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S 000	Initial Comments Complaint #1640821/IL83375 - no deficiency Complaint #1640957/IL83533 - F314 Complaint #1641065/IL83662 - F157, F312, F314, F425 Complaint #1641087/IL83687- F314, F425	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1010h) 300.1210b) 300.1210d)1)2)3)5 300.1220b)3) 300.1620a) 300.1630d) 300.3220f) 300.3240)a) 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 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a	S9999	Attachment A Statement of Licensure Violations	

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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
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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
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

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S9999	Continued From page 2 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 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 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication	S9999		

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S9999	Continued From page 3 d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. 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 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 requirements were not met as evidenced by: Based on interview, observation and record review, the Facility failed to assess/evaluate, treat and prevent pressure ulcers for 3 of 5 (R2,R9, R10) reviewed for pressure ulcers in the sample of 10. This failure resulted in R9's pressure ulcers worsening to Stage 4 with osteomyelitis. Findings include: 1. R9's Diagnosis List, dated 7/16/15, documents R9 was admitted to the facility on 7/16/15 with diagnoses in part: sacral decubitus, spinal cord injury, and schizophrenia. R9's Admission Assessment, dated 7/16/15, documents "2 open areas 1) left buttocks centimeters (cm) x 2 cm x 2.3 cm. 2) Sacral 8	S9999		

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S9999	Continued From page 4 cm x 10.2 cm, depth .7 cm." R9's Wound Assessment Details, dated 8/6/15, document R9 was seeing Z4, Wound Nurse Practitioner, in-house until 11/9/15 when R9 was sent to Z2, Wound Management Physician, for treatment of a stage 4 sacrum pressure ulcer and an unspecified stage right ischium pressure ulcer. R9's Admission Minimum Data Set (MDS), dated 7/23/15, documents R9 is cognitively intact, requires extensive assistance from one staff for Activity of Daily Living (ADL's), is at risk for developing pressure ulcers, and has 2 stage 3 pressure ulcers. R9's quarterly MDS, dated 1/20/16, documents R9 is cognitively intact, requires extensive assistance from staff for ADL's, and has 2 stage 4 pressure ulcers. R9's Care Plan, dated 7/16/15, with updates 10/20/15 and 12/26/15, has no documentation that R2 is non compliant with dressing changes. R2's Care Plan documents: "sacral ulcer stage IV, ischial ulcer stage IV, left lateral Left ankle ulcer osteomyelitis: Improvement in skin condition and no further breakdown thru admission review and care plan. Treatment per order- See Physician Order Sheet (POS) for current treatment cleansing, medicine application and/or dressing. Assess and measure wound weekly and PRN (as needed). Skin check daily. Notify Medical Doctor (MD) if condition worsens or if no improvement of wound over time with current treatment. Monitor site for infection-redness, drainage, foul smell, decline in function, pain. Report signs of infection to MD for recommendations. Abt (antibiotic) per orders see physician order sheet. Skin check daily with treatments, see POS."	S9999		

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R9's lab work, dated 11/17/15, documents a protein level of 7.5 with a normal range of 5.7-8.2 and an albumin level of 3.2 with normal range of 3.2-4.8.

R9's Braden Pressure Ulcer Risk Assessment, dated 7/16/15 upon admission, and on 12/26/15, documents R9 is high risk for pressure ulcers.

R9's November 2015 Treatment Administration Record (TAR) documents R9's refusal for dressing changes on 11/4, 11/5, 11/7, 11/14, 11/17, 11/19, 11/25, and 11/29/15. On 11/18/15, the back of the TAR documents a note "skin w/d (warm and dry) Color good. Open areas to coccyx and right ischium continues. Heels intact. Area around colostomy with some redness noted however no open areas noted. On 11/19/15, the back of the TAR documents a note "(R9) refused for me to change it, says she wants it to change when she goes to bed." No other documentation that dressing change to R9's sacral wound were done on 11/19/16 at a later time as requested by R9. Wound measurements documented on the back of TAR for November as follows: 11/4/15 coccyx 7.7 cm x 8.2 cm x 1 un (undermining) 9-12 o'clock 1 cm with mild drainage and no odor. Ischium 3 cm x 2.3 cm x 1 with mild drainage and no odor. 11/11/15 measurement 1) coccyx 7.5 cm x 8.5 cm x 1 cm, undermining 9-12 at 1.2 cm with mild drainage and no odor. 2) ischium 2.8 cm x 2.5 cm x .1 cm with mild drainage and no odor. 11/18/15 coccyx 7.1 x 7.7 x .9 with mild draining and no odor. Ischium 3 cm x 7.1 x 3. mild drainage and no odor. 11/23/15 coccyx 7 cm x 7.5 cm x. 7 with mild drainage and no odor. Ischium 3 cm x 2 cm x 2 cm with mild drainage and no odor. No other documentation for R9's left lateral malleolus pressure area or any skin breakdown prior to 11/30/15 when R9's wound

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S9999	Continued From page 6 clinic identified the new area. R9's Physician Order Details from Z2, R9's Wound Doctor, dated 11/30/15, document: "clean wound with normal saline. Clean wound with wound cleanser. May shower and or cleanse wound with mild soap and water. Primary wound dressing: Left lateral malleolus-santyl ointment-in wound center only. Secondary dressing-left lateral malleolus: foam and kerlix gauze. Frequency of dressing changes- change dressing every other day." R9's Physician Order Details, dated 11/30/15, document for sacrum, right ischium, and left lateral malleolus to clean wound with normal saline. "Clean wound with wound cleanser. May shower and/or cleanse wound with mild soap and water. Primary Wound Dressing: Alginate-medihoney for right ischium and sacrum wounds, santyl ointment in wound center only for left later al malleolus. Secondary Dressing for sacrum and right ischium-foam. For left lateral malleolus-foal and kerlix gauze. Radiology: X-ray and MRI (Magnetic Resonance Imaging), left ankle- subacute osteomyelitis, left ankle and foot." R9's Telephone Order (TO) from Z1, R9's Medical Doctor, documents on 12/1/16: "Cleanse (left outer ankle) with theraworks, apply medihoney/calcium alginate. Cover with dressing. Changed daily and PRN." R9's Physician Order Details, dated 12/7/15, document for sacrum, right ischium and left lateral malleolus to clean wound with normal saline, clean with wound cleanser. "May shower and/or cleanse wound with mild soap and water. Primary Wound Dressing: alginate-medihoney	S9999		

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for right ischium and sacrum wound, wound gel and alginate-medihoney for left lateral malleolus. Secondary dressing for right ischium, sacrum and left lateral malleolus- foam. Consults: Podiatry-to nail trimming. Notes: Please obtain MRI pelvis and left ankle as directed."

