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	IL6004287	A. BUILDING: _____ B. WING _____	C 05/20/2022

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HERITAGE HEALTH-MOUNT STERLING	435 CAMDEN ROAD MOUNT STERLING, IL 62353

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S 000	Initial Comments Complaint Original Investigation #2223920/IL147071	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 300.1210 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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: 6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by the following: Based on interview and record review the facility failed to revise pressure relief measures or change treatment orders for one of three residents (R1) reviewed for pressure ulcers in a sample of three. These failures resulted in R1 developing a stage four pressure ulcer to the coccyx with wound infection, a deep tissue injury (DTI) to the right heel and a stage three pressure ulcer to the left heel which required hospitalization. Findings include: A Wound & Ulcer Policy and Procedure dated 1/10/18 states, "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management." This policy states, "All residents will be assessed to determine the degree of risk of the developing a pressure ulcer using the Braden Scale-Ulcer Risk Assessment."	S9999		

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S9999	Continued From page 2 This policy states, "Residents with existing ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment Score." This policy states that residents with moderate or high risk for developing pressure ulcers will have pressure reduction approaches placed on their care plans. In addition, this policy states, "Orders for Vitamin C 500mg (milligrams) and/or Zinc Sulfate 220 mg daily and /or MVI (multivitamin) daily may be requested in addition to treatment of an ulcer," and "Care interventions for staff involved in the resident's care are communicated via the resident care plan." This policy also states, "When an existing or newly developed pressure ulcer(s) is present, a skin assessment ("skin check") will be documented each shift to monitor the individual resident's tolerance to the current positioning schedule ("tissue tolerance") and the facility will re-evaluate the frequency of repositioning if indications of further breakdown occur." This policy also states that a Suspected Deep Tissue Injury (DTI) is a "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear." This policy documents that for a DTI the facility protocol is to treat the DTI using protectant wipes and a dry dressing." R1's list of current diagnoses includes Chronic Kidney disease, Aortic Valve Disorder, Osteoarthritis, Metabolic Encephalopathy, Difficulty Walking, Muscle Weakness, Hyperglycemia, Anxiety Disorder, Sepsis, Neuromuscular Dysfunction of Bladder, and Major Depressive Disorder. R1's Minimum Data Set (MDS) assessment dated 4/1/22 documents R1 was admitted to the facility on 3/25/22, is moderately cognitively	S9999		

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S9999	Continued From page 3 impaired, requires extensive assistance of two people for bed mobility, transfers, dressing, toilet use, personal hygiene, and uses a wheelchair for mobility with the extensive assistance of one. This MDS assessment also documents R1 is always incontinent of bowel, has an indwelling urinary catheter in place, is at risk for the development of pressure ulcers, and at the time of the assessment, R1 had developed a stage two pressure ulcer. R1's Care Area Assessment (CAA) Summary signed 4/7/22 documents R1 has identified care area problems that need to be addressed in R1's care plan. These care areas include, (R1) has a stage two pressure ulcer to (R1's) right buttock." This same CAA Summary documents as an analysis of factors putting R1 at risk for pressure ulcers includes pressure to the area, immobility, altered mental status, cognitive loss, incontinence, poor nutrition; diagnoses of Sepsis, Depression, Chronic or End-Stage Renal, Liver or heart disease. In addition, R1's CAA Summary documents R1's Pressure Ulcer will be addressed in R1's care plan with the overall objective to "slow or minimize decline, " and "Maintain current level of functioning." R1 Braden Scale for Predicting Pressure Ulcer Risk dated 4/1/22 documents R1 is at risk of developing a pressure ulcer because R1 is occasionally moist, requiring an extra linen change approximately once per day; R1 is bedfast but has no limitation to mobility, R1's food intake is probably inadequate, and has the potential for friction and shear because R1 moves feebly or requires minimum assistance, during a move; R1's skin probably slides to some extent against the sheets, chair, restraints, or other devices, and occasionally slide down. This same	S9999		

