

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006472	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2017
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NAME OF PROVIDER OR SUPPLIER MULBERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906
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Z 000	<p>COMMENTS</p> <p>Annual Licensure Survey</p> <p>Annual Certification Survey- W102, W104, W122, W125, W126, W149, W153, W154, W157, W186, W227, W256, W263, W316, W318, W322, W331, W336, W356, W362, W455</p> <p>Inspection of Care Survey</p> <p>Complaint Survey 1750790/IL91663-W268</p> <p>Complaint Survey 1750791/IL91665- no deficiencies cited</p> <p>Complaint Survey 1750703/IL91562- W331</p>	Z 000		
Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1210 350.1220j) 350.1230b)6)7) 350.1230c) 350.1230d)1)2) 350.3220f) 350.3240a) 350.3240b) 350.3240d) 350.3240f)</p> <p>Section 350.620 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the</p>	Z9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Z9999	<p>Continued From page 1</p> <p>facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or 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.</p> <p>Section 350.1230 Nursing Services</p> <p>b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:</p> <p>6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.</p> <p>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p> <p>c) A registered nurse shall participate, as appropriate, in planning and implementing the</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>training of facility personnel.</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</p> <p>2) Basic skills required to meet the health needs and problems of the residents.</p> <p>Section 350.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 350.3240 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> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the governing body failed to provide necessary operating direction over the facility which assures that policy and procedures are developed and implemented by the facility to protect the health and safety of 13 individuals (R9, R11, R14, R16, R20, R27, R28, R29, R30, R31, R33, R34 and R35) of the facility with the potential to affect the remaining 31 individuals of the facility when they failed to provide necessary oversight to ensure that:</p> <p>1) The facility's policy and procedures for Missing Persons/Elopement includes proactive and reactive systems (staffing, electronic monitoring devices, door alarms, e.g.) that are to be implemented by the facility to ensure the provision of supervision necessary to prevent elopement.</p> <p>a) After an incident of elopement on 08/23/16, the facility's investigation inferred a security system would be installed on the outer gate of the</p>	Z9999		
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Z9999	<p>Continued From page 4</p> <p>courtyard to prevent further elopement attempts and that individuals would be supervised while out in the courtyard until this system was installed. As of 01/23/17 the door leading to the courtyard is not alarmed and the gate does not have a security system installed to alert staff of an individuals attempt to elope affecting 7 of 7 (R9, R11, R20, R27, R30, R31, and R35) individuals identified by the facility who are at risk of elopement and wear electronic monitoring bracelets.</p> <p>2) After an incident of PICA on 01/08/17, the facility's policy and procedures for Ingestion of non-food items (PICA) was implemented by the facility to prevent further potential incidents of PICA as evidenced for 1 individual (R20) who is not constantly supervised while outside smoking and has documented incidents of ingesting quarters and metal rings attached to soda cans when unsupervised.</p> <p>3) The facility implements their policy and procedures prohibiting abuse of the individual by their failure to thoroughly investigate peer to peer abuse and injuries of unknown origin; report these incidents to the Illinois Department of Public Health; and take corrective action to prevent further potential incidents of peer to peer abuse for 7 of 44 individuals of the facility (R9, R14, R16, R20, R28, R29, and R30), and has the potential to affect all 44 individuals residing in the facility.</p> <p>4) The facility updated their policy and procedures for pressure injuries as per the National Pressure Ulcer Advisory Panel (NPUAP) April 2016 guidelines regarding changes in terminology and staging updates of pressure injuries. The facility failed to ensure the facility's updated policy and</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>procedures were implemented for the pressure injuries of 3 individuals (R27, R33, and R34) having current pressure injuries acquired in-house.</p> <p>a) Develop and implement a comprehensive skin integrity program for R34 by their failure to follow the facility policy's and procedures, physician orders, and plan of care. Have reproducible documentation of ongoing documentation of R32's, R33's, & R34's pressure injury after discovery.</p> <p>Findings Include:</p> <p>1) The facility's policy on Missing Person/Elopement with a revised date of 09/25/07 defines Elopement as; "leaving the facility grounds with the intention not to return or without informing staff. Leaving the program area without supervision is not to be considered elopement." This policy further states, "It is the policy of this facility to provide adequate supervision of the individuals receiving services, based on their needs." The procedures within this policy identifies what staff are to do if the individual is missing. No procedures are included within this policy to delineate what systems (staffing, electronic monitoring devices, door alarms, e.g.) the facility is to implement to ensure the necessary supervision is provided to prevent elopement.</p> <p>Review of the facility roster dated 01/17/17, documents R31 is a 68 year old male who functions at a Mild Level of Intellectual Disability.</p> <p>Review of the R31's Individualized Service Plan/Behavior Program with a start date of</p>	Z9999		