R9's Physician Order Details dated 12/14/15 document for sacrum, right ischium and left lateral malleolus to clean wound with normal saline, clean with wound cleanser. "May shower and/or cleanse wound with mild soap and water. Primary Wound Dressing: alginate-medihoney for right ischium, sacrum wound, and right great toe, wound gel and alginate-medihoney for left lateral malleolus. Secondary dressing for right ischium, sacrum, right great toe and left lateral malleolus- foam. Notes: Please obtain MRI pelvis and left ankle. Send reports when available, obtain foam booties and have patient wear at all times."

R9's December 2015 TAR documents daily skin checks were not done 12/18-12/31/15. R9's TAR further documents no dressing changes to R9's sacral wound, ischial wound and left outer ankle from 12/19-12/25/15. R9's TAR documents on 12/1/15, left outer ankle 2.3 x 2 x .5, mild drainage and no odor. Ischium 3 x 2.1 x 2, sacral 7.1 x 7.7 x 0.9, both with moderate drainage and no odor. On 12/8/15, R9's left outer ankle measurements as 2 x 2 x .5, mild drainage and no odor. Coccyx 7 x 7.5 x. 9, mild drainage and no odor. Ischium 3 x 2 x 2 with mild drainage and no odor. On 12/14/15, measurements for left outer ankle 2.7 x 2 x 1.8 mild drainage , no odor. Coccyx 7.1 x 9 x 0.9 with mild drainage and no odor. Ischium 3 x 2.3 x 0.4 with mild drainage and no odor. On 12/29/15 measurement: 1) sacrum 7.4 x 8.3 x 0.9 cm with moderate

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drainage, no odor. 2) right ischium 2.7 x 2 x 1.8, tunnel time 7, 1.8 cm moderate drainage and no odor. left lateral malleolus 3.2 x 2.5 x 0.7 with mild drainage, no odor. There is no measurements for the week of 12/21/15 documented.

R9's Physician Order Detail, dated 1/5/16, documents: "subq debride. left ankle more necrotic.. MRI left ankle scheduled for 12/10/15 canceled. Will ask NH to reschedule."

R9's January 2016 TAR documents no dressing changes to sacral pressure ulcer from 1/15/16 through 1/31/16. The TAR further documents the treatment of medihoney to wound bed for ischial wound is crossed out. The TAR documents the treatment for left outer ankle with medihoney is also crossed out. R9's order, dated 12/28/15, for sacrum, right ischium wound is Alginate-medihoney and the left lateral malleolus dressing is wound gel, alginate-medihoney. Cover all with foam. R9's wound dressing order for 1/5/16, 1/14/16, 1/21/16 for sacrum, right ischium and left lateral malleolus is alginate-medihoney. Cover all with foam dressing. R9's January TAR further documents measurements on 1/4/16 sacrum 7.4 cm x 8.3 x 0.9, right ischium 2.7 x 2 x 1.8 cm, left lateral hell 3.2 x 2.5 x 0.7. All wounds with moderate drainage. No odor. On 1/11/16, sacrum 7.3 x 8 x 0.7, right ischium 2.6 x 1.8. 1.8, left lateral mild drainage, no odor, l malleolus 3.4 x 2.3 x 0.5. Mild drainage. No odor. On 1/18/16 sacrum 7.3 x 7.8 x 0.7. Right ischium 2.5 x 2 x 1.7. Left lateral malleolus 3.3 x 2.1 x 0.4. All having mild drainage. No odor. 1/25/16 sacrum 7.7 x 8.5 x 1, undermining 3 cm. Moderate drainage. No odor. Right ischium is 1.7 x 0.6 x 1.6, tunneling 1 cm, mild drainage, no odor. Left malleolus 3.4 x 3.2 x

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1, mild drainage. no odor. On 1/6/16, R9's dressings were not completed. A note on the back of R9's TAR documents: "(R9) refused to get her Treatment done around 9:00 PM went in and she said she wants it (treatment) done later..around 11-11:30 PM. (R9) said she don't want to be touched right now." There is no documentation that R9 was re-approached for dressing changed for 1/6/16.

R9's Wound Care Communication Log from the Wound Clinic, dated 1/5/16, documents Z3, Registered Nurse (RN) called and spoke with E3 and documents the following: "Called and spoke with (E3) regarding order for MRI and foam boots for pressure relief.
(R9) had MRI of pelvis on 11/25/15 and was scheduled for transportation for 12/10/15 for MRI of ankle (no record in hospital system of ankle MRI being done). (E3) is going to call and find out what happened with that test."
Wound care Communication from 1/21/16 documents Z3 spoke with E3 to follow up on MRI of left ankle. "(E3) stated she sent over the MRI of the pelvis had set up MRI of the ankle to be done. That is scheduled for January 26 th at 8 AM."

R9's Wound Assessment from Wound clinic, dated 2/25/16, documents sacrum wound measurements as follows: "Length 10.2 x 7.6 x 2.1 cm with undermining starting at 7 o'clock and ending at 5 o'clock. Wound description: Classification: Category/Stage IV, Wound Margin: fibrotic scar, thickened scar, Exudate Amount, Type and Color: Large, Purulent, yellow, brown, green. Foul odor after cleansing: yes. Fascia Exposed: yes; Muscle exposed: yes; Bone exposed: Yes. Assessment Notes Bandage removed was not dated; heavy purulent

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drainage with strong odor upon removal. Purulent drainage noted leaking into and beginning to saturate her depends around the dressing. Positive odor after cleansing. New bone exposed in wound bed." R9's Wound Assessment, dated 2/25/16, documents right ischium wound measurements as follows: "Length 0.4 x 1 x 1.5 cm. Wound description: Classification: Category/Stage III, Wound Margin: distinct; Exudate Amount, Type and Color: Medium, serosanguinous, red, brown. Foul odor after cleansing: no. Assessment Notes: There was no dressing on this wound upon arrival."

