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F9999	. FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS

300.610a)
300.1210b)
300.1210d)5)
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. (B)

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

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as

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indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility neglected to accurately assess, aggressively treat, follow physician's orders, turn and reposition, provide adequate pressure relief and follow their policy and procedure for pressure ulcers for one of four (R14) residents reviewed with pressure ulcers in the sample of 18. These failures resulted in R14 developing multiple Stage II and Unstageable pressure ulcers to his left and right lower extremities.

Findings include:

1. The Facility's Policy "Skin Care, Assessment and Maintenance of" dated 9/20/12 documented "Skin assessment shall be performed at admission and quarterly utilizing Braden Risk Assessment Scale. All residents who are unable to turn themselves shall be turned every two (2) hours unless contraindicated by physician's order. An impairment in skin integrity shall be documented " The Policy continued to document "The effectiveness of wound care treatment will be reassessed on a weekly basis by the Director

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of Nursing and/or physician as needed." The Policy continued to document under the section of Procedure "2. Check braces, traction, casts, splints, bedding, restraints and bed rails for contact with skin/irritation of skin. " The Policy continued to document under the section Decrease Pressure "Apply elbow/heel protectors when desired or ordered."

The Facility's Policy "Facility Policy: Management of Wounds" not dated documented under the section "3. Determining the Wound Etiology: a. Pressure Ulcers - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged to determine the extend of tissue damage. Treatment of the ulcer, dietary management, management of tissue loads and interventions to improve tissue tolerance to pressure, friction and shearing forces are critical components."

The Facility's Policy "Treatment of Pressure Ulcers" (undated) documented, "3. Signs of healing (i.e., decreased size and depth of ulcer, decreased drainage) should be evident after 2 to 4 weeks of treatment. Notify physician if any evidence of deterioration is noted."

2. R14's Nurse's Note dated 10/4/12 documented he was found on the floor in front of his wheelchair. R14's Nurse's Note dated 10/6/12 documented R14 began complaining of severe pain to his right leg. R14 was sent to the hospital. R14's Xray Report dated 10/6/12 documented he had a Right Femur Fracture.

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R14's Nurse's Note dated 10/6/12 at 11:00 AM documented "Resident returned from hospital, report was given to this nurse that resident does have a R (Right) Femur Fracture. Resident R leg placed in an immobilizer." R14's Physician's Order dated 10/6/12 documented "Return from Hospital c (with) immobilizer in place".

R14's Nurse's Note dated 10/9/12 documented "Spoke with (Z3, Physician) . Order rec'd (received) to assist res (resident) OOB (Out Of Bed) c (with) (mechanical lift) & must wear immobilizer @ (at) all times to RLE (Right Lower Extremity)."

The facility's Weekly Pressure Ulcer Surveillance Report dated 10/3/12 documented he had one area to his left great toe and one area on his left 2nd toe. This report documented these areas a diabetic ulcers. The Weekly Pressure Ulcer Surveillance Report dated 10/10/12 documented he continued to have these two areas.

R14's Nurse's Note dated 10/14/12 documented "Daughter here for visit was concerned c (with) residents leg turning out. Is concerned that resident may have injury to R (Right) ankle. Assessment completed ." An order was obtained for an Xray."On 10/15/12 the Xray result documented R14 had an incomplete fracture of the right ankle.

R14's Nurse's Note dated 10/16/12 documented he developed a new pressure area on his right buttock. The note documented "CNA (Certified Nurse's Assistant) reports res (resident) has sore bottom. Entire area to (upper) coccyx, L (left)

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medial buttock and R medial buttocks c (with) red superficial openings. Area measures proxy (approximately) 10 cm (centimeters) x 10 cm including peri wound redness. MD notified of this info and TX (treatments)." On 10/16/12, Z1, R14's Physician, ordered staff to cleanse bilateral buttocks with wound cleanse and to apply Vasolex every shift and as needed.

The facility's Weekly Pressure Ulcer Surveillance Report dated 10/17/12 documented he had a facility acquired Pressure Ulcer with an onset date of 10/16/12 to his right buttocks measuring 4.0 cm by 3.0 cm by 0.1 cm.

