

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	FINAL OBSERVATIONS 300.1210(a) 300.1210(b)(2) 300.1210(b)(5) 300.3220(f) 300.3240(a) The facility must provide the necessary care and services to attain or maintain the highest	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 19</p> <p>practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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.</p> <p>All treatments and procedures shall be administered as ordered by the physician.</p> <p>A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident.</p> <p>These requirements are not met as evidenced by :</p> <p>Based on clinical record review, staff interviews, other interviews, and review of facility documents, the facility failed to ensure that one resident (R2), was free from neglect and failed to ensure that R2 received the necessary care and treatment for multiple pressure sores on her right leg and right heel.. This is evidenced by the facility's failure to provide necessary services and treatments for pressure sores from October 27,</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 20</p> <p>29, Nov 2, 3, 4. This resident was already compromised with decubitus ulcer with significant changes, including increasing sizes, very foul odor, bone exposure.. R2 had a total of 9 pressure sores since June 2004. Numerous layers of maggots of varying sizes developed in the right lower leg and right heel wounds of R2. Lack of skin services and treatments, lack of pressure relieving measures, lack of accurate documentation, put R2 with wounds/pressure sores at risk for infection and a negative outcome.</p> <p>R2 was transferred to a local hospital on 12/06/04 with a diagnoses of Sepsis.</p> <p>Findings include:</p> <p>(1) R2, is a 71 year old with diagnoses including Cerebral Vascular Accident with Left Hemiplegia, Diabetes Mellitus, and Seizure Disorder and was admitted to the facility on 04/20/04.</p> <p>At the time of admission, the "Skin Risk Assessment Sheet" documented that the resident's total score indicated that R2 was at high risk for skin breakdown. There was no evidence that the facility implemented their protocol for prevention of pressure sores for this resident. The facility had not used mattresses, repositioning or special devices on R2 to prevent further breakdown. According to the most recent comprehensive resident assessment (Minimum Data set), R2 had modified independence with cognitive skills for decision making. R2 was aphasic and required total care of staff for activities of daily living. R2 could not turn or position herself and relied on staff for this care.</p> <p>(2) Review of the facility's weekly wound</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 21</p> <p>assessment and interview with E15(wound care coordinator) revealed R2 had one pressure sore/wound to her right lateral leg on 06/04. There were no other wounds or pressure sores on R2 at this time. On 08/24/04 wound assessment documentation and interview with E15 revealed that R2 developed blisters to both heels. There was no evidence heel protectors had been put into place to help with the heel pressure. A podiatrist was consulted, an assessment was done, and treatments were ordered by the podiatrist. R2 had no order for preventative measures.</p> <p>There was no documentation reviewed or provided to surveyor with evidence that staff initiated pressure sore prevention policy including pressure relieving measures or devices.</p> <p>(3) Interview with E15 further added, "The blisters on R2's heels opened up around 09/04 and her Doctor ordered a treatment to be done every 3 days. I'll have to find that order, since R2's chart was thinned, because R2 was in and out of the hospital several times".</p> <p>(4) During a telephone interview with Z1 (podiatrist) on 12/09/04 regarding the origin and deterioration of R2's wounds, Z1 stated, "I really don't believe any of R2's wounds started in the hospital. I have been following R2's wounds since 08/04, when she got her first pressure sore on her leg. If any started in the hospital, they were very superficial and worsened at the nursing home." Z1 continued, "The wounds on R2's heels are primarily because pressure was not kept off of them at the nursing home. I always found R2's heels on the bed each week that I visited her."</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 22</p> <p>Upon further interview Z1 stated, "I always make rounds on wounds with E15."</p> <p>(5) Review of the weekly wound progress notes dated 10/20/04, revealed "Necrosis post right heel, foul odor purulent. Post right heel 6.0cm. Apply Betadine soaked gauze daily x 7." This form was signed by the podiatrist/wound Doctor.