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Z9999	<p>Continued From page 6</p> <p>08/01/16 documents; "Problem area: R31 has left facility grounds without staff's knowledge. When he returned he told staff he was going for chips. Profile: R31 is a very quiet person who prefers to spend time alone. He likes to sit outside to smoke. He will be allowed to smoke in the enclosed court yard independently. In the past when R31 did leave the facility grounds he was walking to the store to purchase a food item. R31 will wear a tracking device which will alert staff when he decides to leave the building. The device does not activate when he goes into the court yard to smoke. R31 will be encouraged to tell staff when he is in need of something so that they may accompany him on the outing. He still becomes confused at times and will make statements that he is going back to Belleville or getting out of this place."</p> <p>Per interview with E2 (QIDP) on 01/20/17 at 2:00 P.M., E2 stated R31 has a window alarm which is to alert staff of his attempt to leave the facility through his bedroom window. No methods are included within his behavior program to identify the need for the window alarm and a plan for fading the window alarm out.</p> <p>Review of the facility Injury/Accident Report dated 8/23/16 identifies R31 left the facility without staff's knowledge through the gate off of the smoking patio. The facility's investigation dated 08/23/16 documents: "On 8/23/16 at 6:05 PM resident R31 went into the court yard to smoke. Less than a minute later E12 (Direct Support Person) entered court yard and noticed back gate was open. Resident (R28) was in court yard and was asked by E12 why is the gate open. R28 told E12 that he opened it. When asked why did you open it R28 stated that he let peer R31 out. Staff (E12) immediately began searching for R31. He</p>	Z9999		

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Z9999	<p>Continued From page 7</p> <p>was found by E12 near the police station. R31 was returned to the facility and assessed by nursing staff. No injuries were noted upon assessment."</p> <p>Continued review of the facility's investigation documents under plan of action... "5) The maintenance supervisor is exploring the possibility of securing a system which can be installed on the gate to the court yard which would alert staff of anyone leaving or entering. If this system is installed R31 would be able to go into the court yard independently..."</p> <p>During the survey dates, R31 was observed to be unsupervised while smoking on the patio in the courtyard. It was noted the facility had not installed a security system on the gate of the courtyard following R31's 08/23/16 elopement from the facility.</p> <p>On 01/19/17 at 3:00 PM, R31 was observed sitting outside on the smoking patio by himself. No staff were present in the area and/or near the exit door to the patio. The outside gate leading to the street and residential area is not equipped with an alarm. No staff were present in the area to provide necessary supervision to prevent R31 from eloping from the facility if he attempted to elope.</p> <p>On 01/20/17 at 1:30 PM, R31 was observed outside on the smoking patio. The door going into the courtyard did not alarm when R31 exited through it or when he entered back into the facility. No staff were present on the outside patio and the outside gate was not armed with an alarm.</p> <p>On 01/23/17 at 4:08 PM, R31 was observed exiting the building into the courtyard area to smoke. There were no staff in the area during this</p>	Z9999		

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Z9999	<p>Continued From page 8</p> <p>time. The door going into the courtyard did not alarm when R31 exited through it or when he entered back into the facility. The outside gate was not armed with an alarm.</p> <p>On 01/23/17 at 4:45 PM, Z8 (facility consultant) was interviewed. Z8 walked with surveyor to the fence to the gate at the back of the courtyard. The gate was closed with two latches, with one latch towards the bottom and one latch closer to the top. Both latches lifted up to open the gate. Neither latches were locked and no security alarm was in place to alert staff of anyone opening the gate to leave. During this interview and observation, Z8 confirmed the facility did not have an alarm system that would alert staff if R31 or any other individual were trying to elope from the facility through the courtyard area.</p> <p>The facility roster dated 01/17/17 documents R27 is a 65 year old male who functions at a Moderate Level of Intellectual Disability.</p> <p>Review of R27's Individualized Service Plan/Behavior Program with a start date of 5/1/15 documents, "Problem Area: R27 has a history of elopement. Since his admission to (name of facility) R27 has made no attempts to leave the facility grounds...R27 is a 64 year old...primary dx. (diagnosis) of schizophrenia, ethanol abuse, pre-senile dementia...R27 spent four years on forensics unit at (name of local facility) until he was admitted to (name of facility). Records report that R27 has made no attempts to elope while at (name of forensics unit). R27 has more than adequate verbal skills. He can communicate his wants and needs but with the DX of Pre-senile dementia R27 needs constant reminders. R27 will be equipped with an electronic monitoring device that will track his location by the local police</p>	Z9999		
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Z9999	<p>Continued From page 9</p> <p>department...R27's guardian wants R27 to continue to wear tracking device since R27 has made numerous request to go back to Chicago to live. R27 is not talking about living in a home. He wants to live out on his own and is not able to take care of himself anymore.</p> <p>Method/Approach/Include Reinforcement Plan: 1. If in the event R27 is missing, staff will report to supervisor on duty immediately. 2. Supervisor on duty will inform staff to conduct a complete search of the building and the entire premises and if he is on the premises its not an elopement. If the event that R27 can not be located (keep in mind R27 has dementia and may be in someone else's bed asleep.) 4. Supervisor on duty will call 911 and explain that we have a resident that is on a tracking program and wears a electronic monitoring device and we are unable to locate him..."</p> <p>Review of R27's behavior program does not identify the level of supervision staff are to provide to him while smoking in the courtyard unsupervised. This program does not address that the back door leading to the courtyard nor the gate leading to the street and residential backyards are not alarmed. No methods are included within this plan to identify how frequent staff are to check on him since his tracking device does not activate an alarm system when he goes into the courtyard area unsupervised or if he opens the gate and leaves the facility grounds while in the courtyard unsupervised.</p> <p>On 1/20/17 at 1:30 PM, R27 was outside sitting in the smoking area. A male staff member (E17) was outside smoking with him. R27 used a wheelchair while outside smoking. When E17 assisted R27 back into the building, no door</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>alarm was heard. R27 was later observed at 2:15 PM walking in the facility dining room without assistance and staff supervision.</p> <p>On 01/23/17 at 4:08 PM, R27 was observed walking outside into the courtyard area to smoke. There were no staff in the area during this time. The door going into the courtyard did not alarm when R27 exited through it or when he entered back into the facility. The outside gate was not locked nor armed with an alarm.