Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003842	A. BUILDING: ______ B. WING ______	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW ROSE REHAB & HEALTH	410 FLETCHER JERSEYVILLE, IL 62052

(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
S 000	Initial Comments Annual Health with Complaint #1846136/IL105878 Statement of licensure violations	S 000		
S9999	Final Observations 1 of 3 Licensure 300.610a) 300.1210b) 300.1210d)1) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:
Based on record review and interview the facility failed to follow a physician's order for 1 out of 3 residents (R38) reviewed for medications in the sample of 25 causing R38 to become anxious and lose sleep due to worrying about her medications. Reasonable person concept would expect in a similar situation to suffer as a result of the noncompliance.

Findings include:

R38 was admitted to facility on 12/2/2015. Admitting diagnosis; Non-Hodgkin lymphoma, Acquired absence of right leg above knee, Anemia, Generalized anxiety disorder, Hyperlipidemia, Thyroiditis and Essential primary hypertension.

On 9/19/18 at 10:00 during the resident council meeting R38 stated that a couple of weeks ago I didn't get my medications because they ran out. I didn't get it for 3 days and I really need it. It took

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them 3 days to get my medications. My daughter called the Administrator and the Administrator didn't know that I was out of medication for 2-3 days, I am still recovering. Twice I didn't get my medication at bedtime. I told the nurse and she acted like she didn't believe me. Then they said we will look and see if it's marked off. She could mark it off and not actually give it. I am still recovering from not having my medication. I have been on that medication for a long time and I really need it. It is very unpleasant not to have my medication.

R38's Medication Administration Record (MAR) documents R38's medication Alprazolam 0.5mg, Take 1 tablet by mouth 3 times daily. On 9/10/18 at 12:00 pm and 8:00pm, on 9/11/2018 at 08:00 am, 12:00pm and 8:00pm, on 9/12/18 at 08:00am, 12:00pm and 8:00 pm.

On 9/20/2018 at 1:30 PM V10 Registered Nurse (RN) stated that she doesn't know what happened because she was on vacation but confirmed that resident missed her medication for approximately 3 days 3 x daily. V10 also stated on these dates and times a circle around the initials indicate that there was no medication given.

On 9/21/2018 at 10:30 AM R38 stated that she went without her medication for 3 days and she became very anxious and began to worry and asking staff where her medications were at. R38 also then stated that she couldn't sleep because she was getting worried maybe she wouldn't receive it any more. R38 stated that staff would blame pharmacy. R38 said she is still recovering but each day that she receives her medication she gets a little better.

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Physician's Orders Medications and Treatments dated 9/1/2018-9/30/2018 documents in part; Alprazolam 0.5mg by mouth 3 times daily.

Facility's policy and procedure Medication Administration dated 7/3/2013 documents in part; Document any medications not administered for any reason by circling initials and documenting on back of the MAR the date, the time, the medication and dosage, for any reason for omission and initials. If medication is not available for a resident, call the pharmacy and notify the and notify the physician when the drug is expected to be available. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason.

(B)
2 of 3 Licensure
300.1210b)4)
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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition

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demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

1. Based on observation, interview and record review, the Facility fails to implement measures to ensure that 1 of 2 residents (R4) reviewed for tube feeding (restore eating skills) in the sample of 25, obtains their highest practicable level of physical well-being causing resident to be nothing by mouth (NPO) for approximately 2 years. Reasonable person concept would expect in a similar situation to suffer as a result of the noncompliance.

2. Based on observations, interviews and record review the facility failed to follow recommendations of speech therapy for FEES (Fiberoptic endoscopic evaluation of swallowing) diagnostic test, reevaluate to restore eating skills, implement interventions for weight loss for 2 of 5 residents (R4, R15) reviewed for tube feedings and weight loss in sample of 25. Reasonable person concept would expect in a similar situation to suffer as a result of the noncompliance.

Findings include:

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R4 was admitted to facility on 9/15/2016. Nursing Admission Assessment dated 9/15/2016 documents; Admitting Diagnosis; Empyema, malnutrition, vocal cord dysfunction, failure to thrive, aspiration of food. Fluid restriction NPO (nothing by mouth).