</p> <p>Review of the weekly assessment skin alteration sheet dated 10/21/04 revealed Right heel measurements 5.5 x 8.5 x 0.2cm, wound bed: granulation= 5%, eschar = 85% slough/fibrin yellow = 10%, small amount of sero-sanguinous (clear/with blood) exudate and foul odor. treatment: Betadine (per doctor). This form was signed by E15.</p> <p>Further review of this documentation dated 10/27/04 (1 week later) revealed Right heel measurements 5.5 x 8.5 x 0.2 cm., wound bed: granulation = 90%, eschar = 85% slough/fibrin yellow = 10%, small exudate sero-sanguinous (clear/with blood), bone exposed. treatment: Betadine.</p> <p>Review of the weekly wound progress notes dated 11/01/04 reveals "painful heel ulcers. Onset = gradual , duration = chronic, severity = severe (right), timing = pressure. Foul odor post right heel and moderate drainage 4x8cm. Stage 1V right heel and right leg 9x7cm lat dorsally. Full debridement deep fat to bone right heel. Xenograft, xerofoam unna boot don't change for 7 day or prn (as needed) unless soiled." This form was signed by the podiatrist/ wound Doctor.</p> <p>This order as written above was never</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 23</p> <p>transcribed to the POS (physician order sheet) and signed by the physician and was never followed by staff or referred to the MD.</p> <p>The most current order at this time was 'Right heel cleanse with nss (normal saline solution) apply Betadine moist gauze, cover with ABD and wrap with kerlix Q day 11-7 shift and as needed", as well as a current order for "daily skin checks." Which also was not consistently done by the staff</p> <p>Review of the weekly assessment skin alteration sheet dated 11/01/04 revealed Right heel measurements 5.3 x 8.5 x 0.2cm wound bed: granulation = 100%. exudate = small sero-sanguinous 9 clear/with blood) bone exposed. treatment: BMG (betadine moist gauze).</p> <p>Review of the weekly wound progress notes dated 11/08/04 (1 week since the last visit) reveals "painful heel ulcers bilaterally. Onset = gradual, duration= chronic, severity = severe and timing = pressure. Heels post aspect, foul odor right, bone exposed, no change in size, right leg 7x12cm and 3cm x 1.5cm med granular, right heel mixed granulation/down to the bone 6cm x 5cm x 2cm; left heel 4 and 1/2cm x4 cm mixed granulation above left ankle 1cm ; maggots noted right heel. Accuzyme to right heel, panifil to left heel allevyn to right leg. This form was signed by the podiatrist/wound Doctor.</p> <p>(6) Z1 was interviewed regarding R2's wound status and the observation of maggots. Z1 stated, "E15 tours with me weekly when I make my rounds and E15 also saw the maggots on 11/08/04. There were many maggots on R2's right leg and right heel, and they were very large,</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 24</p> <p>some were approximately 1 centimeter in size and some were smaller. Having maggots in a clinical setting is never acceptable! I would say the dressing was not changed since I saw R2 last week. R2's unna boot had been removed and R 2 should have been receiving dressing changes and skin checks daily." It was noted by surveyor that Z1 also noted continued infestation of maggots one week later on 11/15/04 visit showing that the facility did not totally clean out the wound even after being made aware of the maggots on 11/8/04. TAR shows again no treatment for the heel was done on November 9 and November 12.</p> <p>(7) Review of the facility's TAR (treatment administration record) dated 10/21/04 - 11/18/04 (there were 2 pages of the TAR with these dates). On page 1 of this TAR there was a treatment order dated 10/25/04 as follows: Right heel; cleanse with nss (normal saline solution) apply Betadine moist gauze, cover with ABD and wrap with kerlix Q day 11-7 shift and prn (as needed). There was also an treatment order on this TAR as follows: Right lateral lower extremity; cleanse with nss apply allevyn hydrocellular and wrap with kerlix Q 3 days 11-7 shift and as needed'. These treatments were initialed / signed off by E 15 with a symbol "e" indicating the treatments were not done to R2's right leg on 11/2/04 nor 11/08/04 nor were these treatments done to R2's right heel on 10/27/04, 10/29/04, 11/02/04, 11/03/04 and 11/04/04., 11/9/04 and 11/12/04. The TAR had an 'e' on these dates. E15 admitted that she uses the symbol for tracking when treatments were not done and when the TAR had a blank unsigned signature on it. So, the "e" is put in later by E15 who reviews the form.