10/18/12 's Nurse's Note dated 10/18/12 documented "Spoke to (Z1) Fx (Fracture) of R (Right) Fibula 0 (not) complete. OK to continue use of ankle immobilizer c (with) R leg immobilizer. MD states spoke c (with) daughter R/T (related to) this also. 1350 Brace applied as ordered."

R14's Nurse's Note dated 10/22/12 at 10:30 AM documented "In bed. Awake & talking c (with) wife. Pleasant. Brace on R (Right) leg & R (Right) ankle."

R14's Nurse's Note dated 10/23/12 documented "Orders rec (received) to (change) A & D to buttocks q shift to Calazime oint (ointment) Q (every) shift and PRN (as needed)." However, R14's Physician's Order dated 10/23/12 documented "Cleanse RT (Right) buttock with wound cleanser, apply skin prep & DuoDerm to open area, change every 72 hours."

R14's Nurse's Note dated 10/24/12 at 6:00 PM

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F9999	Continued From page 48 documented R14 had multiple newly developed pressure ulcers. The note documented "nurse in room for wkly skin assess (and) R foot brace removed (and) nurse observed a 3 x 1/2 cm dk (dark) purple area with 1/2 cm red area around right heel. Also observed a 9 x 3 1/2 cm light pink bruise to R lateral ankle c (with) scabbed center. (Upper) heel a 1 1/2 cm x 1 1/2 cm lgt (light) pink area noted. 0 (not) opened. (Below) that area a 1 1/2 cm x 1.9 cm light pink area noted, 0 (not) opened. L (Left) heel soft/mushy to touch. leg brace removed (and) nurse observed a 9 x 8 x 6 cm dk (dark) purple bruise behind knee in bend. Area marked c (with) marker at widest to observe if area gets lger (larger). 6:30 PM DON (Director of Nurses) to room. Will leave ankle brace off (and) use soft heel protectors. MD made aware of findings. " R14's Physician's Orders, dated 10/24/12 documented "Wipe Lt (Left) heel with Allkare & apply DuoDerm every 72 hrs (hours) and as needed." R14's Physician Order dated 10/24/12 documented "Cleanse Right Heel with Wound Cleanser, apply Allkare twice daily & as needed." The facility's Weekly Pressure Ulcer Surveillance Report dated 10/24/12 documented he had the following new facility acquired pressure ulcers: An area on his right buttock measuring 2 cm x 3 cm by 0.4 cm; an area on his right heel measuring 3.0 cm by 0.5 cm; an area on his Right achilles measuring 1.5 cm by 1. 5 cm and another area (location not identified) measuring 1. 5 by 1.9. This documentation does not correspond with the documentation made in the nurse's notes at 6:00 PM. The Report does not document the area identified in the nurse's notes under his right knee.	F9999		

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F9999	Continued From page 49 On 10/24/12, E8, Licensed Practical Nurse documented on FAX to Physician report "Nurse observed res to have 9 x 8 x 6 cm dk (dark) purple bruise to back of R knee bend. Also noted lgt (light) yellow bruise to R (Right) shin. On R (Right) a 3 x 1/2 cm dk (dark) purple area c 1/2 cm red around. Area cleansed (and) Allkare applied. May we leave foot brace off (and) use heel protectors? Res also noted to have L heel soft and mushy. Area cleansed (and) DuoDerm applied. Can we cont TX. Res also noted to have a 1 1/2 cm dk purple bruise and a 1 1/2 x 1.9 cm dk bruise on Achillis heel. 0 (not) opened. Can we cont Allkare to R heel + (and) DuoDerm to L (left heel c heel protectors. " On 10/25/12 at 2:59 PM, Z7, Z1's Physician's Assistant, returned the fax and documented "YES" regarding the above questions. R14's Physician's Order, dated 10/24/12 documented R14 was to have heel protectors to his bilateral feet every shift. Although Z7 ordered the removal of the foot brace via fax, R14's Physician's Order dated 10/25/12 documented "R (Right) leg immobilizer to R (Right) leg for a fx (fracture of femur - on @ all x's (times). R ankle support to R ankle on @ all x's. Order clarification." R14's Care Plan was revised on 10/25/12 and documented "R (Right) ankle support on at all times." R14's Physician's Order dated 10/30/12 documented "Air soft cast to RLE (Right Lower Extremities) " His Treatment Administration	F9999		

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Record undated documented "Air soft cast to R (Right) ankle on @ all x's."

