/19, the Aloe Vesta Cream treatment was applied only once a day on December 14, 18, 20, 22, 23, 24, 25, 26 and 27. No treatment was applied to R16's coccyx/ buttocks on December 16, 17, 19 and 21. According to R16's December TAR, the treatments to R16's left ankle, left knee, right hip, left heel, and right lateral ankle were not done on December 14, 16, 17, 18, 19, 21, 24, 25, 26 and 27. There was no order on the December TAR for treatment of wound to the back of R16's right hand.

On 12/26/19 at 1:40 PM V3 stated she was going to change the dressings on R16, but she did not know where his TAR was, so she was just going to put some dressings on. V3 removed a dressing from a wound on the back of R16's right hand, cleansed it with Theraworx, applied Medihoney and a dry dressing. V3 stated the wound on the back of his right hand was from a fluid filled blister that had popped. She then removed a dressing from his left lateral knee, cleansed a Stage II pressure ulcer that was covered with slough, with Theraworx, and applied skin protectant with vitamins A&D to the wound and covered it with Mepilex. V3 stated the wound on his left knee had some kind of ointment on it but she wasn't sure what it was, so she was just

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going to put protectant ointment on it.
She then removed the gauze dressing that was wrapped around his left heel and saw another dressing to his left lateral ankle. Upon removing dressing that was dated 12/23/19 (three days ago) from left lateral ankle, she stated, "Oh, this one is kind of bad." An unstageable pressure ulcer to the left lateral ankle was covered with yellow slough, and the old dressing was saturated with serosanguinous bloody drainage. V3 cleansed the wound with Theraworx then applied Medihoney and a dry dressing. She then cleansed the necrotic pressure ulcers on R16's medial and lateral left heel with Theraworx, applied protective ointment with vitamins A &D and a dry dressing, wrapped it with gauze and then wrapped it with an ace bandage. V3 stated she did not measure the wounds because the Wound Doctor would do that. R16's unstageable pressure ulcers were uncovered and V3 stated she had applied the Aloe Vesta that was ordered for that area.

On 12/26/19 at 11:26 AM, V1, Administrator, was asked for an accurate wound report that included all the residents with pressure ulcers in the facility. The list of residents with pressure ulcers provided on the first day of the survey, 12/24/19, included only one resident with a pressure ulcer. The accurate list, labeled "Skin Care Treatments" provided on 12/26/19 from V2, MDS Coordinator, included 6 residents, including 3 with pressure ulcers. V1 stated, "To be honest, this is a problem that I'm hoping to address with my new Assistant Director of Nursing who is starting on 12/30/19. No one is following up with weekly wound assessments or measurements except the Wound Physician."

On 12/27/19 at 11:55 AM V9, LPN stated she had

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notified V21, FNP, of R16's new unstageable pressure ulcers to his buttocks and requested a referral for the Wound Physician to evaluate and treat him. V9 stated that V21 responded that she had already given that order on 12/09/19, but to go ahead and make the referral now. V9 stated she did not know why the referral for the Wound Physician was not done on 12/09/19, but that sometimes the nurses waited until the Wound Physician was in the facility before informing him of new referrals. V9 confirmed there was a 21-day delay in the FNP being notified of the unstageable pressure ulcers on R16's buttocks from when they were discovered on 12/06/19.

On 12/27/19 at 11:55 AM, V21, FNP, stated she had not been informed that R16 had two new unstageable pressure ulcers on his buttocks. She stated she had given an order on 12/09/19 for R16 to be seen by a Wound Specialist, for wounds he had after a hospitalization to his lower extremities. V9, LPN, had requested another referral for a Wound Specialist and for a low air loss mattress on 12/27/19 for R16 due to new wounds on his buttocks. No wounds had yet been evaluated. V21 stated she would have expected the staff to notify her or the Physician of any changes in R16's condition for prompt, appropriate treatment.

On 12/27/2019 at 12:10 PM V22 Physician Wound Doctor stated Medihoney and silver gel are not the same type of treatment and are not interchangeable. He stated he would expect nurses to follow Physician Orders and perform wound care as ordered and notify either him or the Medical Doctor of any changes in wound status.