The diagnosis was placed on resident in 2016, my observations of resident in 2018 was just the opposite, resident was very much thriving and wanting to eat and drink.

On 9/18/18 at 12:15 PM R4 was observed sitting outside the dining room watching the other resident's eating lunch. stated that he was hungry and that he was hoping that he gets fed soon.

R4's Minimum Data Set (MDS) of 6/8/18 documents R4 cognitively intact with a Brief Interview of Mental status of 14 with 15 being the highest.

Facility failed again to recognize that R4 was hungry and wanted to eat and drink. A reasonable person concept, one would consider going 2 years with NPO would be harmful and suffering to one's mental and psychosocial well-being.

R4's Care Plan dated 5/11/2017 documents in part; Restorative Nursing Program- Eating Problem/Need Non-compliant with NPO status. High risk for aspiration, has signed a waiver aware of risk. Takes foods and fluids when staff not looking regardless of signing a waiver in regards to noncompliance with NPO status. The Care Plan has several added dates, last being 10-19-2018. This would be considered a revision date to care plan that facility's write on care plans so that they know when it needs looked at again.

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With R4 having a history diagnosis of failure to thrive, before entering facility, but R4 has come a long way and now, wanting to eat and drink. The facility has failed to implement measures in the progress for this resident to progress him back into the community.

Approach/intervention;
Staff will provide ongoing education of harm to self and risk for PO food or fluid intake. Do not leave fluids and foods to where "R4" has assessed to them. Do not leave cans of feeding in room. Start date 5/11/2017. Report any S/SX- (signs and symptoms of) coughing, discomfort during swallowing. Care plan has several added dates the last being 10-19-2018.

R4's Nurses note dated 6/10/2018, 6/13/18, 6/17/18, 6/18/18, 6/19/18, 6/20/18, 6/22/18, 6/23/18, 6/27/18, 6/28/18, 7/2/18, 7/3/18, 7/11/18, 7/13/18, 7/15/18, 7/17/18, 7/19/18, 7/20/18, 7/23/18, 7/28/18, 7/29/18, 7/30/18, 8/1/18, 8/2/18, 8/3/18, 8/4/18, 8/5/18, 8/8/18, 8/9/18, 8/15/18, 8/17/18, 8/20/18, 8/22/18, 8/24/18, 8/25/18, 8/26/18, 8/27/18, 9/8/18, 9/9/18, 9/11/18, 9/12/18, 9/15/18 and 9/17/18 documents in part; non-compliant with NPO (nothing by mouth) status/orders.

R4's Nurses note dated 6/15/18 documents in part; New Order discontinued skilled Speech Therapy due to decreased patient participation. Nurses note dated 6/16/18 documents in part cont. to drink lemonade. Staff has been educated on aspiration risk. States doesn't care. R4's nurse's note dated 8/23/18 documents in part; (R4) has been drinking lemonade this am. Resident has been educated on aspiration risk.

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On 9/18/18 at 12:15 PM R4 was observed sitting outside the dining room watching the other resident's eating lunch. R4 stated that he was hungry and that he was hoping that he gets fed soon.

On 9/20/2018 at 09:15 AM V7 Licensed Practical Nurse MDS/Care Plan Coordinator stated, "He's been NPO since I have been here a little over 3 months." R4 drinks mountain dew and everything, he does fine when he drinks." "I only ordered that one test 2 weeks ago and it came back promising."

Speech Therapy Plan of Care dated 6/15/2018 (end of care) documents in part; Patient has vocal cord dysfunction which places him at high risk of aspiration. SLP recommends a FEES (Fiber Optic endoscopic evaluation of swallowing) vs MBSS (Modified Barium swallow study) to assess swallow function and determine safety with various consistencies.

On 9/21/18 V7 at 1:00 PM stated that a "FEES" test was not conducted because the facility had no contract with agency."

On 9/21/2018 at 1:00 PM V7 stated, "It took a care plan meeting with (R4's) family and the family requested to have the test done." "I then called the doctor and asked for the test (barium swallow)."