</p> <p>During interview on 1/23/17 at 4:15 PM, E3 (Qualified Intellectual Disability Professional-QIDP) stated, R20, R27, and R31 all wear electronic monitoring bracelets and go out to smoke with staff. When told they were observed outside smoking in the courtyard without staff E3 stated, "We probably need to discuss that at the meeting and have staff with them."</p> <p>The facility roster dated 01/17/17 documents R9 is a 43 year old female who functions at a Severe Level of Intellectual Disability.</p> <p>Review of R9's Individualized Service Plan/Behavior Program dated 6/27/16 documents, "Problem Area: R9 has a Hx of leaving supervised area and may attempt to leave the grounds without staff's knowledge. She is a very curious person and is just being inquisitive and does not realize she is no longer within the boundaries of the facility.</p> <p>Method/Approach/Include Reinforcement Plan: 1. Staff will explain to R9 why she needs to tell them she is going outside...4. In the event R9 attempts to leave a supervised area staff will ask her to return to supervised area and point out areas</p>	Z9999		

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Z9999	<p>Continued From page 12</p> <p>time when everyone is asleep. A bed alarm was placed on his bed, an alarm was placed on his door to alert staff of any movement and a wander guard device has been placed on ankle which sets off main door alarms. Due to him climbing out window in his room a window alarm was installed...During waking hours he is placed on same supervision where he is closely monitored by staff."</p> <p>The facility roster dated 01/17/17 documents R35 is a 56 year old male who functions at a Profound Level of Intellectual Disability.</p> <p>Review of R35's Individualized Service Plan/Behavior Program with a start date of 4/1/16 documents, "Problem area: R35 wandered away from supervised area. He is very curious person and is just being inquisitive and does not realize he is no longer within the boundaries of the facility. R35 would not be able to avoid danger and could easily be taken advantage of by a stranger.</p> <p>Profile: R35 likes to wander around the facility. He is very curious...He seldom will tell staff that he is going outside. R35 may go out in the enclosed court yard at (name of facility) independently. If R35 attempts to leave supervised area or go out side other than court yard, use the following procedure...Staff will track R35's presence by marking a wander guard monitoring sheet every 30 minutes."</p> <p>E1 (Administrator) was interviewed on 01/23/17 at 4:40 PM and stated the facility had disabled the door alarm on the door leading into the courtyard for, "some reason." E1 stated she wasn't sure why the door alarm had been disabled.</p>	Z9999		
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NAME OF PROVIDER OR SUPPLIER MULBERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906		
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Z9999	<p>Continued From page 13</p> <p>Following the incident of 8/23/16 the facility's investigation documented that a security system would be installed on an outer gate off the courtyard to prevent further elopement attempts. As of 01/23/17 the door leading to the courtyard is not alarmed and the gate does not have a security system installed to alert staff of individuals attempts to elope. Six individuals (R9, R11, R20, R27, R31, and R35), are identified by the facility at risk of elopement and wear electronic monitoring bracelets.</p> <p>2) The facility's policy regarding, "Ingestion of non-food items (PICA) dated 7/15/16 documents, "It is the policy of this agency to ensure the safety of the Individuals receiving services. The goals of this program are to assist in developing improved ability to function without exhibiting pica behavior...7. All incidents will be investigated to determine any causative factors related to the incident and to determine any corrective measures that may be needed to prevent further occurrences...8. Procedure for Room Sweep: A room sweep for possible inedible/ingestible items will be conducted in every room before a resident enters. The sweep will remove any inedible/ingestible objects smaller than two by three inches. Visual sweeps are to be documented. If items are removed, this should be documented in a progress note as well."</p> <p>a) Review of the facility roster dated 1/17/17 documents R20 is a 58 year old female who functions at a Mild Level of Intellectual Disability.</p> <p>Review of R20's Individualized Service Plan/Behavior Program dated 5/23/16 documents, "Problem area: R20 has a Hx</p>	Z9999		

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Z9999	<p>Continued From page 14</p> <p>(history) of leaving supervised area and may attempt to leave the grounds without staff knowledge. R20 will usually warn staff when she is going to go outside without assistance...Profile: R20 is very social. She likes staff interaction and will often seek it. R20 likes to go outside and smoke and will go outside without staff at times. Not to leave the grounds but to sit outside. R20 has a history of elopements. If you ask her where she is going she will respond. If R20 attempts to leave supervised area use the following procedure:</p> <p>Method/Approach/Include Reinforcement Plan: 1. Staff will explain to R20 why she needs to tell them she is going outside. 2. A wing teacher will reinforce the need to tell someone of her intent to go outside in Personal Development Class which R20 attends. 3. R20 will be given verbal praise when she remembers to inform staff of her intention to go outside. 4. In the event R20 attempts to leave a supervised area staff will ask her to return to supervised area and point out areas where she can sit supervised with staff: under porch/swing/picnic table. R20 will be allowed to go into the fenced in courtyard without supervision..." R20's behavior program does not address that the back door leading to the courtyard nor the gate leading to the street and residential backyard is not alarmed. No methods are included within this plan to identify how frequent staff are to check on her since her tracking device does not activate an alarm system when she goes into the courtyard area unsupervised or if she opens the gate and leaves the facility grounds while she is in the courtyard unsupervised.</p> <p>As observed, during the survey dates, R20 was observed to be unsupervised while smoking on</p>	Z9999		