On 12/27/19 at 1:45 PM, V29, R16's mother and

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Responsible Party according to R16's undated Face Sheet, stated the facility would notify her any time R16 was sent to the hospital. The facility did not notify R16's mother that R16 had bed sores on his buttocks. V29 stated the hospital had notified her when he was admitted to the hospital and that R16 had bed sores and stated they had taken pictures of the sores on his ankle, heels and hip. V29 stated R16's sister visits him more often than V29, and stated he is often wet when she comes to visit. V29 stated this could cause his bed sores.

The Facility's Policy, "Notification for Changes in Resident Condition or Status" dated 07/01/12 documents, "Policy: The Facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA, etc.) of changes in the resident's medical/mental condition and/or status. Responsibility: Administrator, Director of Nursing, Charge Nurse. Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending Physician or on-call Physician when there has been: a. Any symptom, sign, or apparent discomfort that is: 2. A marked change (i.e. more severe) in relation to usual signs or symptoms, and 3. Unrelieved by measures already prescribed. and o. Onset of pressure ulcers or stasis ulcers. and 2. The nurse supervisor/charge nurse will notify the DON (Director of Nursing), Physician, and unless otherwise instructed by the resident, the resident's next of kin or representative when the resident has any of the afore mentioned situations."

2. On 12/26/19 at 5:50 AM V19, CNA, provided incontinent care for R1, who was lying flat on her

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back. R1 stated this was the first time V19 or any other staff had come in to check and change her on the night shift. When V19 rolled R1 onto her right side to cleanse fecal material from her rectum and buttocks, R1 had deep red wrinkles on both of her buttocks that remained while V19 cleansed her skin and put on a new adult diaper. When V19 was finished with R1's incontinent care, she left R1 on her back with no repositioning with pillows to relieve pressure from her buttocks.

R1's MDS dated 09/19/19 documents she is alert and oriented to person, place, time and situation. The same MDS documents she requires extensive assist with bed mobility.

On 12/27/19 at 9:20 AM R1 stated she is afraid she will get a sore on her bottom because she is not able to move herself around in bed, and staff do not come in to reposition her. She stated she wished staff would give her one hour of good care a day and that would make her feel much better.

R1's Braden Scale for Predicting Pressure Ulcer Risk dated 9/17/19 documents her score of 14 indicating she is at high risk of developing pressure ulcers.

R1's Care Plan dated 09/28/19 documents R1 is at risk for Pressure Ulcers related to her High Risk per Braden Scale. It documents interventions to include: Reposition per positioning schedule- see positioning schedule (Schedule not part of R1's Care Plan); Prevent skin area from prolonged contact. Use pillows, place padding between legs, etc.

R1's TAR documents an order to perform skin checks weekly on Saturdays, but there is no

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documentation that skin checks have been performed in December 2019.

3. R18 was admitted to the facility 4/07/2016 (current) and 5/30/2008 (original) with a diagnosis of: severe intellectual disabilities, Hydrocephalus, Urinary tract infection and Contracture of muscle. R18's Minimum Data Set (MDS) dated 10/02/2019 document a Brief Interview of Mental Status (BIMS) score being blank indicating severe cognitive impairment and is totally dependent on staff assistance for most Activities of Daily Living (ADLS).

On 12/26/2019 at 10:00-10:50 AM R18 was observed sitting in a small TV room across the nurse's station. At 10:50 AM R18 was then pushed into the dining room. At 10:50-12:45 PM R18 was observed in dining room. At 12:45 PM V20 Certified Nurse's Assistant (CNA) is observed pushing R18 from dining room to his room. V20 CNA and V12 CNA transferred R18 from wheelchair to bed operating a mechanical lift. A strong foul-smelling urine noted and R18's pants were visibly wet. V20 and V12 stated that another CNA got R18 out of bed for the 8:00 am breakfast and that they hadn't laid R18 down until now.

V12 CNA left the room and returned with one partially wet white towel. V20 and V12 then removed R18's incontinent brief and deep red creases noted on R18's buttocks and back of legs. A deep open stage 4 pressure area noted on R18's right buttocks, with no dressing. V20 then took the wet towel and wiped R18 from the scrotum area back to his right buttocks wiping 2-3 times and then discarded towel. V20 then pulled R18 onto his right side and scar tissue noted on

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R18's left buttocks and dried feces noted on buttocks and rectum area. V20 and V12 then pulled up the incontinent brief and covered R18 up with covers. V20 and V12 then removed their gloves and left resident's room without washing their hands.