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S9999	Continued From page 4 pressure risk document contains a list of clinical suggestions which could be initiated or added to R1's plan of care to reduce R1's pressure ulcer risk, however, none of the clinical suggestions are checked off. R1's Braden Scale for Predicting Pressure Ulcer Risk dated 4/8/22 documents R1 is at moderate risk for developing a pressure ulcer because R1's sensory perception is slightly limited, R1 is occasionally moist, requiring an extra linen change approximately once per day; R1 is bedfast and only makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, R1's food intake is probably inadequate, and has the potential for friction and shear because R1 moves feebly or requires minimum assistance, during a move; R1's skin probably slides to some extent against the sheets, chair, restraints, or other devices, and occasionally slide down. This same pressure risk document contains a list of clinical suggestions which could be initiated or added to R1's plan of care to reduce R1's pressure ulcer risk, however, none of the clinical suggestions are checked off. R1's Braden Scale for Predicting Pressure Ulcer Risk dated 5/1/22 documents that R1 is at moderate risk for developing a pressure ulcer because R1's sensory perception is slightly limited, R1 is occasionally moist, requiring an extra linen change approximately once per day; R1 is chairfast with ability to walk severely limited or non-existent and cannot bear own weight and/or must be assisted into chair or wheelchair, R1's food intake is probably inadequate, and has a problem with friction and shear because R1 requires moderate to maximum assistance in moving which make lifting R1 without sliding	S9999		

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S9999	Continued From page 5 against the sheets impossible. This same pressure risk document contains a list of clinical suggestions which could be initiated or added to R1's plan of care to reduce R1's pressure ulcer risk, however, none of the clinical suggestions are checked off. R1's Physician's Orders Sheet (POS) documents R1 was prescribed the supplement Med Pass 60 ml (milliliters) two times daily starting 4/21/22, Protein Liquid 30ml two times daily for wound healing starting 5/9/22. R1's POS documents R1 was prescribed a right buttock stage two pressure ulcer treatment of paste three times daily from 3/31/22 to 5/12/22. The POS documents that on 4/18/22 a new order for Hydrophilic paste wound dressing was ordered to treat an open area to R1's Coccyx (base of the back) which was discontinued on 5/2/22. R1's POS documents that on 5/2/22 a physician's order was written to treat R1's coccyx wound with dressing changes using Hydrogel gauze with transparent film until healed. This same order was discontinued on 5/5/22. R1's POS documents that on 5/5/22 a physician's order was written to treat R1's coccyx wound using Calmoseptine Ointment around the peri wound every shift. This order was discontinued 5/12/22. R1's POS documents that on 5/12/22 a physician's order was written to treat R1's coccyx wound by applying barrier cream around the edges of R1's wound then placing a hydrogel saturated fluffed gauze into the wound then cover with an absorbent pad and secure with tape. This order has no discontinuation date. In addition, R1's POS documents that a specialized pressure reduction cushion and to float R1's heels was not ordered until 5/2/22, and a specialty pressure reduction air mattress was not ordered until 5/5/22. R1's POS does not include any wound culture orders.	S9999		