R9's February 2016 Treatment Administration Record (TAR), documents R9 refused treatment to left ankle on 2/9/16, and 2/12/17 through 2/24/16. The treatment documented on the TAR is "calcium alginate with bordered foam to left ankle and non bordered to left heel daily." R9's TAR where refusals were documented does not document any reasons for treatment refusals for R9's left ankle. A 2nd page of R9's February TAR documents treatments for R9's sacrum, Right ischium and Left lateral malleolus with no start date as follows: "cleanse with wound cleanser-apply medihoney alginate cover with ABD (absorbent dressing), change every other day." The treatment order from Z2, dated 2/4/16, documents for R9's sacral, right ischium, and left lateral malleolus pressure ulcers - "Medihoney alginate, bordered foam." R9's treatment order changed on 2/18/16 to prisma with foam for R9's sacrum, right ischium and left lateral malleolus pressure ulcers. R9's February TAR does not document the Medihoney or the prisma dressing change orders. The February TAR does not document any measurements from 2/1/16 through 2/25/16 of R9's sacral, right ischium or

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left lateral malleolus pressure areas when R9 was admitted to the hospital for osteomyelitis of decubitus.

R9's POS, dated 2/9/16, documents a copy of a prescription from Z2 on 2/4/16, faxed 2/9/16, for Keflex 500 milligram (mg) three times a day (TID). R9's POS documents a copy of a prescription order from Z2, dated 2/11/16, faxed 2/12/16, for Ceftin 500 mg one twice daily (BID) and Doxycycline 100 mg BID. The fax sheet further documents "start these antibiotics, stop Keflex until appointment with (Z5, Infectious Disease Doctor)." The sheet has a handwritten note, dated 2/23/16, 1 PM to start above as written.

R9's February 2016 Medication Administration Record (MAR) documents Keflex 500 mg TID x 14 days started on 2/9/16 and ended on 2/23/16. This should have stopped on 2/12/16 as ordered. The February 2016 MAR further documents Ceftin 500 mg one BID x 21 days and Doxycycline 100 mg one BID x 21 days started on 2/24/16. These should have started on 2/12/16 as ordered.

R9's Nursing Notes, dated 2/9/16 9 PM, document, in part: "Started Keflex this evening."

R9's Nursing Notes, dated 2/23/16, document: "1 PM: Wound clinic notified that orders faxed over on 2/12/16 were never initiated and order received to start antibiotics as ordered."

R9's Wound Assessment from Wound Clinic, dated 2/4/16, documents left lateral malleolus measurements: "Length 3.8 x 3.2 x 1 cm. Wound description: Classification:

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S9999	Continued From page 12 Category/Stage IV, Wound Margin: distinct, Exudate Amount, Type and Color: Medium, serosanguinous, red, brown. assessment Notes Bandage that was removed was dated 2/21/16; purulent drainage weeping from bandage. Strong odor upon removal; positive odor after cleansing. Wound bed is moist and soft." R9's Debridement Detail from Wound Clinic, dated 2/18/16 and 2/25/16 documents, R9's left lateral malleolus, sacrum, and right ischium was debrided. R9's Wound Assessment from Wound Clinic, dated 2/25/16, documents left lateral malleolus acquired date: "11/30/2015; measurements: Length 3.5 x 2.6 x 1 cm. Wound description: Classification: Category/Stage IV, Wound Margin: distinct, Exudate Amount, Type and Color: Large, Purulent, yellow, brown, green. Foul odor after cleansing: yes. Fascia Exposed: yes; Fat layer exposed: yes; Muscle exposed: yes. Assessment Notes Bandage that was removed was dated 2/21/16; purulent drainage weeping from bandage. Strong odor upon removal; positive odor after cleansing. Wound bed is moist and soft." R9's Wound Care Notes from the Wound Clinic, dated 2/25/16, documents: "Notes; right medial malleolus has reddened area appears to be stage 1 pressure ulcer 2.2 length x 2.5 width; bilateral feet dry and scaly, bilateral toenails curled under toes. Dressing on left malleolus has purulent drainage seeping out; date on it 2/21/16. Strong odor." R9's Physician Order Details, dated 2/18/16, documents for sacrum, right ischium and left lateral malleolus: "change dressing every other	S9999		

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day. Clean wound with normal saline. Clean wound with wound cleanser. May shower and/or cleanse wound with mild soap and water . Wound dressing: prisma. Secondary dressing: foam. Off loading: keep weight off area of wound at all times, felt/foam/ortho-wedge/surgical shoe-foam booties, do not sit for long periods of time. Notes: continue antibiotics."

R9's Progress note from Wound Clinic, dated 2/18/16, documents in part: "subq debride. appeared that ankle dressing had not been changed recently. On Ceftin/doxy for osteo."

R9's Progress note from Wound Clinic, dated 2/25/16, documents: "concerns remain regarding dressing changed. one wound has not dressing. one wound last changed 2/21 (dated) per wd care nurse. cont prism/foam. discussed with hospitalist. will admit for social service evaluation."

R9's History of Present Illness (HPI) Progress Note Details from Z2 dated 11/9/15, 11/30/15, 12/7/15, 12/14/15, 12/28/15, 1/5/16, 1/14/16, 1/21/16, 2/4/16, 2/18/16, 2/25/16, and 3/4/16 documents: "Patient has an ulcer to sacrum/r (right) gluteus, deep stage 4. Pt device used in NH (Nursing Home) not working properly needs KCL wound vac to date, no wound vac obtained in nursing home. Tissue cultures showed slight growth of e coli."