On 12/26/2019 at 1:20 PM V3 Licensed Practical Nurse (LPN) stated, "R18's wounds are being treated by the Wound Doctor." V3 also stated, "The wound is open, so the Wound Doctor can pack it when they come." V3 stated, "Apparently he (Wound Doctor) doesn't want a dressing on it. V3 stated, "I will send the CNA's back in to clean R18."

On 12/27/2019 at 09:20 AM V4 LPN stated, "No, R18's wounds are not supposed to be open, they are supposed to be covered. I haven't had a chance to do my dressing changes yet." V4 LPN stated, "It looks like there are 2 different orders, one for day shift and one for evenings." "I have never had 2 different orders for one wound before, I think one of those orders should have been discontinued." V4 stated, "V3 is Agency Nurse, so when she stated that R18's wound should be open to air, then she should of wrote the new order." V4 stated, "(R18) wounds need dressings because R18 is incontinent of urine and stool."

On 12/27/2019 at 08:00-11:45 AM R18 was observed sitting in wheelchair in TV room across from the Nurses station. No staff observed off loading or repositioning R18 during this time.

On 12/27/2019 at 12:10 PM V22 Physician Wound Doctor (R18's MD) stated, "I would expect the Nurses to follow my orders." V22 stated, "(R18) is supposed to receive one treatment a

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day for his right and left buttocks." V22 stated, "Most of the nurses have left and now they have Agency Nurses that don't know what's going on." V22 stated "that the facility has had no Director of Nursing or Assistant Director of Nursing for months." V22 stated "that Silva Gel and Medi-Honey are not the same treatment." V22 stated, "There is no guidance at that facility, they need management." V22 stated, "(R18) only has treatments to his right and left buttocks and wasn't familiar with left hip."

R18's Treatment Administration Record dated 12/1/2019-12/31/2019 documents:
Cleanse Right Buttock apply crushed Flagyl, Silvadene, Collagen, Calcium Alginate & Dry Dressing every other day and as needed. On 12/6/19 and 12/20/2019 there are initials indicating treatment was completed. There are no initials on 12/02, 12/04, 12/08-12/16 to indicate treatment was completed.

R18's TAR 12/01/2019-12/30/2019 documents: Cleanse Left Buttock, Pack with Bacitracin coated Iodoform, Cover with Dry dressing every other day and as needed. (Dated 07/30/19 on TAR), only on 12/6 and 12/20 were initials indicating treatment was completed.

R18's TAR dated 12/01/2019-12/30/2019 documents: Cleanse wound to left hip apply Mupirocin, collagen, calcium alginate daily and as needed. (Order has no start date indicated on TAR)

Weekly Skin Assessment with note on Saturday 2-10 PM. On 12/16/2019 there are initials indicating skin check completed.

R18's Wound Evaluation & Management

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Summary dated 11/04/19 documents: Stage 4 Pressure Wound Left Buttock Wound Size 1cm x 1cm x 1.5 cm. Undermining 10cm at 9 o'clock. Wound Progress: No change. Dressing Treatment Plan: Dry Protective dressing apply once daily for 9 days; Gauze packing strips (iodoform) apply once daily for 9 days; Alginate calcium apply once daily for 16 days; Silver sulfadiazine apply once daily for 9 days.

R18's Wound Evaluation & Management Summary dated 11/4/2019 documents: Stage 4 Pressure Wound of Right Buttock Wound Size 1 cm x 0.5 cm x1 cm. Wound Progress: No change. Dressing Treatment Plan: Dry Protective dressing apply once daily for 9 days; Silver sulfadiazine apply once daily for 9 days; Gauze packing strips (iodoform) apply once daily for 23 days. These Physician orders were not transcribed to R18' s' November`s TAR or followed.