R4's Radiology Report dated 9/13/2018 documents in part; Modified Barium Swallow resulting in: Impression
1. Mild to moderate pooling of thin and thickened barium preparations with subtle trace penetration of thin and thickened barium from pooling.
2. There was minimal aspiration of barium with

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uncontrolled bolus from a cup seen once.
3. Overall swallowing improves with chin tuck maneuver.

Doctor visit dated 9/14/2018 documents in part Reason for visit; Visit for f/u (follow-up) recent swallow study noted. If will be able to get off TF (tube feeding). Pleasant and cooperative, voices no concerns.

On 9/24/2018 at 1:20 PM V13 Medical Doctor (MD) advised that the facility did order a barium swallow recently, and that the last time that he saw resident he recommended that the resident be seen by speech therapy. V13 stated that he was aware of resident being noncompliance with NPO order. V13 stated that resident was doing well and that he never have known resident to have developed aspiration pneumonia.

2. On 9/18/2018 at 12:15 PM R15 was fed by staff at lunch consumed 50 percent of meal. On 9/19/2018 12:13 PM R15 fed self at lunch today consumed 80 percent of meal.

On 9/21/2018 at 10:20 AM V25, Regional Nurse stated "We do monitor weight and have interventions but we will not provide to the (state agency) our weight log and information."

R15's "Dietary Notes" dated 4/20/2018 documents in part "Resident has experienced a significant weight loss of 6.48% in 1 month. April weight is 101 pounds. Reweigh with 108.2 pounds (consistent with March weight). Resident is on a mechanical soft diet, Magic cup Bid (twice daily). PO (by mouth) intake of meals variable at 25-100 percent, fluids 120-240 cubic centimeters (CC) per meal."

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R15's Dietary Note dated 5/24/2018 documents in part "Resident readmitted to facility 5/12/18 dx (diagnosis) knee abcess. May weight is 98 pounds which is 82 percent IBW (ideal body weight) is a significant weight loss of 10.91% in 3 months. Resident is on a mechanical soft diet with po intake mostly R (refusal) - 50%. Recommend 2 cal supplement 90 ml (milliliters) bid (two times a day) and mvi (multivitamin)."

R15's Dietary Note dated 6/28/18 documents in part "Resident readmitted to facility 6/19/18 dx right knee cellulitis. Hospice admitted 6/20/18. June weight is 96 pounds which is 80% IBW with significant loss of 11.11% in 3 months. Will request 2.0 cal supplement 120 ml tid (three times a day)."

R15's Dietary Note dated 8/29/2018 documents in part "Resident has experienced a significant weight loss of 14.29% in 3 months, 23.64% in 6 months. August weight is 84% which is 70% IBW. Resident is on a pureed diet, magic cup bid. Refuses 2 cal cupplement. Consuming magic cup continue it will also request supercereal."

The facility's "Resident Weight Monitoring" Policy dated 10/14 documents in part "11. Significant weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any trends of gradual weight loss or gain. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed. 12. Resdients who have been determined by the Weight Committee to be at increased risk for weight loss will be put on weekly weights for at least 4 weeks. 14. When weekly weights are obtained, they must be reviewed weekly and

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action must be taken for any significant change."

(B)

3 of 3 Licensure
300.610a)
300.1210b)
300.1210d)5)
300.3240a)

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. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, record review and interview, the facility failed to identify, assess, evaluate, monitor and treat pressure sores for 3 of 7 residents (R27, R43, R150) reviewed for pressure ulcers in the sample of 25 causing R150 and R43 pressure ulcers to worsen.

Findings include:

1. R150 was admitted to facility on 9/4/2018. No admission assessment was located. Baseline Care plan dated 9/4/2018 documents; Identified Skin Risks: Skin Plan of Care documents the following; High Risk Braden Assess,W/C (wheelchair cushion), Wkly (Weekly) Skin chk (check), Current wound and Assisted Toileting. Cognition; Alert to: Time, Self, Others, Place and Make decisions. Ambulation assist of 1, Transfer