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Z9999	<p>Continued From page 15</p> <p>the patio in the courtyard and the door is not alarmed and a security system has not been installed on the gate leading off of the courtyard.</p> <p>Review of the PICA Incident on 01/18/17 report (not dated) documents; "On Sunday, January 8th 2016 (sic) R20 was in her room with employee's E5 and E9. R20 has one soda tab in her hand and was threatening to swallow. Staff E5 and E9 asked R20 repeatedly to hand over the tab, R20 refused and started becoming combative with both staff; hitting and kicking, and screaming. R20 then stuck the tab in her mouth and would not spit it out. Staff made every attempt to get the tab from her but it was unsuccessful. R20 then stated, "How do you like that bi*****?" and then stuck her tongue out to show staff she did swallow it. At this time, E9 came and got this writer to inform me that R20 swallowed a soda tab." Upon entering R20's room she was sitting on her bed with her head down and employee E5 was monitoring her at this time.</p> <p>E10 (Licensed Practical Nurse) did assess R20 and found her to be in no distress. Z1 (physician) was notified of incident.</p> <p>R20 was interviewed and asked what happened? R20 replied, 'I swallowed a tab'. R20 was then asked, Why did you swallow a soda tab? R20 replied; "I don't know I just did it, I couldn't help it and I'm sorry." R20 was asked where she got the tab? R20 stated; "outside in smoking area by trash can." At this time the area was swept for any items smaller than 2x3. Trash can was emptied out and all trash removed from area. R20's room was swept as well.</p> <p>R20 was immediately placed on 1 on 1 with staff, 15 min bed checks initiated during sleeping</p>	Z9999		
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Z9999	<p>Continued From page 16</p> <p>hours. QIDP will determine when to discontinue monitoring."</p> <p>Review of the 15 minute monitoring sheets for R20 document R20 was monitored every 15 minutes for 1/8/17 and 1/9/17. Documentation on a plain sheet of paper documents 1/9/17 at 9:30 approximately QIDP Dc'd (discontinued) 1 on 1 and 15 min bed checks on R20.</p> <p>On 01/18/17 at 2:00 PM, E3 (QIDP) was interviewed. E3 stated; "R20 was placed on 1-to-1 while an investigation was completed on where R20 found the soda tab and the area outside had a PICA sweep completed on it."</p> <p>On 01/19/17 at 3:10 PM, R20 was observed entering the activity room leading to the patio-courtyard area to smoke. R20 used a wheelchair for mobility and propelled herself outside. R20 showed the surveyors her electronic monitoring device that she wore on her right ankle. R20 went out the door by herself and shortly after returned inside the facility. No alarm was heard to sound when she exited and/or entered the door which leads to/from the patio/courtyard. R20 stated she couldn't get her cigarette lit and went to the dining room for help. Z8 (Consultant) lit R20's cigarette and she went back outside on the patio to smoke. No staff were present in the area or out on the courtyard area while R20 was smoking. At 3:30 PM, R20 was later seen without her wheelchair, walking at a fast pace to go outside to smoke on the patio. R20 stated, They want me to use the wheelchair cause of my medical condition but I really didn't need it" when asked by the surveyor as to the whereabouts of her wheelchair. R20 walked outside to the patio-courtyard area and sat in one of the chairs on the patio. No alarm sounded</p>	Z9999		
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Z9999	<p>Continued From page 17</p> <p>when she opened the door to go out to the patio. The outside gate was not armed with an alarm during this observation. No staff were present in the area while R20 was outside smoking to provide her with necessary supervision to prevent her from eloping from the facility if she attempted to elope. Staff were not observed to complete a pica sweep prior to her going outside on the patio. At 3:25 PM, R20 went back outside to smoke on the patio. Staff were not observed to complete a pica sweep prior to her going back outside on the patio. R20 returned back into the facility at 3:27 PM and handed E2 (QIDP) a metal screw which she stated she found outside on the patio while smoking.</p> <p>Review of the facility PICA sweeping form documents sweeps are completed in the smoking area in the morning, afternoon, and NOC (night). There are no documented sweeps of the smoking area throughout the evening shift when staff and residents are in the smoking area routinely.</p> <p>On 01/2/3/17 at 10:45 AM, E3 (QIDP) was interviewed. E3 was asked if there were any other changes put in place after R20's 01/08/17 PICA incident? E3 (QIDP) stated, "No."</p> <p>3) The facility's policy for, "Procedure for Investigation - Resident to Resident Abuse" dated 6/23/09 documents, "All resident to resident abuse must be thoroughly investigated and reported to Public Health within 24 hours. Conclusion to Resident to Resident abuse must be sent to Public Health within 5 days." The facility's policy for, "Reporting Incidents/Accidents to the Illinois Department of Public Health dated 10/22/07 states that serious and/or suspicious injuries and resident to resident altercations are to be reported to Public Health.</p>	Z9999		
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Z9999	<p>Continued From page 18</p> <p>a) Review of the facility resident roster dated 1/17/17 documents; R16 is a 36 year old female who functions at a Profound Level of Intellectual Disability and R20 is a 58 year old female who functions at a Mild Level of Intellectual Disability.</p> <p>Individualized Service Plan/ Behavior Program (dated 11/1/16) documents R16 has a history of physical aggression. Behavior Program also documents R16 may become agitated in large or noisy crowds and R16 may grab, pinch or hit others.</p> <p>Individualized Service Plan/ Behavior Program (dated 6/1/16) documents R20 has diagnoses of Bipolar Disorder and Schizophrenia -Paranoid Type Disorder. The Behavior Program also documents R20 will lash out by kicking, pulling hair, biting and throwing objects when confronted or if she feels concerned. The behavior program documents R20 will become physical if she is hit and will strike out if a client hits her.</p> <p>Behavior Frequency Sheet (dated January 2017) documents R20 had an incident of physical aggression and verbal aggression on 1/17/17 at 4:10 PM when she pulled R16's hair. There was no further documentation on R20's documentation of what occurred prior to R20 pulling R16's hair or of staff notifying administration or nursing staff for individuals to be assessed.</p> <p>On 1/17/17 from 2:30 PM-5:05 PM, 7 individuals were observed in the activity room on A Hall at 3:50 PM. E7 (Direct Support Person) sitting across the room with R6 and E6 (Direct Support Person In Training) at the activity table with 5 individuals (R9, R11, R10, R18 and R16). E6</p>	Z9999		