R9's Problem list from Wound Clinic, dated 2/25/16, documents Pressure ulcer of right hip, unspecific state, pressure ulcer of contiguous site of back, buttock and hip, stage 4 and subacute osteomyelitis, left ankle and foot.

R9's Physician Order Details, dated 2/25/16,

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documents for sacrum, right ischium and left lateral malleolus: "Change dressing every other day, clean wound with normal saline. May shower and or cleanse wound with mild soap and water. Wound dressing: Prisma Secondary Dressing: Foam; Off-loading: keep weight off area of wound at all times, felt/foam/ortho-wedge/surgical shoe-foam booties. Notes: continue antibiotics. Patient being admitted for stage 4 pressure ulcer."

R9's Hospital records, dated 2/25/16, document, in part: "chief complaint, decubitus ulcer, osteomyelitis. History of Present Illness: 39 year old female with subtotal colectomy and ileostomy, sacral decub ulcers with chronic osteomyelitis was here at the wound care center and was sent in by (Z2) for poor care at the nursing home. According to him the patient did not have dressing changed since the last time she was seen at the wound care center about a week ago..."

R9's Encounter Discharge information, dated 2/25/16, documents: Discharge destination: admitted to hospital.

R9's Hospital Nursing Notes, dated 2/25/16, document in part: "2:30 PM, (R9) admitted from wound clinic to hospital..admitting diagnosis osteomyelitis decubitus."

On 3/2/16 at 10:30 AM, R9 stated she doesn't refuse dressing changes and that staff changes her dressings. R9 stated she thinks her dressings are changed daily.

On 3/2/16 at 10:40 AM, E2, Director of Nursing (DON), and E14, RN, did a skin check on R9. R9's dressing to her sacrum was soiled with old

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brown drainage with a foul odor. E14 stated R9 gets dressing changes on evening shift. E14 took off R9's sacrum dressing and large area over sacrum/coccyx noted to have bone and adipose tissue exposed. The wound bed was cleansed with theraworks and dried with 4 x 4's. A foul odor continued to be noted after the wound bed was cleansed . The dressing was dated 2/29/16. There was no dressing to R9's right ischium. E14 stated "You're (R9) missing other bandage on right ischium." There was no dressing on R9's left lateral malleolus. E2 retrieved a 4 x 4 from the inside of R9's sock. E14 stated R9 gets a Duoderm to her left ankle. At this time, E1 stated she has never seen any of R9's pressure areas prior to today.

On 2/29/16 at 12:00 PM, E2 stated pressure ulcers measurements are documented on the back of TAR. E2 stated R9 goes to wound clinic offsite so no one at the facility measure her wounds. E2 stated the wound clinic measures them. E2 stated that E9 transcribes R9's measurements to the back of the TAR after R9 returns from wound clinic. E2 stated she doesn't know why February TARS do not have measurements for R9's pressure areas. E2 stated she was unsure why R9 had so many pressure ulcer treatments documented as not done or refusals with no reason why or documentation on re-approaching R9 at a later time. E3 stated she would expect staff to re-approach R9 at a later time if she was refusing, or try on different shift or re-educate R9. E3 stated R9 has schizophrenia so sometimes R9 is non-compliant when she is out of cigarettes. E3 stated she has educated staff on re-approaching R9 when she refuses treatment changes. E3 stated she thought R9's dressing change refusals are on R9's Care Plan. E3

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further stated she did not know why R9's Ceftin and Doxycycline antibiotic that were ordered on 2/4/16 did not get started until 2/24/16 or why R9's Keflex that was to be discontinued when the Ceftin/Doxycycline started continued until 2/23/16. E2 further stated E9 transfers the dressing orders to R9's TAR after each visit. E2 stated she wasn't aware that the treatments were not being transcribed or carried out as ordered by Z2. E3 confirmed that R9 has osteomyelitis in her left lateral malleolus pressure ulcer and also the sacrum pressure ulcer. E3 stated she wasn't aware R9 had a new area on the right medial malleolus.

On 3/2/16 at 9:25 AM, Z3, Wound Clinic RN, stated that she had concerns with R9 getting dressings changed timely and the decline in R9's wounds. Z3 stated when R9 had a visit to the wound clinic on 2/18/16, R9's dressing had drainage that was dried hard with blood in it. Z3 stated "It takes a long time for drainage to set up in that condition." Z3 stated R9's hip/ischium pressure ulcer did not have a dressing on and the sacrum dressing "looked terrible." Z3 stated when R9 came for visit on 2/25/16, R9's left lateral malleolus dressing was dated 2/21/16. Z3 stated R9's dressings are ordered to be changed every other day and when needed. Z3 stated R9 was admitted to the hospital on the visit on 2/25/16 for osteomyelitis to left lateral malleolus and ischium. Z3 stated the clinic found a new stage 1 on the inside of R9's right ankle and the facility was supposed to be offloading and using foam booties. Z3 stated R9's heels are very dark and very spongy and R9 is at risk for breakdown. Z3 stated their clinic first observed R9's left lateral malleolus on 11/30/15. Z3 stated it was a stage 3 pressure area at that time and now it is a stage 4 with osteomyelitis. Z3 stated the facility did not

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notify the clinic of this new pressure area on R9's left lateral malleolus, that the wound clinic discovered it during a skin check. Z3 further stated the wound clinic doesn't routinely do skin checks, but given R9's poor wound care and new areas the clinic identified, it has become routine for R9 to have skin checks done on each visit. Z3 stated the measurements on 11/30/15 for R9's left lateral malleolus were 2.4 x 1.6 x 0.3. Z3 stated R9 has never refused care at the wound clinic and is very cooperative. Z3 stated R9's pressure areas have gotten worse since treating R9. Z3 further stated that Z2 ordered X-ray and MRI of R9's sacrum and left lateral malleolus on 11/30/15, but the facility did not follow through with testing until 1/26/16 (a delay of almost 2 months) for the left lateral malleolus. Z3 stated the facility did not inform the wound clinic that R9's Ceftin and Doxycycline antibiotic duo ordered 2/11/16, were not started until 2/24/16 and that Keflex continued to be given after being discontinued on 2/11/16. On 3/3/16 at 9:42 AM, Z3 stated Z2 ordered a wound vac for R9's sacrum/coccyx and still would like for R9 to have a wound vac. Z3 stated she does not have any communication from the facility why R9 has not received a wound vac to date. Z3 stated the wound clinic was not aware the facility was not following Z2's order for wound care and that prisma was not used as ordered. Z3 stated there would be a note in the wound clinic system if the facility called and Z2 changed R9's order to calcium alginate, but there is no record of Z2 changing R9's orders.