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S9999	Continued From page 6 A facility wound log dated 3/2022 to 5/18/22 and listing V2 (Director of Nurses/ DON) as the documents scribe, documents that R1 developed a stage two pressure ulcer to the right buttock on 3/31/22, six days after R1 was admitted to the facility, which was measured on 4/1/22 as 0.3cm (centimeters) long x 0.3 cm wide x 0.1cm depth. The wound log documents the treatment ordered for R1's wound as of 3/31/22 was Triad cream with a Mepilex dressing. The wound log documents that on 4/8/22 R1's right buttock stage two pressure ulcer had increased in size to 2cm long x 1.4cm wide x 0.1 cm depth with the treatment orders remaining unchanged. The wound log dated 4/15/22 documents R1's stage two pressure ulcer measured 2cm long x 1.5 cm wide x 0.1cm depth on that date with the treatment orders remaining unchanged. The wound log dated 4/22/22 documents R1's wound was 2cm long x 1.4cm wide x 0.1 cm depth with the treatment orders remaining unchanged. The wound log dated 4/29/22 documents R1's stage two pressure ulcer was 2cm wide x 1.4 cm long x 0.1cm depth with the treatment orders remaining unchanged. The wound log dated 5/5/22 documents R1's stage two pressure ulcer had increased in size on that date measuring 2.4cm long x 2.0cm wide x 0.2cm depth with the wound bed a pink color and containing slough (dead tissue). V2's note on R1's 5/5/22 wound documentation stated that V10 (Nurse Practitioner) was concerned R1 had a fistula or "anatomy issue." The 5/5/22 wound log does not indicate what treatment was being used at that time. The wound log dated 5/12/22 documents R1's coccyx pressure ulcer was downgraded to a stage three pressure ulcer with deeper edges that were healing but with slough within the wound. The 5/12/22 wound log also documents R1 was	S9999		

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S9999	Continued From page 7 prescribed oral liquid protein in addition to dressing changes to R1's wound using the medicated wound treatment Santyl. R1's care plan initiated 3/29/22 documents the facility developed a plan of care with interventions to address R1's "risk for impaired skin integrity." This same care plan does not document any additional care plan interventions or revisions were made after R1 developed a stage two pressure ulcer to the right buttocks on 3/31/22, after that pressure ulcer increased in size, or when R1 developed an additional stage three pressure ulcer to the coccyx until 5/18/22. R1's Registered Dietitian notes document that no dietary recommendations were made for R1 until 4/19/22 at which time R1 was ordered to have the dietary supplement Med Pass 60ml two times daily. R1's progress notes dated 5/1/22 and entered by V7 (Licensed Practical Nurse/LPN) documents that R1's coccyx wound was 3.2cm long x 3.0cm wide with a wound bed containing white slough tissue and with some bruising around the edges of the irregularly shaped wound. This same nursing progress note documents R1 had developed a "bruise" measuring 1.0cm wide x 1.0cm long on R1's right heel. R1's nursing progress note dated 5/15/22 and entered by V7 documents that R1 had also developed an open and draining blister to the left heel which measured 0.4cm in diameter. This note documents R1's physician was notified, and the wound was wrapped with gauze for protection. R1's nursing progress note dated 5/16/22 and	S9999		

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entered by V2 (Director of Nurses/DON) documents, " V10 in house-checked (R1's) bottom. She would like (R1) sent to ER (emergency room) for evaluation and treatment due to drastic change in the appearance of the wound."

R1's ER records dated 5/16/22 document R1 arrived at that facility at 1:33p.m. and was transferred out to another hospital because of needing a higher level of care at 4:10p.m. that same date. This same ER record documents R1's level of care was "Urgent." During R1's emergency room admission, a wound culture and sensitivity was performed to R1's buttock wound and showed R1's wound contained the infection causing organism Proteus Mirabilis.

R1's hospital physician's consultation notes dated 5/17/22, after R1 was transferred for a higher level of care, document R1 was found to have a stage four pressure ulcer to R1's coccyx, a stage three pressure ulcer to R1's left heel, and a deep tissue injury to R1's right heel. This physician's note documents that "Where the wound is located and the continued soilage from her stool make this next to impossible for (R1) to overcome." This note documents that R1 was not a surgical candidate to repair her coccyx wound and was recommended for palliative care.

