STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146102	A. BUILDING _____ B. WING _____	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	**2170 WEST NAVAJO DRIVE FREEPORT, IL 61032**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Validation survey for Subpart U, Alzheimer Unit The facility is in compliance with Subpart U, 77 Illinois Administrative Code Section 300.7000	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make available the most recent survey, and post a sign concerning its availability and location. This effects all 78 residents. The example includes: On 9/13/2011 at 9:30 AM E2 (Assistant Administrator) presented a binder that E2 identified as Federal Surveys. The contents shows the most current Certification survey is dated 8/19/2010 and the (Federal Form 2567) was not contained in the binder. E2 confirmed at the time of the review, the most current Certification survey was not in the binder. On	F 167		9/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 167	Continued From page 1 9/14/2011 at 10 AM, during the group meeting residents expressed that they did not know where the most current Federal Survey results (2567s) were located, and were unaware they should be readily available. During the tour on 9/13/2011 at 9:30 AM, no information posting was available concerning the location of the most current surveys. The Federal form 672 identifies 78 residents in certified beds.	F 167		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		9/28/11

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F 225	Continued From page 2 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate and report allegations of abuse, and an injury of unknown origin for 1 of 16 residents in the sample (R12) reviewed for abuse/neglect, and 1 resident (R18) in the supplemental sample. The findings include: 1. On 9/13/2011 E1 (Administrator) presented one report of abuse. E1 stated, "This is the only allegation reported this year." The report shows the allegation was made on 9/7/2010 by R18, and was not reported to the Department until two days later (September 9, 2010). On 9/15/2011 at 8:20 AM, E1 stated, "I am unable to find the investigation. It happened a year ago, right after the annual survey". The facility's report does not contain the name of the alleged abuser, or any of the interviews, or the circumstances surrounding the allegation or determination of it's validity.	F 225		

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F 225	Continued From page 3 2. A Physician Notification Sheet dated 6/13/2011 shows R12 sustained a 10 cm. long scratch of unknown origin discovered at midnight bed check. Located on the right back below the scapula extending towards right side. Some sanguinous drainage was noted on bed-sheets. The laceration not bleeding at time of discovery. Wound cleansed and petroleum jelly applied. The nurse practioner was called and gave an order for 'continue above treatment, may cover with dressing if drainage present.'. Resident Progress Notes dated 6/13/2011 at 12:52 AM, document, "A 10 cm long scratch to resident's mid back and rib region. Not bleeding at this time put dried bloody drainage found on sheets. Edges of scratch are well approximated and only open in few areas along the 10 cm scratch". The Minimum Data Set of 6/14/2011 identifies R12 as being totally dependent with 2 assist in the areas of transfers and ambulation, dressing, and hygiene. Extensive assistance of one for eating. R12 is assessed as having limited range of motion on both sides of the body, both upper and lower extremities. The Facility's Policy No. 1.13, Subject Prohibition dated 12/04, states: 2. If the incident involves alleged abuse or neglect, the Administration shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or neglect by telefaxing to the Department a copy of a report of the incident completed within 24 hours after the incident becomes known.	F 225		

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F 225	Continued From page 4 C. Investigation 1. Interviews with all involved parties or potential witnesses will be completed. If possible at least two interviewers shall be present for each witness interview. At least one interviewed shall take notes. 2. Signed statements from those persons who saw of heard information pertinent to the incident shall be obtained. 3. The Administrator shall keep copies of all notes from the interviews conducted by the Administrator of other facility interviewer in the course of the investigation. F. Injuries of Unknown Sources- The facility shall notify IDPH of any injury of unknown source, which has or is likely to have a significant effect on the heath, safety or welfare of residents. Notification shall be made by phone call to the Regional Office within 24 hours of discovery, a copy of the report of the incident concerning the injury shall be faxed to the Department within 24 hours of discovery.	F 225		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		9/30/11