On 3/2/15 at 9:40 AM, Z2 stated he and his office staff had concerns with R9's pressure dressings being changed. Z2 further stated R9 comes to wound appointments and there have been times

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when R9 pressure areas are not covered. Z2 stated he ordered an MRI of R9's left ankle and sacrum and it took the facility a long time to complete the order. Z2 further stated his wound clinic identified R9's left lateral malleolus pressure area. Z2 further stated the order for alginate-medihoney is a combo dressing. Z2 stated there is medihoney impregnated with the alginate. Z2 stated he expected the medihoney to be used for R9's dressing when it was ordered. Z2 stated he was not aware pressure dressing orders were not done as prescribed.

On 3/4/16 2:50 PM, via telephone, Z3 stated R9 had returned to the wound clinic 3/4/16 and had the same concerns that R9 did not have dressings on her left lateral malleolus or her right ischium and R9's sacrum dressing was soiled and needed to be changed. The dressing was dated 3/2/16. At this time, Z2 stated he would want R9 to have a wound vac to the sacrum pressure ulcer if patient would comply. Z2 stated the delay in proper antibiotic treatment delayed R9's treatment for osteomyelitis.

On 3/2/16 at 2:04 PM, E2 stated she was unaware R9 needed a wound vac. E2 stated that E3 gets R9's Wound Physician Details with the orders and measurements from the wound clinic and that E3 transcribes the measurements and orders on the back of R9's TAR. E2 stated she did not know why there was a scheduling delay in getting R9's MRI to left lateral malleolus.

On 3/3/16 at 10:28 PM, E3, Licensed Practical Nurse (LPN)/ Resident Care Coordinator, stated she was not the treatment or wound nurse. E3 stated she has been told this several times by different people but that she is E2's assistant. E3 stated the floor nurses do the treatments and the

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facility doesn't have a treatment nurse. E3 stated she oversees the treatments when she can. E3 stated "I try to oversee it all. My job is to make sure (R9 and R10) go to the wound clinic and follow up." E3 stated E1 oversees 100 hall pressure ulcers and she (E3) oversees 200 hall. E3 stated they were to ensure new orders and treatments. E3 stated she saw R9's pressure ulcers on 2/29/16 when R9 re-admitted back to the facility. E3 stated it had been 2-3 weeks since she had seen R9's wounds before then. E3 stated she gets an update from the Wound Clinic and the wound clinics measurements and documents the Wound Clinic's measurements on the back of R9's TAR. E3 stated the floor nurse does the treatments and will come and get her if they need help. E3 stated the facility gets new orders from the wound clinic via fax or it comes with residents. E3 stated once the facility gets the new orders then staff carries them out-put in Nurses' Notes, put order on TAR, and let R9's mom know of any changes. E3 stated she is unsure why R9's Keflex continued past the ordered stop date on 2/4/16. E3 stated she is unsure why R9's Ceftin and Doxycycline antibiotic due didn't start until 2/24/16 when it was ordered on 2/4/16-unless the facility couldn't get the antibiotics. E3 further stated she was unaware that Z2 wanted a wound vac put on R9's sacrum and to her (E3's) knowledge R9 never had a wound vac while at the facility. E3 stated there would be no reason why R9 couldn't have a wound vac unless it wasn't coordinated. E3 stated she did not know why there were no measurements on the back of R9's TAR for February 2016.

On 3/3/16 at 11:00 AM, E1, Administrator, stated it is a joint venture between E2 and E3 for woundcare and overseeing coordination of wound

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care. E1 stated E2 used to do wound care but when she took over as DON it transferred to E3.

The Facility's Decubitus Care/Pressure Areas Policy, dated 5/2007, 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. Procedure: 2) The pressure area will be assessed and documented on the TAR. 3) Complete all areas of the TAR. i) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). ii) document the stages of the pressure ulcer as follows..iii) document the color according to the following:...4)Notify the physician for treatment orders. The physicians orders should include: i) type of treatment. ii) frequency treatment is to be performed. iii)how to cleanse, if needed. iv) site of application v) no PRN order is acceptable for pressure ulcer. The order must have specific frequencies vi) Initiate physician order on treatment sheet. 5)Documentation of the pressure area must occur upon identification and at least once each week on the TAR. The assessment must include: i) Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.) ii) treatment and response to treatment."

2. On 2/22/16 at 12:15 PM, E2 and Z4 performed a treatment to R2's sacral wound. At this time, there were pressure ulcers present on the left and right distal buttocks.

On 2/22/16 at 1:29 PM and 2/23/16 at 8:50 AM, R2 was observed in bed with heels directly on a pillow, not floated.

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On 2/22/16 at 12:15 PM, E2, stated, "I was unaware of these pressure areas, I usually don't do the treatments."

On 2/22/16 at 12:15 PM, Z4, stated, "These 2 buttock pressure ulcers are new since I saw (R2) last week and I was unaware of them." Z4 further stated, "These pressure ulcers are avoidable, (R2) had a heavy bath blanket between her bottom and the low airloss mattress. The bath blanket was wrinkled and pushed into (R2's) buttock creases. There should only be a sheet between (R2's) buttocks and the low airloss mattress."

On 2/22/16 at 1:29 PM, E13, Certified Nurses Aide (CNA), stated, "I noticed her buttocks had areas where the skin was off. I did tell the nurses it was either (E7, LPN) or (E12, LPN)." E13 further stated, "This was probably on Tuesday of last week, they were smaller when I first saw them."