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Z9999	<p>Continued From page 19</p> <p>was providing activities for the 5 individuals at the table when R20 came into the room propelling herself in her wheelchair up to the activity table. R16 grabbed R20's arm and was quickly prompted by E6 to let go. R20 jumped up out of her wheel chair and started to reach for R16. E6 tried to block R20 and said; "You know R16 doesn't know what she's doing." R20 then charged past E6 and pulled R16's hair. E7 jumped up and ran across the room to assist in getting R20 to release her grip from R16's hair. R20 went to the end of the table and whispered into R18's ear. E3 (Qualified Intellectual Disability Professional) walked into the room at 3:55 PM. E6 and E7 continued with the individuals in the activity room. Surveyor did not witness E6 or E7 report the peer to peer incidents to E3 or nursing.</p> <p>The facility incident report for R16 dated 1/17/17 documents;"reported by surveyor with IDPH on 1/19/17 peer R20 grabbed R16 by the hair-staff quickly intervened and counseled."</p> <p>The facility incident report for R20 dated 1/17/17 documents; "reported to this writer by Public Health Surveyor that peer R16 apparently grabbed peer R20 arm (right) surveyor didn't witness this part of the incident. Staff quickly intervened and noted no apparent injury at this time. Bruising may appear later.</p> <p>Review of R16 and R20's Nurse's Notes (Dated January 2017) noted there was no documentation that nursing had been made aware of the peer to peers between R16 and R20 on 1/17/17.</p> <p>On 1/19/17 at 11:40 AM, an interview was conducted with E3 (Qualified Intellectual Disability Professional) and E1 (Administrator). E3 and E1 were asked if they had been made aware of the</p>	Z9999		
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Z9999	<p>Continued From page 20</p> <p>peer to peer that occurred on 1/17/17 when R16 grabbed R20's arm and R20 grabbed R16's hair that required two staff to get R20 to release R16's hair? Both replied; "No". E3 stated; "They (staff) are to report to nursing so that individuals can be examined." When asked if peer to peers are reported to Illinois Department of Public Health; E1 stated, "Yes". When asked if the peer to peer on 1/17/17 had been reported, E1 stated; "Was not made aware of the incident."</p> <p>On 1/19/17 at 11:35 AM, an interview was conducted with E4 (Director of Nursing). E4 was asked if she had been made aware of the peer to peer incident that occurred on 1/17/17 when R16 grabbed R20 and R20 pulled R16's hair. E4 confirmed the last nursing documentation was made on 1/6/17.</p> <p>b) Review of the facility incident/accident report dated 12/17/16 documents; "no injury noted at this time, was hit/kicked on left side of head." The employee statement dated 12/17/16 and attached to the incident report documents; "R14 pushed R16 down into the floor, and kicked R16 in the side of the head. R14 hit R16 upside the head with her fist. Staff intervened and R14 was escorted to her room by staff. The nurse down A wing to assist R16. The nurse escorted R16 to her room to examine her head. R14 was sent to her room for time out."</p> <p>On 1/23/17 at 10:45 AM, E2 (Assistant Administrator/QIDP) was unable to provide evidence this incident had been investigated and corrective action implemented.</p> <p>c) Review of the facility resident roster dated 1/17/17 documents R9 is a 43 year old female who functions at a Severe Level of Intellectual</p>	Z9999		

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Z9999	<p>Continued From page 21</p> <p>Disability and R28 is a 53 year old male who functions at a Mild Level of Intellectual Disability.</p> <p>Review of the facility incident report dated 10/27/16 documents, "peer to peer (R28 and R9) separated and counseled, no further problems. Reddened area to right side of chest able to move arms with no difficulty or pain. Area may bruise later."</p> <p>The employee statement dated 10/27/16 and attached to the incident report documents, "At approx (approximately) 7:30 AM, R28 was bothering R9 when she became upset and picked up a chair tossing it, grazing his chest area. Nurse notified. R28 did state he was bothering her and did apologize. He was counseled on pestering peers. There are no further problems at this time."</p> <p>On 01/23/17 at 10:45 AM, E2 (Assistant Administrator/QIDP) was interviewed. When asked about this incident, E2 stated; "I talked to E11 (Direct Support Person) and she said she sent her (R9) to her room and maybe documented in behavior book. I'm not sure." When asked if she (E2) investigated peer to peers E2 stated, "Yes, I do." When asked where the documentation was on her investigation, E2 stated, "I don't know. I knew her (R9) behavior program was followed and he (R28) was counseled."</p> <p>d) Review of the Accident/Incident report dated 10/6/16 documents; "Had seizure (R23) while riding to work. After initial motor activity of seizure he began climbing over seats and driver while attempting to keep R23 from hitting peers. He fell in floor at w/c (wheelchair) area of bus. Fell onto back onto w/c buckle which was on floor.</p>	Z9999		
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Z9999	<p>Continued From page 22</p> <p>Sustained an abrasion just under lower shoulder."</p> <p>On 1/23/17 at 10:45 AM, E2 was interviewed. When asked if she had any information on this incident E2 stated, "No." When asked if she had investigated this incident, E2 stated, "No."</p> <p>e) Review of the facility Injury/Accident report dated 11/06/16 documents, "Bite mark to Rt (right) upper arm, area raised, broke skin slightly. No bleeding area measures 3 cm (centimeter) circ (circular) slight bruising and reddened."</p> <p>Review of the employee statement dated 11/6/16 documents, "R30 bit peer on rt arm immediately intervened and separated resident away from all peers, reported to nurse and ABS card completed on resident."</p> <p>On 1/23/17 at 10:45 AM, E2 was interviewed. E2 was not able to provide documentation this incident had been investigated.</p> <p>f) The facility's "Procedure for Investigating Unknown Incidents/Accidents revised 6/23/09 documents, "Unknown Incident/Accident: All unknown incidents/accidents must be investigated and reported to Public Health within 24 hours. All incident/accidents will be reviewed monthly or more often if necessary by Safety Committee to determine trends and patterns which could affect resident overall plan of care."</p> <p>Review of the facility incident/accident report dated 10/30/16 documents, "R6- small cut above left eye."</p> <p>On 1/23/17 at 10:45 AM an interview was conducted with E2. E2 was asked how R6 cut her eye, E2 stated; "I thought I remember a</p>	Z9999		