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F 272	Continued From page 5 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the date and location of the assessments used in the Care Assessment Area (CAA) for 9 of 16 residents whose Resident Assessment Instrument (RAI) were reviewed (R18, R26, R53, R62, R80, R81, R82, R40, R71). The findings include: 1. R71's RAI, CAA dated 4/8/2011 lacks the locations and dates of the CAA Information in the	F 272		

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F 272	Continued From page 6 areas of incontinence, falls, nutrition, and pressure sores. At present R71 has a stage II on her heel. 2. R80's RAI, CAA dated 11/19/10 lacks the locations and dates of the CAA Information in the areas of cognition, ADL, incontinence, behavior, falls, pressure sore/Braden. 3. R81's RAI, CAA dated 11/23/2010 lacks the locations and dates of the CAA Information in the areas of cognition, incontinence, nutrition. On 9/13/2011 at 1:45 PM, E3 (Director of Nursing) verified the lack of the dates and location of the CAA information. E3 verified that some of the CAA information is based on certified nurse aide (CNA) charting for several days, and not assessments. Further examples of CAA Information that were undated or lacked the location of the information used, and were based on CNA charting include: R18, R26, R53, R62, R82, R40.	F 272		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record	F 314		9/29/11

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Review, the facility failed to monitor, document and prevent a stage II pressure ulcer from progressing to a Stage 3 which resulted in the wound requiring debridement, ultrasound and electronic stimulation treatment (R18). The facility failed to prevent and identify a Stage 3 pressure ulcer. (R26)

This applies to 2 of 7 residents (R18, R26,) reviewed for pressure ulcers in the sample of 14.

The findings include:

1. R18 is a 96 year old female resident admitted post Right Hip Fracture/Repair according to the Computer Generated Diagnosis List. The Minimum Data Set (MDS) dated 8/6/11 identified R18 as having no cognitive deficits. The MDS also shows R18 was admitted for rehabilitation and plans to return to the community.

On 9/13/11 at 11:50 AM, R18 was observed in the Physical Therapy Department lying on her left side receiving Electronic Stimulation treatment to her right heel wound. The wound was noted to be healing from the inside out. The deeper center tissue was beefy red with granulation tissue forming on the wound margins.

The documentation of R18's heels began on 7/2/11. On 7/2/11, the Skin Integrity Event documents a Stage 2 Pressure Ulcer with Granulation Tissue and Light drainage. The Nursing Note of 7/2/11 documents: "Resident has a blister that fluid has drained from on R (right) heel. Area measured 5.1 X 2.9 (no depth documented). Applied Optifoam dressing to absorb drainage and additional pillows as well as

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heel protectors." On 7/6/11, the Nursing Note showed the right heel wound measured 4 cm X 3 cm (no depth documented). The Nursing Note documents a transparent dressing was applied.
The 7/7/11 event documentation identified the wound as a Stage 2 with moderate serous drainage. No further measurements or documentation on the wound status was available until 7/20/11 (14 days later). The documentation found was as follows:
7/20/11 Event Documentation identified the right heel wound as a Stage 3 with light purulent drainage and Necrotic Slough.
7/27/11 Event Documentation identified the right heel wound as a Stage 3 with light purulent drainage and Erythema to surrounding tissue.
7/27/11 , 7/28/11 and 7/29/11 PT (Physical Therapy) Treatment Note showed "wound cleansed with 4 X 4's and wound care cleanser, removing non-viable tissue as able."
8/10/11 Event Documentation (13 days later) - Stage 3 with light sero-sanguineous drainage and surrounding wound tissue Maceration.
8/15/11 PT Progress Note - Removed devitalized tissue.
8/23/11 PT Progress Note - Removed devitalized tissue, debridement as needed to remove non-viable tissues.