On 2/22/16 at 1:40 PM, E7, stated, "I was unaware of new buttock wounds."

On 2/22/16 at 2:02 PM, E11, CNA, stated, "I worked a double on Friday and she had 2 small blisters on her lower buttocks. I told (E12)."

On 2/22/16 at 2:05 PM, Z4, stated, "If I had been made aware of the blisters, I would have ordered skin prep or betadine to be applied to the blisters daily in an attempt to keep them intact. Also (R2) should have been kept off her buttocks. Where these areas are if they were blisters it would be classified as a Stage 2 pressure ulcer because it is directly over bone."

On 2/22/16 at 2:24 PM, E12, stated, "I was told

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on Friday of (R2's) buttocks. The areas were little intact blisters. I informed (E2) and I sent the measurements to (E3) via text message." E12 further stated, "(E2) did not say anything about the wounds." E12 stated, "I determined that we were using a thick sheet under her buttocks and we changed it to a thinner sheet. (R2) has had skin issues in the past and a small change would fix it. I was hoping for the best. I did not document my measurements/ assessment of the areas, I did not inform the doctor, I did notify the family though. Not charting the wounds probably was a failure on my part."

On 2/22/16 at 2:45 PM, E3 stated, "I got texted over the weekend on (R2's) new wounds. (E12) was suppose to notify the doctor, family and chart on the wounds."

On 2/25/16 at 3:00 PM, E2 stated, "(E12) should have implemented our policy and procedure for pressure ulcers when he found the wounds."

R2's MDS, dated 1/21/16, documents, in part, R2 was re-admitted 1/11/16 with diagnoses of Heart Failure, Hypertension, Arthritis, Pressure Ulcer Back Buttocks and Ventricular Fibrillation. The MDS also documents, R2 was admitted with 1 Stage 4 pressure ulcer, is totally dependant on 2 staff for bed mobility and transfers and is moderately impaired with a memory problem.

R2's Braden Scale For Predicting Pressure Ulcer Risk, dated 11/17/16, documents R2 is at high risk for pressure ulcers.

R2's Care Plan, dated 1/11/16, documents, in part, "Pressure ulcer worsen upon readmission. (Pressure relieving) boots per orders see P.O.S. (Physician Order Sheet)."

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S9999	Continued From page 23 R2's Multi Wound Chart Details, dated 2/22/16, documents, "The right distal buttocks had a Stage II pressure ulcer measuring 1.0 cm X (by) 2.4 cm X 0.1 cm with a small sero-sanguineous exudate amount. The left distal buttocks had a Stage II pressure ulcer measuring 0.6 cm X 1.1 cm X 0.1 cm with a small sero-sanguinous exudate amount." R2's 2/2016 Treatment Administration Record does not document the distal bilateral buttocks pressure areas/blisters. R2's Nurses Notes, dated 2/10/16 6:00 AM thru 2/22/16, do not document bilateral distal buttock pressure areas/blisters. 3. R10's admission MDS, dated 5/15/15, documents R10 was admitted on with 5/4/15 with diagnoses, in part, of Atrial Fibrillation, Coronary Artery Disease, Hypertension, Diabetes Mellitus, Cerebrovascular Accident, Depression and a Pressure Ulcer. The MDS also documents R10 had 1 Stage 2 penile pressure ulcer. R10's quarterly MDS, dated 1/25/16, documents R10 requires extensive assistance of 2 staff for bed mobility and extensive assistance of 1 staff for transfer. This MDS also documents R10 has 1 Stage 2 Pressure Ulcer and 2 unstageable Pressure Ulcers with the largest unstageable Pressure Ulcer measuring 5 cm X 5.5 cm. R10's Braden Scale for Predicting Pressure Ulcers, dated 2/10/16, documents R10 is at high risk for pressure ulcers. R10's Nurses Notes, dated 9/10/15 at 10:00 PM, document, in part, "Performed skin assessment and found blackened areas on bilateral heels. Voicemail left on (Z1's, primary physician)	S9999		

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machine. Skin prep applied to heels."
R10's Physician Telephone Order, dated 9/14/15, documents, Skin prep to bilateral heels every shift.
R10's TAR documents skin prep to bilateral heels every shift was started 9/11/15.
R10's TAR, dated 9/14/15, documents, Bilateral heel breakdown treatment applied. Left heel 3 cm X 5 cm, right heel 2 cm x 2 cm.
R10's TAR, dated 9/18/15, documents, Left heel 3.8 cm X 5 cm, right heel 3 cm x 1.8 cm.
On 3/3/16 at 1:18 PM, E2 stated, "We do not stage pressure ulcers. It probably took so long to stage (R10's) heel pressure ulcers because we have (Z4) (outside wound consultant)stage the wounds. Our nurses are not trained to stage pressure ulcers." When asked why the policy states that a pressure ulcer will be staged when found, E2, states, "I am unsure you will have to ask (E15, Regional Corporate Nurse)."
On 3/3/16 at 2:20 PM, E15 stated, "Some nurses in general are better at staging than others so we ask them to document size, color, pain, everything associated with the wound."
R10's TAR, dated 9/25/15, documents, Left heel 6.5 cm X 8 cm, right heel 4 cm x 6 cm. Both heels unstageable.
R10's initial Wound Assessment from Z4, dated 9/25/15, documents Left heel 4.4 cm X 6.8 cm and right heel 4.5 cm x 4.5 cm. Both heels were staged by Z4 as Suspected deep tissue injury.
R10's TAR, dated 9/30/15, documents, Left heel 4 cm X 6 cm, right heel 6.5 cm x 8 cm. Both heels unstageable.
R10's 10/2015 TAR documents, Paint bilateral heels with betadine.
R10's TAR, dated 10/7/15, documents, Left heel 2 cm X 3 cm, right heel 2.2 cm x 1.8 cm. No description of these wounds is documented.
R10's TAR, dated 10/14/15, documents, Left