On 5/19/22 at 1:26p.m. V10 stated that she is a Nurse Practitioner for V12 (R1's physician). V10 stated she had been providing care for R1 since her admission to the facility 4/25/22. V10 stated that she first evaluated R1 on 4/28/22 at which time there was no documentation of R1 having any wounds. V10 stated that R1 developed a stage two pressure ulcer to the right buttock on 3/31/22. V10 stated that although the facility

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documented the wound had a length and a width, when she examined the wound, it was a superficial circular wound which measured 0.3cm in diameter. V10 stated that the facility has a protocol to use Triad paste for that type of wound until V10 can examine it. V10 stated that she did not examine R1's wound until 4/7/22. V10 stated she continued the Triad paste for R1's wound following that visit. V10 stated that she did not examine R1 again until 4/21/22. V10 stated that during that visit R1 was seated in the dining room so she only examined R1's legs for edema. V10 stated that sometime in 4/2022, R1 also developed a wound to her coccyx area. V10 stated that R1 still had the right buttock stage two pressure ulcer, but it became a satellite wound to R1's new coccyx wound. V10 stated that she did not examine R1 again until 5/5/22 when she noted R1's coccyx wound had worsened. V10 stated that in early 5/2022 R1's right buttocks wound resolved and she discontinued treatment for it but continued treating R1's coccyx wound. V10 stated that on 5/2/22 V10's office received a fax from the facility notifying V10 that R1's coccyx wound had a white slough in the wound bed and that R1 had also developed a bruise to R1's right heel. V10 stated that R1's right heel bruise was actually a DTI pressure wound. V10 stated that on 5/2/22 is when she ordered for R1 to start using a pressure relieving air mattress and a pressure relieving cushion for her chair. V10 stated the cushion R1 was using prior to V10's order was not really for pressure relief. V10 stated she did not examine R1 on that date, but she gave temporary orders until the next time she visited the facility. V10 stated that R1 was already wearing some padded boots prior to developing the right heel DTI, but that those boots do not provide much pressure relieve because R1's heel rested against the fabric of the boot. V10 stated

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S9999	Continued From page 10 that she prefers the pressure relief boots that have the heels cut out which provides better heel pressure prevention. V10 stated she does not think this facility uses that kind of pressure relief boot. V10 stated that she did not refer R1 to see a wound specialist, but instead, V10 spoke with a wound specialist on the phone for recommendations on treating R1's coccyx wound. V10 stated that the wound consultant did not come into the facility to examine R1's wound. V10 stated that based on their recommendations, V10 made several wound treatment changes from 5/5/22 until R1 was sent to the hospital 5/16/22. V10 verified that she did not change any of R1's coccyx wound treatment orders until 5/2/22 despite R1's wound increasing in size from the time it was being called a stage two pressure ulcer to the right buttock until 5/2/22 after the wound had enlarged to include the coccyx and the right buttock became a satellite wound to the coccyx. V10 stated R1's wound worsened very quickly. V10 stated she thought R1's wound might be a Kennedy Terminal Ulcer which is a pressure wound which develops rapidly when someone is at the end of life. V10 stated that R1 also had an "interesting" anatomy where there was not much distance between R1's rectum and the area around R1's vagina. V10 stated that R1 also had a problem with continuous oozing stool after she had developed her wound to the right buttock which continued until R1 went to the ER. V10 stated that on 5/10/22 she ordered for R1 to have a fiber supplement to bulk up her stools. V10 stated that on 5/9/22 facility staff notified her (R1) was still having pasty stools which was making it difficult to keep R1's wound clean. V10 stated that on 5/11/22 she ordered for R1 to have a rectal tube placed to aide in wound healing. V10 stated the facility did not get the rectal tube from their supplier before R1 went to the ER on 5/16/22.	S9999		