The facility's Weekly Pressure Ulcer Surveillance Report dated 10/31/12 documented R14 had an area on his right heel measuring 1.5 cm by 3. 4 cm with eschar. This area had increased in size and became necrotic from when it was first acquired on 10/24/12. The Surveillance Report documented a pressure ulcer his right buttock measuring 1.7 cm by 1.7 cm by 0.1 cm. No other pressure areas were documented on this form.

R14's Physician's Order dated 11/1/12 documented "1) Cleanse L (left) great toe & L 2nd toe c (with) wound cleanser. Apply silvadene crm (cream) & leave OTA (Open to Air) daily. 2) DC (Discontinue) Alazine oint (ointment) 3) cont Allkare wipe to L heel (DC) DuoDerm). 4) Cleanse R heel c wound cleanser. Apply Vasolex & cover c DD (Dry Dressing. (Change) duly (daily) and PRN."

R14's Nurse's Note dated 11/7/12 at 8:00 PM documented he had developed new pressure ulcers. "Wkly skin assess done. Res (Resident) noted to have 3 open area to R (Right) lateral (lower) leg/ankle. 1) 2 cm x 2 1/2 cm area, 2) 1 cm x 1/2 cm c black center (and) yellow around (and) under that close to ankle 3) a 1 1/2 cm x 0.9 cm area noted. foot swollen. All area are red around (and) warm. MD made aware. 8:30 PM Res turned to L (left) side (and) pillow placed behind. Res keeping R (right) leg off bed. R (Right) knee immobilizer in place. 3 AM R (Right) leg ulcers as described above. Small amt (amount) of serosanguinous drainage noted on pillow care (lower leg to elevate) so area

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cleansed (and) dressed. Immobilizer intact to leg removed (and) skin observed. 0 (no) new areas of concern. Hydrocodone earlier this shift for leg pain."

R14's Physician's Order dated 11/9/12 documented "May be seen by (wound consultant) for consult et (and) tx (treatment).

The facility's Pressure Ulcer Surveillance Report dated 11/12/12 documented R14 had four areas. The Report documented he had an opened areas to his right heel, R lateral ankle, left great toe and left second toe but did not document the Stages, Sizes or Status of these areas. The Surveillance Report had no documentation regarding the pressure areas to his right buttock, behind his right knee, and his right lateral leg.

Z2's, Wound Management Nurse Practitioner, note dated 11/13/12 documented the following areas:
Wound #1: Pressure Ulcer on Lower Right Lateral Leg measuring 10 cm by 3. 3 cm. She documented the pressure ulcer had moderate slough, moderate necrotic tissue, moderate yellow drainage with erythema.
Wound #2: Pressure Ulcer on Lower Right Distal Leg measuring 2.2 cm by 2.2 cm with moderate slough, a yellow wound base color and a small amount of yellow drainage. The "Notes" section for Wound #2 documented "Protection from splint/immobilizer from wounds was advised."
Wound #3: Pressure Ulcer Great Left Toe measuring 0.7 cm by 0.5 cm with minimal slough and no necrotic tissue.
Wound #4: Pressure Ulcer to the Right Buttock measuring 2.0 cm by 1.8 cm depth 0.1 cm. The