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heel 5.4 cm X 7 cm, right heel 5.6 cm x 3.9 cm. No order from wounds.
R10's TAR, dated 10/23/15, documents, Left heel 5.3 cm X 6.8 cm, right heel 3.8 cm x 4 cm. No description of these wounds is documented. This was the last wound measurement for the month of October documented on the TAR.
R10's 11/2015 TAR documents, Povidone-Iodine 10%, Apply to both heels as directed and heels must be kept suspended.
R10's 11/2015 TAR documents, daily skin checks from 11/1/15 thru 11/30/15 documents a zero under the initials.
R10's TAR, dated 11/4/15, documents, Left heel 5 cm X 5.5 cm, right heel 4 cm x 3.5 cm. No description of these wounds is documented.
R10's TAR, dated 11/11/15, documents, Left heel unstageable 6 cm X 7.5 cm with complaint of pain, right heel unstageable 4.5 cm x 4.3 cm. No description of these wounds is documented.
R10's TAR, dated 11/18/15, documents, Left heel unstageable 5.6 cm X 7.4 cm, right heel unstageable 4.4 cm x 4 cm with some complaints of pain. No description of these wounds is documented. This is the last day the wounds were documented on the TAR.
Z4's Progress Note, dated 11/23/15, documents, "left heel is an acute necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. Wound encounter measurements are 5.2 cm X 6 cm. No undermining has been noted. There was no drainage noted. Wound bed is 76-100% dry, black eschar. Right heel is an acute necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. Wound encounter measurements are 5 cm X 5.4 cm. No undermining has been noted. There was no drainage noted. Wound bed is 76-100% dry, black eschar. Patient requested to see podiatrist. Will follow up as needed. Wound treatment for

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both heels apply betadine to wound bed." There is no documentation of further visits of R10 by Z4.
R10's TAR, dated 12/1/15 thru 12/17/15, documents, Povidone-Iodine 10%, Apply to both heels as directed and heels must be kept suspended. On 12/14/15/,12/15/15 and 12/17/15 there is no documentation that this treatment was done.
R10's TAR, dated 12/3/15, documents, Left heel unstageable 5 cm X 5.8 cm, right heel unstageable 4.8 cm x 4 cm. No description of these wounds is documented.
R10's TAR, dated 12/8/15, documents, Left heel unstageable 5 cm X 5.5 cm, right heel unstageable 4.8 cm x 5 cm. No description of these wounds is documented.
R10's TAR, dated 12/31/15, documents, Left heel unstageable 5 cm X 7 cm, right heel unstageable 5.5 cm x 6 cm. No description of these wounds is documented.
R10's POS, dated 12/3/15, documents to refer to wound clinic.
R10's Nurses Notes document an entry for 12/7/15 regarding transportation. There are no other Nurses Note documented until 12/30/15.
On 3/7/16 at 11:00 AM, when asked if there were more Nurses Notes for R10 for the period of 12/7/15 thru 12/30/15, E2 stated, "I don't think (R10) required daily charting during that time, but I will check."
On 3/7/16 at 1:45 PM, a written statement from E2 documents that R10 was not on medications that require daily charting from 12/7/15 - 12/22/15.
The Wound Clinic Progress Note for R10's first visit, dated 12/16/16, documents, in part, Left Calcaneous: "The wound measures 6 cm X 6.4 cm X 0.1 cm. No present amount of drainage, there is a large (67-100%) amount of necrotic tissue within the wound bed including eschar.

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S9999	Continued From page 27 Right Calcaneous: The wound measures 5 cm X 5.5 cm X 0.1. No present drainage, there is a large (67-100%) amount of necrotic tissue within the wound bed including eschar." The Wound Clinic Physician Order, dated 12/16/15, documents: "Left calcaneous: change dressing daily, clean wound with normal saline, clean wound with wound cleanse, dry sterile gauze, Silver Alginate- over open medial eschar, Kerlix gauze. Right calcaneous: change dressing daily, clean wound with normal saline, clean wound with wound cleanse, dry sterile gauze, Kerlix gauze." R10's 12/2015 TAR documents, "Left foot 1) cleanse wound with wound cleanser 2) Apply dry ; silver alginate to open area 3) Cover with dry gauze 4) Secure with Kerlix and tape." R10's 12/2015 TAR documents, "Right foot 1) cleanse foot with wound cleanser 2) Apply dry, gauze 3) Secure with Kerlix and tape." R10's 12/2015 TAR documents Left and Right foot dressings were completed on 12/19/16 thru 12/21/16. On 3/3/16 at 3:00 PM, E2 stated, "We have never had silver alginate in our building, it is not on our formulary." R10's Wound Clinic Progress Note Detail, dated 12/22/15, documents, "dry gangrene has converted to wet gangrene. blood pressure low, to emergency department for evaluation. The left heel measures 6 cm X 6.4 cm X 0.1 cm. There is large 76-100% amount of necrotic tissue within the wound bed including eschar. The right heel measures 5 cm X 5.5 cm X 0.1 cm. There is large 76-100% amount of necrotic tissue within the wound bed including eschar." R10's hospital record dated, 12/22/15, documents, Date of Admission 12/22/15. R10's discharge record, dated 12/30/15, documents "discharge diagnoses, 1. leukocytosis 2.	S9999		