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S9999	Continued From page 11 V10 stated that from 5/2/22 until 5/16/22 R1's coccyx wound worsened from a large wound with yellow slough to a big hole in her coccyx. V10 stated that on 5/16/22 when she examined R1's coccyx wound, the wound had, "opened up into a big hole with bone visible in the wound." V10 stated, "I could smell it when I went into (R1's) room." V10 stated that during her examination of R1 on 5/16/22, R1 had developed a new wound to her left heel. V10 stated the wound was macerated all around the wound bed because a dressing which holds moisture close to the wound instead of wicking it away was used by facility staff to cover R1's left heel wound. V10 stated that if the facility had put all possible pressure relief measures in place upon R1's admission to the facility, R1's pressure ulcers could have been prevented. On 5/19/22 at 10:16a.m. V11 (Hospital Wound Nurse) stated that she is the hospitals Wound Clinic Case Manager and evaluates hospital patients for wound care treatments and recommendations. V11 stated that she was referred to evaluate R1 when she was admitted to the hospital on 5/16/22. V11 stated during her examination of R1, V11 noted that R1 had a large unstageable pressure ulcer to R1's coccyx which measured 8.9cm long x 6cm wide x 2.9 cm deep. V11 stated bone could be visualized within the wound. V11 stated R1's wound bed was covered with black eschar (devitalized tissue), yellow and brown slough. V11 stated R1's wound had undermining all around the edges of the wound. V11 stated she did not belief R1's wound was a Kennedy Terminal Ulcer (KTU)meaning a wound that quickly develops during the dying process. V11 stated R1's wound did not have the butterfly shape which wraps around the coccyx which is typically associated with a KTU. V11 stated that	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 R1 still had a small stage two pressure wound to her right buttocks which was a separate wound than the coccyx wound. V11 stated that R1 was referred to a colorectal surgeon (V14) and his Nurse Practitioner (V15) because R1's coccyx wound was so close to the rectum that for the wound to heal it would require diversion of her bowel with a colostomy to keep R1's coccyx wound clean during the healing process. V11 stated that it was determined that surgery was not going to be possible and R1 was referred for palliative care instead. V11 stated that R1's wounds were avoidable. V11 stated there were multiple measures the facility could have tried to prevent the development of R1's coccyx, buttock, and heel wounds including turning and repositioning more frequently, additional nutritional measures, wedge pillows and more. On 5/18/22 at 11:45a.m., on 5/19/22 at 2:11p.m., and on 5/20/11 at 8:42a.m. V2 stated that R1 was admitted to the facility on 3/25/22. V2 stated that R1 had poor nutrition and weight loss prior to her admission which put R1 at risk for pressure ulcers. V1 stated that R1's advanced age and other diagnoses also put R1 at a higher risk for developing pressure ulcers. V1 stated she assumed the role as the facility wound nurse on 4/1/22. V2 stated that as the wound nurse she evaluates residents' wound once per week including measuring the wounds, writing out a description of the wounds, and contacting physicians when there is a change in the wound. V2 stated that R1 developed a stage two pressure ulcer to the right buttock on 3/31/22 which V2 assessed and measured on 4/1/22 as 0.3cm long x 0.3cm wide x 0.1cm depth. V2 stated that when the wound was found the facility made sure R1 was being turned and repositioned every two hours and as needed, encouraged R1	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004287	A. BUILDING: _____ B. WING _____	C 05/20/2022

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S9999	Continued From page 13 to go to the dining room for meals and that R1 was provided with puffy cloth boots for pressure relief to her heels. V2 stated that R1 was already using a pressure relieving foam mattress which is standard on all residents' beds and is rated as helping to prevent up to a stage two pressure ulcer. V2 stated she did not assess R1's tissue tolerance to determine how often R1 should be turned and repositioned. V2 stated that R1 received a physician's order for wound treatment which consisted of triad paste and a protective dressing which also provided some pressure relief. V2 stated that she next assessed and measured R1's wound on 4/8/22. V2 verified that on that date R1's wound had increased in size measuring 2cm long x 1.4cm wide x 0.1cm depth. V2 stated that V10 ordered to discontinue R1's foley catheter at that time because she thought the catheter made R1 stay in bed too much. V2 stated that she did not make any recommendations to V10 to change R1's wound treatments or add any additional treatments, nor did V2 assess R1's tissue tolerance to determine if she needed turned and repositioned more frequently than every two hours. V2 stated she next assessed and measured R1's wound on 4/15/22. V2 verified R1's wound had increased in size measuring 2cm long x 1.5cm wide x 0.1cm depth. V2 stated that by that time, R1's wound had grown to include the coccyx area. V2 stated that at that time she requested a change in treatment orders from V10. V2 stated that V10 instructed for R1 to continue with the same wound treatment orders. V2 stated she did not re-evaluate the pressure relieving interventions already being used for R1. V2 stated there were no new interventions attempted to prevent worsening of R1's coccyx wound at that time. V2 stated she assessed and measured R1's coccyx wound on 4/22/22 at which time R1's wound	S9999		