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F9999	Continued From page 52 "Notes" section for Wound #4 documented "To avoid pressure on buttocks, turning pt every 2 hours or more frequently if needed. Stressed importance of keeping dry and clean. May need to change his dressing more often due to incontinence of stool. Wound #5: Pressure Ulcer to Left Buttock measuring 2.0 cm by 2.0 cm by 0.1 cm. Z2's note dated 11/20/12 documented and described the following seven pressure ulcers: Wound #1:Pressure Ulcer on Lower Lateral Leg measuring 10. cm x 5.0 cm with moderate slough and a moderate amount of yellow drainage. Wound #2:Pressure Ulcer on Lower Right Distal Leg measuring 0.6 cm by 0.4 cm with moderate amount of slough with a small amount of yellow drainage. The "Notes" section for Wound #2 documented "Protection from leg stabilizer recommended." Wound #3 :Pressure Ulcer on the Left Great Toe measuring 0.6 cm by 0.4 cm by 0.2 cm. Wound #4: Pressure Ulcer on Right Buttock measuring 1.4 cm x 0.8 cm x 0.1 cm. Wound #5: Pressure Ulcer on Left Buttock measuring 2.5 cm x 0.4 cm x 0.1 cm . Wound #6: An Unstageable Pressure Ulcer to Right Heel measuring 2.5 cm x 2. 7 cm x 6.8 cm. This wound was partially covered with black eschar. This Pressure Ulcer was not documented on the 11/13/12 Wound Management note. Wound #7: An Unstageable Pressure Ulcer on the Right Lateral Leg measuring 1.2 cm x 1.3 cm. with minimal slough and a small amount of yellow drainage. Z2's "Notes" section for Wound #7 documented "Protect lower leg from immobilizer on lower leg with gauze dressing." The Pressure Ulcer was not documented on the 11/13/12	F9999		

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Wound Management Note.

R14's Nurse's Note dated 11/27/12 documented "(Z1) here - Rev (Reviewed) chart and saw res- ordered recd (received) to DC (discontinue) splints & Xray . X-rays scheduled for today." R14's Physician's Order dated 11/27/12 documented "D/C both splints."

Z2's Wound consultant note dated 11/28/12 documented the following seven pressure ulcers:
Wound #1: Pressure Ulcer on Right Lower Lateral Leg measuring 9.5 cm x 5.0 cm fully covered black eschar. The "Notes" section for this wound documented "I have discussed importance of keep pressure off of his lateral side of leg with pt. (patient) nurse and DON (E2). He was not wearing the brace today and I have advised alternative to this, leaving the brace off of his lower leg to prevent pressure to sites. I have suggested have PT (Physical Therapy) see him and suggest a pressure relieving device, such as foam or other alternative to help position his lower leg to keep him from rolling his leg out to his lateral side."
Wound #2: Pressure Ulcer on Right Lower Distal Leg measuring 1.9 cm x 1.23 cm with a moderate amount of slough with a small amount of drainage.
Wound #3: Pressure ulcer to Left Great Toe measuring 0.9 x 0.5 cm. with minimal slough and a small amount of yellow drainage. She documented this wound had deteriorated.
Wound #4: Pressure Ulcer to the Right Buttock Measuring 1 cm x 0.8 cm x 0.1 cm
Wound #5: Pressure Ulcer to the Left Buttock was healed.
Wound #6: Unstageable Pressure Ulcer to Right

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F9999	Continued From page 54 Heel measuring 1.7 x 2.7 cm partially covered with black eschar. Wound #7: Unstageable Pressure Ulcer to the Right Lower Leg measuring 1.3 x 1.3 cm with minimal slough and small amount of yellow drainage. On 11/29/12 at 10:12 AM an interview was conducted with E9, Certified Nurse's Assistant (CNA) in R14's room. E9 asked R14 if she could show surveyor his leg. E9 removed the covers from R14's lower extremities. R14's was lying on his back and gauze covered his left lower extremity. E9 stated "It doesn't look good." On 11/29/12 at 10:20 AM, a interview was conducted with E10, Licensed Practical Nurse (LPN). She stated R14 had sustained fractures to his right knee and ankle. E10 stated "He also has bad pressure sores on his leg from the immobilizer boot." At 11:15 AM, E10 and E9 were treating R14's pressure ulcers. During an interview, E10 stated R14's pressure ulcers had gotten much worse although they were treating them with Santyl daily. E10 removed the gauze from R14's right leg. The areas identified on Z2's Wound Report were observed. E10 stated R14 initially has a small opened area to his right lateral leg. During an interview with E9 during R14's treatment, E9 stated "He wore that cast 24/7. We could loosen it to adjust but it couldn't be removed." Throughout this observation, R14 was lying on his back with no heel protectors in place. On 11/29/12 at 10:12 AM, 10:20 AM, 11:15 AM, 12:22 PM, 12:41 PM, and 1:04 PM, 1:25 PM, 1:33 PM, R14 was observed lying on his back with no heel protectors in place. At 1:45 PM, R14	F9999		

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	145475	A. BUILDING ______ B. WING ______	C 12/11/2012

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continued to lying on his back with heel protectors on. R14 had no significant change in position for over three hours.