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Z9999	<p>Continued From page 23</p> <p>witness statement with that incident but I don't know where it is."</p> <p>The facility was unable to provide reproducible evidence this incident was investigated and how R6 received a cut above her left eye.</p> <p>Review of R6's nurses notes did not document an assessment for this injury.</p> <p>Review of the facility policy "Reporting Incidents/Accidents to the Illinois Department of Public Health dated 10/22/07 documents,</p> <p>"B. The following events are reportable only to IDPH and should be documented on an Incident/Accident form.</p> <ol style="list-style-type: none"> 1. Serious Injury 2. Unscheduled hospital visit for evaluation treatment 3. Xrays or lab work completed in response to an injury 4. Threats/stalking of staff person served that raises health/safety concerns 5. 911 calls for emergency services 6. Police/Fire department intervention that directly impacts individuals who live at the facility. 7. Suspicious injury 8. Resident to Resident <p>C. Reporting Form: The Incident/Accident form is to be completed prior to the conclusion of the shift for the significant events in A or B above by the person discovering/observing the significant event or the Administrative Designees to whom the event is reported. The required reporting form and instructions for completing the form are attached."</p> <p>Review of the facility "Procedure for Investigating</p>	Z9999		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006472	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2017
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NAME OF PROVIDER OR SUPPLIER MULBERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906
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Z9999	<p>Continued From page 24</p> <p>Unknown Incidents/Accidents revised 6/23/09 documents, "Unknown Incident/Accident: All unknown incidents/accidents must be investigated and reported to Public Health within 24 hours. All incident/accidents will be reviewed monthly or more often if necessary by Safety Committee to determine trends and patterns which could affect resident overall plan of care."</p> <p>4) Review of the facility's Policy and Procedure for Documentation of Pressure Ulcers dated 7/22/16 documents:</p> <p>"1. Upon admission any person who is unable to ambulate and is mobile via a wheelchair and/or unable to turn or reposition themselves will have a pressure ulcer risk evaluation completed within seven days and quarterly thereafter.</p> <p>2. Upon development of a pressure ulcer the individual's physician will be contacted for specific treatment orders and a weekly pressure ulcer record form will be placed in the treatment book.</p> <p>3. The prescribed treatment will be placed on the treatment sheet and will be monitored daily and prn (as needed) to ensure specific treatments are parent(sic)/or need to be replaced.</p> <p>4. All pressure ulcers will be documented weekly using the weekly pressure ulcer record documentation form.</p> <p>5. Documentation will include, but not be limited to the date, stage, size in cm (length x width), depth (cm), exudate type/ambient, odor, wound bed, surrounding skin color, surrounding tissue/wound edges, tunneling (cm), and undermining (cm)."</p> <p>Further review of the facility's policies for pressure injuries identifies that the facility has a</p>	Z9999		
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Z9999	<p>Continued From page 25</p> <p>policy regarding "Skin Integrity Program" with a review date of 07/22/16. Review of the protocols within this policy identifies that if a, "...breakdown occurs the individual's protocol will be reviewed and amended as needed and placed in their Individual habilitation Plan". No staging protocols are noted within either policies.</p> <p>As based on review of the facility's policies and procedures for pressure injuries, the facility has failed to update their policies as per the National Pressure Ulcer Advisory Panel (NPUAP) recommended guidelines of April 13, 2016. The NPUAP's website (npuap@npuap.org) identifies that the term pressure injury now replaces the term pressure ulcer and that updates have been made to the staging of pressure injuries. The NPUAP updated staging system redefines pressure injury stages which includes:</p> <p>Stage 1 Pressure Injury - Nonblanchable erythema of intact skin; Stage 2 Pressure Injury - Partial-thickness skin loss with exposed dermis; Stage 3 Pressure Injury - Full-thickness skin loss (if slough or eschar obscures the extent of tissue loss this is an Untraceable Pressure Injury); Stage 4 Pressure Injury - Full thickness skin and tissue loss (if slough or eschar obscures the extent of tissue loss this is an Untraceable Pressure Injury); Unstageable Pressure Injury: Obscured full thickness skin and tissue loss; Deep Tissue Pressure Injury - Persistent non-blanchable deep red, maroon or purple discoloration; Medical Device Related Pressure Injury: and Mucosal Membrane Pressure injury.</p> <p>a) During the Entrance Communication on</p>	Z9999		
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Z9999	<p>Continued From page 26</p> <p>01/17/17, the facility identified that R32, R33 and R34 have current pressure injuries</p> <p>The Physician's Order sheet dated January 1 - January 31, 2017 identifies R34 is a 48 year old male functioning at a severe level of intellectual disability and has diagnoses including Cerebral Palsy. Further review of this order sheet identifies, "Skin Integrity Program" protocol and includes Other orders as to what nursing staff are to do if R34 develops a pressure injury. This order states:</p> <ol style="list-style-type: none"> 1. Add high supplement/milkshake twice daily; 2. Notify MD (Doctor of Medicine) for Tx (treatment) orders/records; 3. Add vitamin C 500 mg (milligrams) twice daily if not currently receiving when breakdown is discovered; and 4. Notify Dietary Consultant for input. <p>A Request for Consultation form dated 11/08/16 identifies that the Physician Assistant (Z10) recommended R34 needed a wheelchair evaluation. Per record review and as confirmed per interview with E18 (Acting Director of Nursing - ADON) on 02/03/17 at 3:45 P.M., no wheelchair evaluation has been completed for R34 as based on Z10's recommendations of 11/08/16.</p> <p>In continuing interview with E18 and per review of R34's Nurse's Notes for December 2016, R34 was discovered on 12/18/16 to have a Stage 1 Pressure Injury. Nursing staff documented, "...reddened area noted to right outer elbow with a dark center - reddened area measures 1 cm (centimeter) black spot 4 cm redness - dark center- not open". After this nursing entry twelve days elapsed before nursing staff made another entry into R34's Nurse's Notes regarding his pressure injury. R34's Nurse's Notes states:</p>	Z9999		