</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 25</p> <p>(8) Surveyor interviewed E16 (nurse 2nd floor 11 pm - 7am) on 12/14/04 per telephone regarding observation of the wound status of R2's right lower extremity and right heel. E16 stated, "I only worked here a little while, I'm new here! I may have done R2's right lower extremity one time and I'm not sure that was the first week in November. I remember R2 had a small eschar on the right heel. I did not see the bone or maggots then. E17 is the other nurse."</p> <p>(9) Surveyor then interviewed E17 (nurse 2nd floor 11-7a) per telephone on 12/13/04 regarding the wound status of R2 especially the 1st week of November. E17 stated, "I usually do the wound treatments on the 2nd floor. I never saw maggots on R2's leg or heel." E17 continued, "I was off work the 1st week of November and while I was off no one replaced me on the floor. There was only one nurse on the 2nd floor on the night shift and no one was doing the treatments. When I came back to work I heard the podiatrist had found maggots on R2's leg and heel." Surveyor further interviewed E17 regarding the initials on the TAR form that an 'e' symbol on the dates 10/27/04, 10/29/04, 11/02/04, 11/03/04 and 11/04/04. E17 stated that 'e' symbol means there was no sign off as being done those days, and E 15 put the "e" symbol there meaning " treatments weren't done". Surveyor noted the above dates had a symbol 'e' which indicates treatments were not done to R2's right leg and/or right heel.</p> <p>(10) E15 was again interviewed by surveyor per telephone on 12/14/04 regarding the treatments</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 26</p> <p>not being done for R2's right leg and right heel and the practice of putting an 'e' in the blank initial column. E15 stated, "Whenever there was an 'e' initial on the TAR sheet it means R2 did not get the treatments for those days and I put an 'e' in the blank signature/initial column so that I can track who I need to talk to."</p> <p>Review of the weekly assessment skin alteration form dated 11/08/04 revealed Right heel measurements 5.6 x 8.5 x 0.2cm wound bed: granulation = 90%, slough/fibrin = 10% exudate: small bone exposed. treatment: Accuzyme (sx debrided). This form was signed by E15. This review revealed an increase in the size of R2's heel wound and did not reflect the maggots that were seen earlier when making rounds with the podiatrist.</p> <p>(11) Since E15's documentation did not reflect maggots on the weekly skin assessment sheet, Surveyor interviewed E15 per telephone on 12/13/04 at approximately 9:40 a.m. regarding knowledge of maggots found on R2's right leg and heel on 11/08/04. E15 stated, "Yes, I did see the maggots on R2's right heel and leg on 11/08/04 when I was making rounds with the podiatrist. I did not document this on my 11/08/04 weekly skin note because I wanted to discuss this with E1 (administrator), so in a private conversation the morning of 11/08/04, I informed E1 about the maggots found on R2's leg and heel. I waited for E1 to get back to me as how to handle this, but E1 never did". Upon further interview, E15 stated, "From the appearance of the wound with dried blood and dressing, I would say the dressing had</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2004
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(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) COMPLETION DATE
F9999	<p>Continued From page 27</p> <p>not been changed in several days. There were a lot/ many maggots noted on the dressing when it was removed and a few on the actual wounds. They were approximately 1/4 inches in size."</p> <p>Surveyor interviewed E1 per telephone on 12/14/04 at approximately 9:25 a.m. regarding staff notifying him of maggots found on R2. E1 stated, "I have no knowledge about maggots on R2."</p> <p>This interview is in conflict with E15 who clearly stated E1 was informed of maggots on R2 in a private conversation on 11/8/04.</p> <p>(12) The four stages of development for the common housefly includes:egg, larvae or maggots, pupa and adult. The second cycle is where the maggots remain in the breeding media for 4-10 days, feeding and growing. In wet breeding areas (resident's wounds) full grown larvae climb to the surface or sides of the breeding media before pupating. Per interview of Z1 and E15 R2's right leg and right heel and dressings were filled with maggots approximately 1/4 inches in length.</p> <p>R2 was transferred from the facility on 12/06/04 to a local hospital because of elevated temperature, "Sepsis".</p>	F9999		