On 11/30/12 at 9:35 AM, an interview was conducted with Z2 regarding R14's pressure ulcers. Z2 stated she began seeing R14 on 11/13/12. She stated she was concerned about R14's leg immobilizer. Z2 stated "My concerns are his right leg rolls causing pressure from the immobilizer. There is no way while his wearing the immobilizer to get pressure off his leg. I told them we've got to do something about that." When questioned if she had any recommendations, Z2 responded "Well, because of fracture I am aware he needed an immobilizer but it does cause pressure. You are aware he had two new necrotic area on his right leg. In addition, his right heel is necrotic."

On 11/30/12 at 9: 55 AM an interview was conducted with Z1 regarding R14's pressure ulcers. Z1 stated he had been at the facility on Tuesday of this week (11/27/12). Z1 stated "They asked me to take a look at his pressure sore. They said he had a little sore. Did you look at it?" Surveyor responded R14's skin condition had been observed. Z1 continued "It is an extensive area. I looked at it and said Good Lord. Get those splints off of him." Z1 was questioned regarding if facility staff had notified him of the condition of R14's skin and he responded "No. When I looked at it all I could think is what a liability to the facility." Z1 responded it would be difficult to heal R14's pressure ulcers. Z1 stated "Now, I was told he had a pressure sore prior but it was not described to me at the extent it was when I saw it. I was not aware of the degree of

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the wounds."

On 12/5/12 at 10:15 PM, an interview was conducted with E2, Director of Nurse's. E2 stated on 10/24/12, E8, LPN, called her into R14's room to look at his leg. E2 stated R14 had a deep tissue injury and she told E8 to remove the splint. E2 stated "It was my intention to have those splints dc'd. I'm not sure why they weren't." E2 stated " You would have to talk to E8 regarding what the physician said regarding these splints." E2 stated R14's right leg rolled inward. E2 stated "All immobilizers would cause pressure to his leg."

On 12/5/12 at 2:20 PM, an interview was conducted with E2. She provided the fax from Z7, Z1's Physician Assistant. This fax documented the right ankle splint could be discontinued. E2 stated E8 did ask for the splint to be removed and Z7 agreed. When asked why this was not done, E2 stated "I don't know."

(A)

300.1210b)
300.3240a)

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

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess, evaluate and timely treat one of four residents (R14) reviewed for pain management in the sampleof18. This failure resulted in R14 to not be able to sleep, limited his daily activities, and having increased pain during dressing changes.

Findings include:

1. The facility's "Pain Management Program" policy, updated on 8/2011, documented "A. Facility will appropriately manage pain and relieve resident suffering in a timely manner with concern for resident safety and side effects of pain treatment." The facility's policy documented "E. Reassessment should occur with the report of each new episode of pain and should focus on the identifying causes of pain, intensity, quality, (character, frequency, duration and location) and level of pain. The effectiveness of pain relief measures will be recorded using the pain rating scale. F. Pain assessment will occur according to but not limited to the following guidelines: 1.

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Upon admission; 2. Within 30 minutes after parenteral pain medication therapy; 3. within one hour after oral pain medication therapy; 4. Whenever there are changes or any new reports of pain."

2. R14's Nurse's Note dated 10/4/12 documented he was found on the floor in front of his wheelchair. R14's Nurse's Note dated 10/6/12 documented R14 began complaining of severe pain to his right leg. R14 was sent to the hospital. R14's Xray Report dated 10/6/12 documented he had a Right Femur Fracture.

R14's Nurse's Note dated 10/6/12 at 11:00 AM documented "Resident returned from hospital, report was given to this nurse that resident does have a R (Right) Femur Fracture. Resident R leg placed in an immobilizer." R14's Physician's Order dated 10/6/12 documented "Return from Hospital c (with) immobilizer in place".

R14's Physician's Order dated 10/6/12 documented "Acetaminophen/Hydrocodone (Vicodin 5/500 mg (milligrams), 1 tab, q (every) 6 H (Hours) PRN (As needed)."