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S9999	Continued From page 12 assist of 2 plus On 9/19/2018 at 10:35 AM V7 Licensed Practical Nurse (LPN) looked through R150's chart and was unable to locate a Nursing Admission Assessment. On 9/21/2018 at 09:30 AM V7 LPN provided a Nursing Admission Assessment dated 9/4/2018 for R150 that documents wound measurements to Left heel 2.9 cm length x 2.1 cm width and Right heel 5.1 cm length x 3.9 cm width. R150's Nurse's note dated 9/4/2018 documents in part, Resident arrived per ambulance escorted by EMS. Alert and Oriented x 4. BLE (bilateral lower extremities) red with "plus" 2 pitting edema et blistered type areas. Areas to Left et Right heels covered at this time. Heels floated in bed. R150's Nurse's note dated 9/5/2018 documents in part; "No" edema noted. Areas to bilateral heels covered. R150's Treatment Administration Record for month of September documents order to cleanse areas to R & L heel with wound cleanser. Apply Betadine and Santyl cover with Hydrocel dressing and wrap daily and as needed. There are no initials for September 4, 5, and 6th indicating that treatment was conducted. R150's Nurse's note dated 9/9/18 documents in part; Tx's (treatment) as ordered. Noted odor. Will have culture done. Nurse's note dated 9/11/2018 documents in part; Tx's to both heels as ordered. Facility provided R150's initial measurements of	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003842	A. BUILDING: ______ B. WING ______	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW ROSE REHAB & HEALTH	410 FLETCHER JERSEYVILLE, IL 62052

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wound evaluation & management summary from previous nursing home dated 9/4/2018 documents in part; Left heel unstageable (d/t necrosis) wound measurements 3cm length x 2cm width x depth not measurable. Right heel unstageable (d/t necrosis) wound measurements 5cm length x 4cm width x depth not measureable.

R150's wound evaluation & management summary dated 9/17/2018 documents in part; Left heel unstageable (d/t necrosis) wound size 4cm length x 2cm width x depth not measurable. Right heel unstageable (d/t necrosis) wound size 10 cm length x 5 cm width x 0.2 cm depth. Wound progress: Deteriorated.

On 9/18/2018 at 12:55 PM R150 stated, "I haven't been here long, I have blood clots in both legs, wound on left heel and cellulite."

On 9/19/2018 at 08:45 AM R150 was observed lying in bed, R 150 stated that, "They didn't change my dressings yesterday, I think they got too busy." "The last time that they straight catch me was around 7:30 PM last night. I'm not having any pain but I know when I have water though."

During observation of R150's wound care on 9/19/2018 at 08:52 AM V11 Licensed Practical Nurse (LPN) removed ace wrap from R150's right foot and removed undated, no initials ensanguine gauze, then cleansed wound with normal saline and applied saintly to wound bed and then applied calcium alginate dressing over entire wound lapping over the margins onto the healthy skin. V11 stated that it was okay for the calcium alginate to be touching healthy skin. V11 then wrapped heel and foot in gauze. R150's pressure ulcer to right heel area was untraceable with slough and necrosis observed. V11 after

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completing the dressing V11 did not timely change her gloves and/or wash her hands during R150's right heel dressing change. V11 then removed the ace wrap from R150's left foot and removed saturated bloody gauze that had no initials or date. Bloody drainage was observed on bed sheet below wound. V11 stated I don't see any date or initials but it was marked on the Treatment Administration Record (TAR) that dressing was changed on the 8th. After V11 removed gauze from left heel a foul odor was noted. V11 stated, 'Yes, I do smell a odor.' V11 treated wound and then covered entire wound and surrounding margins with calcium alginate dressing and then wrapped entire heel and partial foot with gauze. R150's left heel had a foul odor untraceable pressure ulcer with slough and necrosis observed. V 11 stated that R150 was not currently taking any antibiotics.

Manufacture Guidelines for Calcium Alginate Dressings documents in part; 1. Cut (using sterile scissors) or fold the dressing to fit the wound. 2. Apply to wound bed directly. Loosely fill deep wounds, ensuring the dressing does not overlap the wound margins.

On 9/20/2018 at 2:45 PM V12 Wound doctor stated, "I've been doing this for 8 years and it makes no difference if the calcium alginate dressing is covering the wound margins."

On 9/19/2018 at 09:45 AM V7 LPN MDS/Care plan Coordinator stated, 'That when we received report (R150) only had two small areas on heels. We did treatments in house until wound doctor could see him on 9/17/2018. 'No nursing admission assessment for R150.' 'There were no measurements of wounds on TAR's.'