During the interview on 9/14/11 at 9:40 AM, E5 shared the following time line of events, notifications, documentation and order changes related to R18's Pressure Ulcer:
E5 noted draining blister on 7/2/11 to R18's right heel. E5 notified the Nurse Practitioner and an order was obtained for an occlusive dressing to be applied and changed every 5 days.
7/22/11 - dressing changed to Calcium Alginate

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and Hydrocolloid dressing "because the wound wasn't healing. A protein supplement was also started two times a day to promote healing and because R18 was losing weight."
7/26/11 - started ultrasound with Physical Therapy with resident received through 8/26/11.
8/16/11 - dressing changed to Santyl and Border Gauze.
8/29/11 - Electronic Stimulation started and continues to present.

E5 stated Braden Scales (Risk Tool for development of Pressure Ulcers) are only done by the nurse on admission to the facility. R18's Braden Scale score was 13 which is "moderate risk" for development of pressure ulcers.

The facility's Protocol for Pressure Ulcer Prevention and Treatment, revised 03/04, states the objective as "To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure ulcer that might develop." The Principles show: "a skin risk assessment is completed on all residents upon admission, and quarterly thereafter." Under number 7, the policy states, "Assess the pressure ulcers(s) for location, size (measure length, width, and depth), tunneling, drainage, color, odor, and necrotic tissue. Weekly individual treatment report will be done and put on clinical chart."

2. R26 is an 89 year old male resident with diagnoses to include Cerebral Vascular Accident with Left Hemiparesis, Dementia, Coronary Artery Disease, Hyperlipidemia and Thyroid Cancer according to the History and Physical Report dated 10/6/09.

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F 314	Continued From page 10 A physician notification fax dated 7/12/11 identified "area previously fluid filled and swollen now is open. Open area 1.5 cm X 3 cm X <0.1 cm. Center with slough. Below wound area red and irritated." On 7/13/11, the Event Pressure Ulcer Documentation shows a Stage 3 pressure ulcer to right inner buttock with Necrotic Slough and light cloudy sero-sanguineous drainage. Erythema to surrounding tissue. Factors present included immobility and history of pressure ulcers. R26's Braden Scale dated 7/10 identified him as low risk for development of pressure ulcers. The Pressure Ulcer Event Documentation showed the following changes in wound characteristics: 7/20/11 - 2.4 cm X 0.4 cm (no depth) with Necrotic Slough and Purulent drainage; 7/27/11 - 1.5 cm X 2.8 cm (no depth) with purulent drainage and Erythremia to surrounding tissue; 8/9/11 - wound edges pink and tender 8/17/11 - mild pain 8/24/11 - mild pain	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		9/28/11

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F 322	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to check the placement of a gastrostomy tube (G-tube) before administering medication and flushing with water. This is for 1 of 2 residents reviewed with G-tubes in the sample of 16. (R6) The findings include: On 9/14/11 at 11:25 AM, E5 (Licensed Practical Nurse), administered 15 ml of Potassium Chloride 10% diluted in 120 cc of water into R6's G-tube. E5 followed the medication with 250 cc of water. E5 did not check for placement of the G-tube prior to giving the medication and water flush. E5 stated, "I don't check for placement. It's always gone in just fine." On 9/14/11 at 11:50 AM, E3 (Director of Nursing) said G-tube placement should be checked prior to administering any feeding, medication, or water flush. The facility's January 2006 Gastrostomy Feedings policy states, "Check placement of G-tube by placing stethoscope over the stomach, and then injecting air into the tube with syringe and listening for the airflow into the stomach or by aspirating stomach content."	F 322		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		9/28/11

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F 441	Continued From page 12 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to institute and maintain an infection control log to track and trend	F 441		