R14's Nurse's Note dated 10/14/12 documented "Daughter here for visit was concerned c (with) residents leg turning out. Is concerned that resident may have injury to R (Right) ankle. Assessment completed .Pain c (with) PROM (Passive Range of Motion), unsure @ this time if pain is from fx to femur or other injury. An order was obtained for an Xray." On 10/15/12 the Xray result documented R14 had an incomplete fracture of the right ankle.

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R14's Nurse's Note dated 10/24/12 at 6:00 PM documented R14 had multiple newly developed pressure ulcers. The note documented "nurse in room for wkly skin assess (and) R foot brace removed (and) observed ulcers. The note documented "nurse in room for wkly skin assess (and) R foot brace removed (and) nurse observed a 3 x 1/2 cm dk (dark) purple area with 1/2 cm red area around right heel. Also observed a 9 x 3 1/2 cm light pink bruise to R lateral ankle c (with) scabbed center. (Upper) heel a 1 1/2 cm x 1 1/2 cm lgt (light) pink area noted. 0 (not) opened. (Below) that area a 1 1/2 cm x 1.9 cm light pink area noted, 0 (not) opened. L (Left) heel soft/mushy to touch. leg brace removed (and) nurse observed a 9 x 8 x 6 cm dk (dark) purple bruise behind knee in bend. Area marked c (with) marker at widest to observe if area gets lger (larger). 6:30 PM DON (Director of Nurses) to room. Will leave ankle brace off (and) use soft heel protectors. MD made aware of findings. "

R14's Pain Assessment, dated 10/24/12 documented R14 had pain frequently in the last five days. The Assessment documented his pain made it hard to sleep at night and limited his day to day activities. The Assessment documented R14 was able to make his needs known and had a PRN medication. The facility did not reassess R14's current pain medication regime to re-evaluate the effectiveness of controlling R14's pain throughout the night with a PRN medication.

On 11/28/12, Z2, Wound Consultant, came to the facility to treat R14's pressure ulcers. Z2 documented R14 had a large pressure ulcer on his right lateral leg covered with eschar, a pressure ulcer on his right lower distal leg, a

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pressure ulcer on his left great toe, a pressure ulcer on his right buttock, an unstageable pressure ulcer to his right heel and an unstageable pressure ulcer to his right lower leg.

On 11/29/12 at 11:15 PM, E10, Licensed Practical Nurse (LPN) and E9, Certified Nurse's Assistant (CNA) were assisting R14 with a pressure ulcer treatment. E10 removed the gauze from R14's right leg. R14 had a large pressure ulcer on his right lateral leg covered with black eschar. As E10 cleansed R14's pressure ulcer, R14 began moaning in pain and beating his hand on the mattress. R14 moaned "I need a pain pill". E10 explained to R14 she would give him a pain pill after his treatment was done. R14 again asked for a pain pill and E10 said she would get him the medication when the treatment was completed. E10 lifted R14's right leg to view the pressure area on his right heel. R14 moaned loudly and requested a pain pill. When asked where his pain was located, R14 responded "In the whole da-- leg." After E10 completed the treatment, R14 stated "next time please give me a pain pill before you change those."

On 11/29/12 at 1:45 PM, R14 was lying in bed. R14 stated he got a pain pill around 1:00 PM. When asked why he didn't get up for lunch, R14 responded "I don't want to go through that. It hurts so bad."

On 11/29/12 at 2:00 PM, E9 and E11, CNAs, entered R14's room to complete a skin assessment. R14 was lying in bed with his heel protectors on and feet propped up on a pillow. When E9 and E11 lowered R14's bed he called out in pain. When E9 and E11 would change

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F9999	Continued From page 61 R14's position or touch his leg he would call out loudly in pain. During an interview with E9 and E11, they stated anytime they touched R14 he was in pain. Both stated his pain was worse when he was up in the chair and wanted to go back to bed immediately. On 11/30/12 at 10:09 AM, R14 was lying in bed. When asked if he was going to get up today, R14 answered "No I don't think so." When asked why, R14 yelled "I hurt!" R14's Medication Administration Record (MAR) was reviewed for the month of November 2012. There was no documentation as to the intensity and duration of pain. The MAR did not document the effectiveness of pain relief measures using the pain rating scale. (B)	F9999		