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2. R43 was admitted to facility on 7/18/2018. R43's Nursing Admission Assessment dated 7/18/2018 documents in part; Left heel open 2cm x 1.5cm white dry scaly area scabby. R43's Braden scale dated 7/19/2018 scored an 18, moderate risk for pressure ulcers. R43's treatment administration record for September 2018 has no initials for September 1, 7, 10, 13, 14, and 15th for the skin check daily on evening shift with 'CROP' coding skin condition C-clear, R-red, O-open pressures S-skin tear. There are no initials for September 10 and 13th for Left heel- cleanse affected area with NS, apply santyl to wound bed nickel thick cover with wet gauze, wrap foot with gauze daily and prn.

R43's TAR dated 8/1/2018 - 8/31/2018 for treatment of pressure ulcer; Skin check daily on evening shift with CROP coding on 8/8/2018 it is documented that pressure area is marked R (red) and initialed off then on the days August 9-13, 2018 there are no initials for the daily skin checks. On 8/14/2018- 8/17/2018 initials document O (open). On 8/18/2018-8/19/2018 again there are no initials on treatment record.

On 9/21/2018 at 09:50 AM V7 LPN, stated I don't know what happened those days where there's no initials."

R43's Nursing Care Observation Reports dated 9/3/2018-9/17/2018 documents under Functional status, Skin documents no wound descriptions or measurements for R43's left heel.

R43's initial wound evaluation & management summary dated 9/17/2018 documents in part; Stage 3 pressure wound of the left heel wound size 5cm length x 4cm width and 0.2 cm

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Facility's policy and procedure dated 1/18 documents in part the following guidelines will be implemented, daily skin checks and will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse.

3. On 9/20/2018 at 1:20 PM V10, Registered Nurse (RN) completed wound care by washing her hands and donning gloves. On R27's upper right back under the lower part of the shoulder blade V10 removed bandage saturated with green serous drainage. V10 then applied wound cleanser and gently dabbed with sterile gauze, then applied santyl cream with cotton tipped applicator to area with green serous drainage and black eschar. V10 measured the unstageable open area at 4 centimeters (cm) by 3 cm with a reddened , swollen area of 3 cm beyond black escar. R10 then folded calcium alginate and place over the wound with gauze taped on outside dated and initialed tape.

On 9/20/2018 1:20 PM V10 stated "We just identified this area on 9/13/2018. It doesn't seem to be getting any better."

On 9/20/2018 at 2:50 PM V7, Minimum Data Set (MDS)/Care Plan/ Infection Control Coordinator stated "I called the(local lab company) and they said they never did receive the culture on the wound for (R27)."

On 9/25/2018 at 9:30 AM V7 stated "I told you last week that the lab didn't get the culture for (R27's) wound. We have not repeated the culture for (R27's) wound."

On 9/25/2018 V3, RN stated "I identified on

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(R27's) upper right back the 3 cm open area draining green drainage with 3cm reddening around it on 9/13/18. I would have thought it would have at least been reddened prior to opening. I know she is hard to roll so maybe that is why it was not identified it earlier. We are supposed to do a skin check daily. (R27) is really hard to turn in bed. I was off for the three days before 9/13/18 so I can't say if her skin was actually checked. We are supposed to do daily skin checks."

R27 has no Nurses Notes regarding skin assessment until 9/13/2018.

R27's Physician Order Sheet dated 9/1-9/30/2018 documents "Daily skin checks."

R27's Nurses Note dated 9/13/2018 at 10:30 AM documents "Noted 3 cm open area on back with 3 cm surrounding are inflammed. Draining green. Appears to be a boil. Cultured. Send to lab in AM (morning). Notified MD (medical doctor) and guardian."

R27's Nurses Note dated 9/17/2018 at 1:00 PM Resident continues on ABT (antibiotic) therapy as ordered and no adverse reactions noted. T (temperature) 97.4 Dressing changed to back done with wet to dry. Area in center is dark with 1 cm redness surrounding. Drainage green foul smelling. Will observe."

(B)