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F 441	Continued From page 13 infections. The facility failed to institute infection control techniques when changing a pressure sore dressing for R31. This effects all 78 residents in the facility. The findings include: 1. On 9/14/2011 at 2 PM, the infection control log was requested. E3 (Director of Nursing) presented for review. The Weekly Infection Control Report began 3/7/2011. The report shows, the identification of pressure sores, current treatments and measurements. The Weekly Infection Control Report also contains information on type and use of antibiotics, residents discharged to the hospital, and residents with catheters, and skin wound conditions. The facility does not track or trend infections to include, identifying the organism of the infection, lab reports and specific areas of resident location. On 9/14/2011 at 2 PM, and on 9/15/2011 E2 stated, "We do not have an infection control log to identify the organism of the infections, so (we) are unable to track and trend infections." The facility's policy titled Purpose of the Infection Control Committee, Policy 1.1, dated 8/2009 reads: The infection control committee shall develop a practical system of reporting evaluating, and keeping record of infections among residents and personnel in order to provide an indication of an outbreak level of all nosocomial infections, to trace the source of infection (direct and indirect transmission), review both individual and institutional factors and to identify potential outbreak situations.	F 441		

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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) COMPLETION DATE
F 441	Continued From page 14 Responsibility of the infection Control Committee: 2. Distinguish to the best of its ability between infection acquired in the facility and that acquired outside the facility. 3. Set guidelines for corrective and effective nosocomial infections surveillance. The Infection Control Committee should do the following: 3. Review system for reporting, evaluation and keeping records of infections among residents and personnel in order to provide an indication of the endemic level of all nosocomial infections, to trace source of infection and to identify epidemic or potential epidemic situations. 2. On 9/14/11 at 9:00 AM, E5 (Licensed Practical Nurse) removed the dressing from R31's coccyx area by holding the buttock skin taut to remove the tape. The removed dressing had a small amount of light tan drainage. E5 then used her gloved finger to spread antibiotic ointment on R31's open area on the coccyx. E5 used the same finger to spread antibiotic ointment on R31's open area on the left buttock. E5 then applied the clean dressing and anchored it with tape. On 9/15/11 at 9:10 AM, E5 affirmed that gloves should be removed and hands washed after removing dirty dressings and before applying clean treatments. The facility's Infection Control policy and procedure, on page 4 of 8 identifies Transmission-based Precautions: Hand washing is the foundation of controlling	F 441		

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	146102	A. BUILDING _____ B. WING _____	09/16/2011

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F 441	Continued From page 15 infectious disease. Personnel must wash their hands when coming on duty; when they are visibly soiled; when they are between residents; before and after they blow their nose; after eating or off break; after they handle dressings, urinals, bedpans, needles, or syringes; after toileting use and when they complete duty. Gloves disposable in nature will be worn unless sterile gloves are necessary. Gloves will be changed after direct contact with resident's secretions or excretions, even if care of resident has not been completed. The Census and Condition form completedy by the facility during the survey identifies 78 residents in the facility.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210d)5) 300.3240a) 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having	F9999		

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F9999	Continued From page 16 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on Observation, Interview and Record Review, the facility failed to monitor, document and prevent a stage II pressure ulcer from progressing to a Stage 3 which resulted in the wound requiring debridement, ultrasound and electronic stimulation treatment (R18). The facility failed to prevent and identify a Stage 3 pressure ulcer. (R26) This applies to 2 of 7 residents (R18, R26) reviewed for pressure ulcers in the sample of 14. The findings include: 1. R18 is a 96 year old female resident admitted post Right Hip Fracture/Repair according to the Computer Generated Diagnosis List. The Minimum Data Set (MDS) dated 8/6/11 identified R18 as having no cognitive deficits. The MDS also shows R18 was admitted for rehabilitation and plans to return to the community. On 9/13/11 at 11:50 AM, R18 was observed in the Physical Therapy Department lying on her left side receiving Electronic Stimulation treatment to	F9999		

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her right heel wound. The wound was noted to be healing from the inside out. The deeper center tissue was beefy red with granulation tissue forming on the wound margins.