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Z9999	<p>Continued From page 27</p> <p>"12/30/16 2:00 AM Rt (right) outer elbow continues to have redness dark spot on the center, has changed now dry hard dark skin measures 1 cm x 1 cm not opened". Documentation identifies that a message was left for the Physician Assistant (Z10).</p> <p>On 12/31/16 nursing staff documented in R34's Nurse's Notes, "Area to rt elbow, dark center, area surrounding very red with heat noted, no drainage noted. Will keep elbow protector in place, will continue to monitor." There is no documentation Z10 (PA) was notified by nursing staff of R34's increased skin/tissue redness with heat which would be indicative of an infection. No further nursing entries were made in R34's Nurse's Notes about his pressure injury until 01/04/17 when he was seen by Z10 (PA).</p> <p>Review of R34's Physician's Order sheet, Nursing Notes, Medication and Treatment Administration Records for the months of December 2016 and January 2017 identifies after 12/18/16, nursing staff did not implement his Physician's Orders for him to receive a high supplement milkshake twice daily, nor the Vitamin C twice daily after nursing staff discovered a Stage 1 pressure injury to his right elbow on 12/18/16. Review of R34's Nutritional Assessment dated 11/16/16 and review of R34's Nursing Notes for December 2016 - January 2017 identifies nursing staff failed to notify the dietary consultant (Z13) so R34's nutritional needs could be re-evaluated.</p> <p>R34's Treatment Record for January 2017 identifies nursing staff are to monitor his right elbow and to keep the elbow pad on to reduce pressure. This record identifies nursing staff are to document on all three shifts. Out of the thirty</p>	Z9999		
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Z9999	<p>Continued From page 28</p> <p>one days of January 2017, 1st shift nursing staff documented 20/31 times, 2nd shift nursing staff documented 7/31 times and third shift nursing staff documented 12/31 times that they had monitored R34's right elbow and his elbow pad was being used.</p> <p>The Encounters and Procedures report dated 01/12/17 identifies R34 was seen by Z12 (Wound Care Physician) on this date for his pressure injury of the right elbow with cellulitis. Z12 documented R34 has a localized ulcer of his right elbow with necrosis measuring 2.8 cm (centimeters) x 2 cm. with surrounding erythema. This pressure injury was documented as being unstageable. During this visit, R34's area was cultured and debrided. After the debridement, R34's pressure injury measured 3 cm x 2.5 cm x 0.6 cm.</p> <p>The Wound Care report dated 01/01/17 - 01/17/17 documents instructions to reposition R34's elbow every hour.</p> <p>The Wound Care report dated 01/01/17 - 01/17/17 identifies MRSA (Multiple resistant Staphylococcus aureus) infection as based on R34's laboratory results. Z12 ordered Doxycycline Hyclate 100 mg (milligrams) to be taken twice daily for 14 days and Vancomycin 1 gram/250 ml (milliliter) in 0.9% sodium chloride intravenously for 5 days. Instructions are noted to reposition R34's elbow every hour.</p> <p>Review of the Weekly Pressure Ulcer Record dated 01/14/17 identifies nursing staff documented R34 has a 2 cm x 3 cm unstageable pressure injury with eschar and redness of the surrounding skin. The Preventative Measures section of this form identifies R34 is to be turned</p>	Z9999		

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Z9999	<p>Continued From page 29</p> <p>every 2 hours. There is no documentation within this record to indicate nursing staff updated and/or implemented the Wound Care Physician's (Z12) instructions to reposition R34's elbow hourly as opposed to every 2 hours.</p> <p>R34's Encounters and Procedures report dated 01/19/17 identifies he was seen by Z12 on this date. This report documents instructions to avoid prolonged position pressure on R34's elbow and his elbow should be repositioned every hour. Cushions are recommended for R34's right elbow and other pressure points.</p> <p>Review of the Weekly Pressure Ulcer Record dated 01/21/17 identifies nursing staff documented R34 has a 4 cm x 3 cm pressure injury with eschar, clear drainage and redness of the surrounding skin. There is no documentation within this report indicating that nursing staff updated and/or implemented the Wound Care physician's (Z12) instructions to reposition R34's elbow hourly as opposed to every 2 hours and that cushions are to be used under the right elbow and other pressure points.</p> <p>R34's Encounters and Procedures report dated 01/23/17 completed by Z12 identifies a localized open ulcer 2 x 2 x 0.4 cm with no surrounding erythema, moderate drainage, mild necrotic tissue on wound bed. Assessment/Plan: "1. Multiple resistant Staphylococcus aureus infection 2. Pressure Ulcer of elbow established (stable)...Stage 4 - Heel and elbow protector Bilateral - Bone 3 Phase 3. Cellulitis of elbow - right..."</p> <p>The patient instructions within this report again</p>	Z9999		

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Z9999	<p>Continued From page 30</p> <p>states, "... Avoid prolonged position pressure on elbow, change position every hour. Use cushions on right elbow and pressure points..." A DME (Durable Medical Equipment Order) is also contained within this report for, "Heel and Elbow Protector Side: Bilateral".</p> <p>R34's Encounters and Procedures report dated 01/23/17 completed by Z12 identifies a localized open ulcer 2 x 2 x 0.4 cm with no surrounding erythema, moderate drainage, mild necrotic tissue on wound bed. The patient instructions within this report again states, "... Avoid prolonged position pressure on elbow, change position every hour. Use cushions on right elbow and pressure points..." A DME (Durable Medical Equipment Order) is also contained within this report for, "Heel and Elbow Protector Side: Bilateral".</p> <p>There is no documentation that a Weekly Pressure Ulcer Record was completed for R34 after 01/21/17. Review of the Physician's Orders sheet for January 2017 does not reflect orders for Bilateral heel and elbow protectors or instructions for positioning every hour as ordered by Z12 on 01/23/17.</p> <p>Review of R34's Hourly Turn Schedule for December 2016 and January 2017 identifies that especially during the hours from 3:00 P.M. - 8:00 P.M. staff documents that he is up in his wheelchair. Documentation does not identify what side he is on, what side he was repositioned to or what alternative positioning is provided. There is no documentation on this form that would indicate R34's elbow is repositioned hourly as ordered by Z12 or that elbow protectors or heel protectors are worn.</p>	Z9999		