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S9999	Continued From page 14 measured 2cm long x 1.4cm wide x 0.1cm depth. V1 stated that R1's treatment orders for Triad paste with Mepilex dressing remained unchanged. V2 stated at that time V2 did not reevaluate R1's current pressure ulcer prevention measures or make change of treatment recommendations to V10. V2 stated she assessed and measured R1's coccyx wound on 4/29/22 at which time R1's wound measured 2cm long x 1.4cm wide x 0.1cm depth. V2 stated she did not make recommendations to V10 for change of treatment orders for R1's coccyx wound to help with wound healing and did not re-evaluate the pressure ulcer prevention measures that were in place. V2 stated that on 5/1/22 a bruise was found on R1's right heel. V2 stated she did not evaluate R1's right heel until 5/5/12 when she assessed and measured R1's coccyx pressure ulcer. V2 stated that R1's right heel bruise was actually a Deep Tissue Injury which is another type of pressure ulcer. V2 stated that R1's DTI was not listed on the facility's wound log because she only logs open wounds and not DTIs. V2 stated that since R1 was already wearing pressure relieving boots, the intervention was to float her heels on pillows. V2 stated that on 5/5/22 R1's coccyx wound measured 2.4cm long x 2.0cm wide x 0.2cm depth. V2 stated that at that time V10 ordered for R1 to have a pressure relieving chair cushion and a pressure relieving air mattress. V2 stated that R1 did not have a pressure relieving seat cushion until V10 ordered one on 5/5/22. V2 stated that early 5/2022 is when V10 changed R1's coccyx wound treatment orders and consulted with a wound care specialist. V2 stated that she assessed and measured R1's coccyx wound on 5/12/22 at which time R1's wound measured 3.2cm long x 3.0cm wide x 0.2cm depth and with slough covering the wound bed.	S9999		

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S9999	Continued From page 15 V2 stated it was on that date that V10 downgraded R1's coccyx pressure ulcer to a stage three pressure ulcer. V2 stated she assessed R1's coccyx wound again on 5/16/22. V2 stated R1's wound was much larger on that date. V2 stated that V10 evaluated R1's wound and said R1 needed a higher level of care. V2 stated that R1 was sent to the hospital for evaluation and treatment. V2 stated that R1 had also developed a new wound to R1's left heel which appeared to be an open blister. V2 stated that R1 had oozing stool coming from her rectum from the time R1 developed the right buttock pressure ulcer until she was sent to the hospital 5/16/22. V2 stated the oozing stool only became a problem after R1's wounds became larger causing R1's wound to become frequently soiled with stool. V2 stated that V10 discussed inserting a rectal tube for R1 to aide in wound healing. V2 stated V10 ordered for R1 to have a rectal tube on 5/12/22 but that the facility did not receive the tube from their supplier until 5/16/22 after R1 was sent to the hospital. V2 stated that normally there is a wound consultant who comes to the facility, assesses wounds and advises practitioners on appropriate wound treatments. V2 stated that the wound consultant has been unavailable to come to the facility until after R1 left for the hospital. V2 stated R1's pressure ulcers could have been prevented or delayed if, "We could have put some of (R1's) interventions in place sooner as opposed to waiting." (A)	S9999		