The documentation of R18's heels began on 7/2/11. On 7/2/11, the Skin Integrity Event documents a Stage 2 Pressure Ulcer with Granulation Tissue and Light drainage. The Nursing Note of 7/2/11 documents: "Resident has a blister that fluid has drained from on R (right) heel. Area measured 5.1 X 2.9 (no depth documented). Applied Optifoam dressing to absorb drainage and additional pillows as well as heel protectors." On 7/6/11, the Nursing Note showed the right heel wound measured 4 cm X 3 cm (no depth documented). The Nursing Note documents a transparent dressing was applied. The 7/7/11 event documentation identified the wound as a Stage 2 with moderate serous drainage. No further measurements or documentation on the wound status was available until 7/20/11 (14 days later). The documentation found was as follows:
7/20/11 Event Documentation identified the right heel wound as a Stage 3 with light purulent drainage and Necrotic Slough.
7/27/11 Event Documentation identified the right heel wound as a Stage 3 with light purulent drainage and Erythema to surrounding tissue.
7/27/11 , 7/28/11 and 7/29/11 PT (Physical Therapy) Treatment Note showed "wound cleansed with 4 X 4's and wound care cleanser, removing non-viable tissue as able."
8/10/11 Event Documentation (13 days later) - Stage 3 with light sero-sanguineous drainage and surrounding wound tissue Maceration.
8/15/11 PT Progress Note - Removed devitalized

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tissue.
8/23/11 PT Progress Note - Removed devitalized tissue, debridement as needed to remove non-viable tissues.

During the interview on 9/14/11 at 9:40 AM, E5 shared the following time line of events, notifications, documentation and order changes related to R18's Pressure Ulcer:
E5 noted draining blister on 7/2/11 to R18's right heel. E5 notified the Nurse Practitioner and an order was obtained for an occlusive dressing to be applied and changed every 5 days.
7/22/11 - dressing changed to Calcium Alginate and Hydrocolloid dressing "because the wound wasn't healing. A protein supplement was also started two times a day to promote healing and because R18 was losing weight."
7/26/11 - started ultrasound with Physical Therapy with resident received through 8/26/11.
8/16/11 - dressing changed to Santyl and Border Gauze.
8/29/11 - Electronic Stimulation started and continues to present.

E5 stated Braden Scales (Risk Tool for development of Pressure Ulcers) are only done by the nurse on admission to the facility. R18's Braden Scale score was 13 which is "moderate risk" for development of pressure ulcers.

The facility's Protocol for Pressure Ulcer Prevention and Treatment, revised 03/04, states the objective as "To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure ulcer that might develop." The Principles show: "a skin risk assessment is completed on all residents upon

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admission, and quarterly thereafter." Under number 7, the policy states, "Assess the pressure ulcers(s) for location, size (measure length, width, and depth), tunneling, drainage, color, odor, and necrotic tissue. Weekly individual treatment report will be done and put on clinical chart."

2. R26 is an 89 year old male resident with diagnoses to include Cerebral Vascular Accident with Left Hemiparesis, Dementia, Coronary Artery Disease, Hyperlipidemia and Thyroid Cancer according to the History and Physical Report dated 10/6/09.

A physician notification fax dated 7/12/11 identified "area previously fluid filled and swollen now is open. Open area 1.5 cm X 3 cm X <0.1 cm. Center with slough. Below wound area red and irritated." On 7/13/11, the Event Pressure Ulcer Documentation shows a Stage 3 pressure ulcer to right inner buttock with Necrotic Slough and light cloudy sero-sanguineous drainage. Erythema to surrounding tissue. Factors present included immobility and history of pressure ulcers. R26's Braden Scale dated 7/10 identified him as low risk for development of pressure ulcers.

The Pressure Ulcer Event Documentation showed the following changes in wound characteristics:
7/20/11 - 2.4 cm X 0.4 cm (no depth) with Necrotic Slough and Purulent drainage;
7/27/11 - 1.5 cm X 2.8 cm (no depth) with purulent drainage and Erythremia to surrounding tissue;
8/9/11 - wound edges pink and tender
8/17/11 - mild pain

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F9999	Continued From page 20 8/24/11 - mild pain (B)	F9999		