R18's Wound Evaluation & Management Summary dated 11/11/19 documents: Stage 4 Pressure Wound Left Buttock Wound Size 1cm x 1cm x 1.5 cm. Undermining 10cm at 9 o'clock. Wound Progress: No change. Dressing Treatment Plan: Dry protective dressing apply once daily for 30 days; Gauze packing strips (iodoform) apply once daily for 30 days; Alginate calcium apply once daily for 9 days; Mupirocin apply once daily for 30 days. Discontinue Silver Sulfadiazine.

R18's Wound Evaluation & Management Summary dated 11/11/19 documents: Stage 4 Pressure Wound of Right Buttock Wound Size 0.5 cm x 0.5 cm x1 cm. Dressing Treatment Plan: Dry Protective dressing apply once daily for 30 days; Gauze packing strips (iodoform) apply

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once daily for 16 days; Mupirocin apply once daily for 30 days. Discontinue Silver Sulfadiazine. These Physician's orders were not transcribed to R18's November TAR or followed.

R18's Wound Evaluation & Management Summary dated 11/18/19 documents: Stage 4 Pressure Wound Left Buttock Wound Size 1cm x 1cm x 1.5 cm. Undermining 10 cm at 9 o'clock. Wound Progress: No change. Dressing Treatment Plan: Dry protective dressing apply once daily for 23 days; Gauze packing strips (iodoform) apply once daily for 23 days; Alginate calcium apply once daily for 30 days; Mupirocin apply once daily for 23 days.

R18's Wound Evaluation & Management Summary dated 11/18/19 documents: Stage 4 Pressure Wound of Right Buttock Wound Size 0.5 cm x 0.5 cm x1 cm. Dressing Treatment Plan: Dry Protective dressing apply once daily for 23 days; Gauze packing strips (iodoform) apply once daily for 9 days; Mupirocin apply once daily for 23 days. Discontinue Silver Sulfadiazine. These Physician's orders were not transcribed to R18's November TAR or followed.

R18's Wound Evaluation & Management Summary dated 12/9/2019 documents: Stage 4 Pressure Wound of the Left Buttock, Wound size Length 1cm x Width 1cm depth 1.5 cm. Duration greater than 2130 days. Undermining 10 cm at 9 o'clock. Exudate: Moderate Serous.
Dressing Treatment Plan: Dry protective dressing apply once daily for 30 days; Gauze packing strips (iodoform) apply once daily for 30 days; Alginate calcium apply once daily for 30 days; Silver sulfadiazine apply once daily for 30 days.

R18's Wound Evaluation & Management

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Summary dated 12/9/2019 documents: Stage 4 Pressure Wound of the Right Buttock. Wound size Length 0.5 cm x Width 0.5 cm x Depth 1 cm. Duration greater than 306 days. Dressing Treatment Plan: Dry protective dressing apply, once daily for 30 days; Gauze packing strips (iodoform) apply once daily for 30 days; Silver sulfadiazine apply once daily for 30 days. Recommendations: Limit sitting to 60 minutes; Off-load wound; Reposition per facility protocol.

R18's Care Plan date 10-10-2019 documents; Mobility, Impaired physical.
Interventions: Turn and reposition following the resident's reposition schedule at least every 2 hours and as needed. Alteration in Bladder Elimination as related to incontinence.
Interventions: Continue to monitor on going for any signs and symptoms of urinary tract infection. All care and comfort measures extended to assure maximum comfort to keep resident clean dry and free from odor. Encourage fluids.
Pressure Ulcer Present Right and Left Buttock.
Interventions: Assist Resident to turn and reposition every 2 hours and as needed or more frequently per reposition schedule. Braden Scale High Risk daily skin check with documentation, apply house/stock Theraworx to peri area with personal care after every incontinent episode and as needed. Lotion skin with cares and as needed, avoid friction over boney prominences. Wound Doctor consultant every week. Dressing change daily as ordered.

Facility's Policy and Procedure 'Decubitus Care/Pressure Areas' dated 05/07 documents: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. The pressure area will be assessed

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S9999	Continued From page 18 and documented on the Treatment Administration Record (TAR). Complete all areas of the TAR: Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). Documentation of the pressure area must occur upon identification and at least once a week on the TAR. The assessment must include: Characteristic (size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.). Treatment and response to treatment. (B)	S9999		