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Z9999	<p>Continued From page 31</p> <p>On 02/03/17, R34 was observed at 5:05 P.M. in the dining room of the facility. R34 was seated in his wheelchair and wore a right elbow protector. A pillow was noted under his left arm. however the bony prominence of his left elbow was positioned directly on his left leg. E23(Direct Support Person - DSP) fed R34 and stated R34 is a pretty good eater. When E23 was asked about supplements he stated R34 was drinking a chocolate shake that his mom had left for him. At 5:20 P.M., R34 was taken to his room by E20 (non-certified DSP). E19 (Licensed Practical Nurse - LPN) removed R34's dressing and stated R34's pressure injury measured 2 cm. x 2 cm. x .2 cm. E19 stated R34 was scheduled for a bone scan to rule out infection of the bone. R34 wore only one elbow protector and wore tennis shoes on his feet. E19 was asked about the 01/23/17 orders for R34 to wear bilateral elbow pads and heel pads and she stated she was, "not aware" of this order. E19 stated R34 wears heel pads when in bed. After E19 dressed R34's wound, R34's left arm again was positioned directly on his left leg. When this was pointed out to E20, she stated that she had only worked at the facility for a week. When the surveyor asked E20 if they position R34's elbow in the 12 o ' clock - 3 o ' clock position, she stated that they just keep his elbow protector on and his elbow propped up on a pillow. E20 stated they reposition R34 every 2 hours by pulling him up in his wheelchair and changing his position in his chair.</p> <p>Per continuing observations, at 5:35 P.M. E20 assisted R34 back to the dining room in his wheelchair. R34 drug his feet and E20 prompted him several times to lift his feet without success. E19 and the surveyor were directly behind R34 and E20 and the surveyor asked E19 (LPN) about R34's skin integrity and the impact of</p>	Z9999		
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Z9999	<p>Continued From page 32</p> <p>dragging his feet/heels while being propelled in his wheelchair. E19 then verbally prompted E20 to not push R34 forward if he was not lifting his feet.</p> <p>E18 (Acting Director of Nursing - ADON) was interviewed at 3:45 P.M. on 02/03/17 and confirmed R34 had not been placed on a high supplement/milkshake 2x daily or started on Vitamin C as physician ordered after he developed a pressure injury which was noted on 12/18/16. No documentation was located on the MAR (Medication Administration Record) or the TAR (Treatment Administration Record) to identify that either the supplement or the Vitamin C was started in either December 2016 or January 2017. During this interview, E18 confirmed the dietician (Z13) had not been notified of R34's pressure injury in December of 2016. E18 then provided the surveyor with a copy of a Nutritional Progress Record Form for R34 which confirmed he was not assessed by the dietician for a change in his health status until 02/01/17.</p> <p>Per continuing interview of E18 at 6:00 P.M., E18 stated she had recently ordered bilateral elbow pads and heel protectors for R34. When E18 was asked if she was aware if these devices were currently being used, she stated, "I think so". E18 was then informed only a right elbow protector is being used. When asked about R34's order to reposition his right elbow every hour and if a plan of care had been revised, E18 stated she knew staff repositioned R34 every 2 hours but was unsure if staff repositioned his elbow hourly or if his plan of care had been updated to address this order.</p> <p>E18 was informed of R34's observation at 5:30 P.M. and the way staff had positioned his left elbow into his left leg. When E18 was asked if</p>	Z9999		
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Z9999	<p>Continued From page 33</p> <p>staff had been trained on R34's positioning needs, she stated she was not sure. E3 (Qualified Intellectual Disability Professional - QIDP) was at the Nurse's Station at this time and confirmed staff had not been trained on hourly repositioning of R34's right elbow nor his positioning needs since acquiring his pressure injury at the facility in December 2016.</p> <p>2) Review of the facility resident roster dated 1/17/17 documents R32 is a 49 year old male who functions at a Severe Level of Intellectual Disability.</p> <p>During observation on 01/18/17 at 3:10 PM, R32 was observed in bed with E4 (Director of Nurses) present during observation. R32 was observed to have five Stage 2 pressure injuries on his left buttock.</p> <p>Under risk factors the weekly pressure ulcer record documents, diabetes mellitus and incontinence.</p> <p>Under preventative measures/progress the weekly pressure ulcer record documents, "turned every 2 hours cushion in wheelchair, and air mattress."</p> <p>Review of R32's Weekly pressure ulcer record documents on 12/31/16 a Stage 2 pressure injury measuring 8 x 2 centimeters that is superficial with no exudate or odor. The pressure injury record continues to document a second Stage 2 pressure ulcer measuring 5 x 4 centimeters that is superficial with no exudate or odor.</p> <p>Continued review of R32's weekly pressure ulcer record documents a measurement on 1/7/17 of a Stage 2 pressure ulcer 1.2x1.5x0.1 centimeters</p>	Z9999		
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Z9999	<p>Continued From page 34</p> <p>with no exudate or odor. And a measurement on 1/14/17 of a Stage 2-1.2 x 1 x 0.1 centimeters with no exudate and no odor. It is unclear if R32 had five pressure injuries on 01/07 or 01/14/17 or if he acquired these pressure injuries after 01/14/17.</p> <p>During interview on 01/18/17 at 3:10 PM, E4 (Director of Nurses) stated, R32 acquired the pressure ulcers to his buttocks at the facility.</p> <p>During interview on 01/19/17 at 3:49 PM, E4 stated there were no documented assessments or measurements on all five of R32's pressure ulcers.</p> <p>3) Review of the facility resident roster dated 1/17/17 documents R33 is a 62 year old male who functions at a Moderate Level of Intellectual Disability.</p> <p>During observation on 01/18/17 beginning at 3:40 PM, R33 was observed transferring from his wheelchair to his bed with assistance of E4. R33 was observed to have two Stage 2 pressure injuries on his left buttock.</p> <p>Review of R33's weekly pressure ulcer record documents a measurement of a Stage 2 pressure injury on 1/5/17 of 2 x 2 x 0.1 centimeters with no exudate and no odors and a measurement of 2 x 1.5 x 0.1 centimeters on 1/14/17. There is no documented assessment or measurement of the second pressure injury observed on R33's left buttock.</p> <p>During interview on 1/19/17 beginning at 3:49 PM, E4 stated one of the pressure injuries was acquired at the facility and one was acquired at the hospital. E4 stated there was no documented</p>	Z9999		
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Z9999	Continued From page 35 assessments/measurements for R33's second pressure ulcer. (A)	Z9999		
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