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osteomyelitis. Hospital course : MRI was done which showed early osteomyelitis of the both heel."
R10's 1/2016 TAR documents, "Povidone-Iodine 10% Apply to bilateral heels as directed and heels must be kept suspended." 1/1/16 thru 1/5/16 has no documentation of this treatment being done.
R10's TAR, dated 1/10/16, documents, "Left heel unstageable 4.2 cm X 3.6 cm no drainage no odor no sign and symptom of infection, right heel unstageable 3.6 cm x 4.2 cm no drainage no odor no sign and symptom of infection." This is the first measurement for R10's heels in January of 2016.
R10's TAR, dated 1/18/16, documents, "Left heel unstageable 4 cm X 3 cm no drainage no odor no sign and symptom of infection, right heel unstageable 3.8 cm x 4.5 cm no drainage no odor no sign and symptom of infection."
R10's TAR, dated 1/25/16, documents, "Left heel unstageable 5.4 cm X 7.7 cm X 0.1 no drainage no odor no sign and symptom of infection unable to visualize woundbed, right heel unstageable 5.8 cm x 5.8 cm X 0.1 no drainage no odor no sign and symptom of infection unable to visualize woundbed." This is the last date of wound measurements on the January TAR.
The Wound Clinic Physician orders, dated 1/19/16, document, "Left Calcaneous: change dressing every other day, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate rope,Kerlix gauze. Right Calcaneous: change dressing every other day, dry sterile gauze, Kerlix gauze. This visit documents left heel 5.4 cm X 7.7 cm X 0.1 cm gangrenous with large necrotic amount of eschar, right heel 5.8 cm X 5.8 cm X 0.1 cm gangrenous with large necrotic amount of eschar."
R10's 1/2016 TAR documents on 1/19/16 "Cleanse left Calcaneous with normal saline the cleanse with wound cleanser the apply silver

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alginate with dry sterile dressing apply kling." This TAR documents on 1/20/16, 1/21/16 and 1/25/16 silver alginate unavailable. On 1/22/16, 1/23/16 and 1/24/16 it is documented dressing was performed. Cleanse right Calcaneous with normal saline cleanse next with wound cleanser apply dry sterile dressing and kling. This TAR documents both the left and right heel dressing changes were scheduled daily.

On 3/3/16 at 10:28 AM, when asked how the dressings were being performed on R10 when Silver Alginate was not available to the facility. E3 stated, "We don't carry Silver Alginate, staff may have thought Calcium Alginate was suppose to be used for this treatment on 1/22/16 thru 1/24/16."

On 1/25/16, R10's POS documents an untimed TO from Z2 to E6, "Change treatment to heels to as follows: 1) Cleanse bilateral heels with normal saline 2) left heel apply silverdene cream with hydrogel cover with gauze wrap with kling. 3)right heel apply sterile gauze wrap with kling."

On 3/3/16 at 10:00 AM, Z2 (Wound Clinic Physician) stated, hydrogel adds moisture and silvadene cream has some silver properties in it, but it is different than silver alginate." Z2 stated, "I did not order the substitution of silvadene and hydrogel for silver alginate rope and dry dressing. I do not know who did, but I did not. Hydrogel adds moisture and I am trying to dry that wound out."

On 3/3/16 at 10:00 AM, Z3 stated, "There is no record of the facility calling and requesting a different treatment in the computer system."

A written statement from E6, LPN, dated 3/4/16 at 10:30 AM, documents that E6 called the wound clinic on 1/25/16 spoke with an unnamed nurse and received the order for Silvadene cream with hydrogel cover with gauze and kling wrap for a replacement for silver alginate and dry dressing.

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S9999	Continued From page 30 The Wound Clinic Physician orders, dated 2/4/16, document, "Left Calcaneous: change dressing every other day, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate rope, Kerlix gauze. Right Calcaneous: change dressing every other day, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate rope, Kerlix gauze." The wound assessment from this visit documents, "The left heel measured 5.6 cm X 6.4 cm X 1 cm was gangrenous with a large amount of necrotic eschar. The right heel measured 6.3 cm X 5.6 cm X 0.1 cm was gangrenous with a large amount of necrotic eschar." Wound Clinic patient communication log details, dated 2/11/16, documents, "Called (facility) regarding (R10's) appointment @ 1:45 PM and then staff stated they do not have the order dated 2/4/16, yet she has the form with wound center on it. Staff stated (R10) will not be there today. (R10) has weekly visit and facility was educated on this." The Wound Clinic Physician orders, dated 2/16/16 document, "Left Calcaneous: change dressing daily, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate to open perieschar,Kerlix gauze. Right Calcaneous: change dressing daily, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate to open perieschar, Kerlix gauze." The wound assessment from this visit documents, "The left heel measured 5.6 cm X 7.5 cm X 0.2 cm gangrenous with large amount of necrotic eschar. The right heel measured 6.2 cm X 5.5 cm X 0.1 cm gangrenous with large amount of necrotic eschar." The Wound Clinic Physician orders, dated 2/23/16, document, "Left Calcaneous: change dressing every other day, clean with normal saline, clean with wound cleaner, dry sterile	S9999		

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gauze, silver alginate, Kerlix gauze. Right Calcaneous: change dressing every other day, clean with normal saline, clean with wound cleaner, dry sterile gauze, silver alginate, Kerlix gauze." The wound assessment from this visit documents, "The left heel measured 5.1 cm X 6.4 cm X 0.2 cm was gangrenous with large amount of necrotic eschar. The right heel measured 6.6 cm X 5.6 cm X 0.1 cm was gangrenous with large amount of necrotic eschar with a small amount of serosanguinous red brown exudate."
The 2/2016 TAR documents, "Cleanse left and right heel with sodium chloride apply silvadene and hydrogel cover with gauze and kling. Treatment scheduled daily. 2/3/16 and 2/4/16 Silvadene not available dressing change done without Silvadene." 2/26/16 has no documentation of the treatment being completed.
2/5/16 TAR documents "right heel 6.4 cm X 5.3 cm X 0.1 cm small amount of drainage. left heel 6 cm X 5.8 cm X 0.1 cm small amount of drainage no odor no infection noted to both heels."
2/11/16 TAR documents "right heel 6.2 cm X 5.8 cm X 0.1 cm. Left heel 5.6 cm X 6.4 cm X 0.1 cm no odor no drainage."
2/18/16 TAR documents "right heel 6 cm X 5.7 cm X 0.1 cm. Left heel 5.5 cm X 6.2 cm X 0.1 cm no odor no drainage." No other measurements were found for 2/2016 on the TAR.
On 3/4/16 at 2:50 PM, Z2 stated, "The problem with using Silvadene and hydrogel on R10 instead silver alginate and gauze is if the dry gangrene turns into wet gangrene it potentially could spread and that could be a serious problem."

(B)