DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. FOREST CITY REHAB AND NURSING CENTER, LLC, D/B/A, FOREST CITY REHAB & NRSG CTR, Respondent.	))))))))))	Docket No. NH19-S0056

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on December 06, 2018, at Forest City Rehab & Nrsg Ctr, 321 Arnold Avenue, Rockford, Illinois 61108. On February 04, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210c), 300.1210d)5) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 04th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. FOREST CITY REHAB AND NURSING CENTER, LLC, D/B/A, FOREST CITY REHAB & NRSG CTR, Respondent.	)	Docket No. NH 19-S0056

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Abraham Gutnicki
Licensee Info:	Forest City Rehab and Nursing Center, LLC
Address:	4711 Golf Rd, Ste 200 Skokie, Illinois 60076

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 04th day of February, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(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	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

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 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. (Section 2-107 of the Act)

Based on observation, interview, and record review the facility failed to assess, identify and prevent pressure ulcers from developing. This facility failure resulted in R172 developing three unstageable pressure ulcers.

This applies to 2 of 3 residents (R28, R172) reviewed for pressure in the sample of 35.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

1. The Physician's Order Sheet (POS) dated December 6, 2018 showed R172 was admitted to the facility on April 5, 2018 with diagnoses of paralytic syndrome, intellectual disabilities, seizures and atrial fibrillation.

The Minimum Data Set assessment (MDS) dated April 12, 2018 showed R172 needs extensive assistance of one for bed mobility and he had no pressure ulcers. The Braden Scale (pressure ulcer risk assessment) dated April 5, 2018 showed R172 to be at high risk for pressure ulcer development. The admission skin integrity review dated April 15, 2018 showed R172 had no skin issues.

The nursing progress note dated April 24, 2018 showed R172 was assessed by the doctor due to edema and the beginning of pressure ulcers to ankle areas. No further documentation was found about the pressure ulcers until May 7, 2018.

R172's weekly skin alteration review dated May 7, 2018 (13 days after initial physician assessment) shows a deep tissue pressure injury, to the right lateral foot and an unstageable pressure injury to the right lateral ankle. R172's weekly skin alteration review dated May 14, 2018 shows an unstageable pressure injury to the left hip.

R172's wound care specialist initial evaluation dated May 7, 2018 shows an unstageable necrotic pressure ulcer to the right lateral ankle measuring .9 by 1.3 centimeter (CM). The area was covered with 100% necrotic (dead tissue) tissue. The recommendation for staff was to off load the area and wear bunny boots. The same report also shows an unstageable deep tissue injury to the right lateral foot measuring 7.5 by 0.6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

CM caused by pressure. The recommendation for this wound is to off load the area.

R172's wound care specialist evaluation dated May 14, 2018 shows an unstageable necrotic pressure injury to the left hip. The wound measures 1.7 by 1.1 CM and was covered by 100% necrotic tissue. The wound was debrided by the physician. The post debridement wound was staged as a four.

R172's POS dated December 6, 2018 shows an order to ensure off loading boots are on daily three times a day was started on September 13, 2018.

On December 5, 2018 at 9:15 AM, V19 (wound care nurse) was observed changing the dressing to R172's left hip and right ankle. The wounds have red wound beds with minimal drainage and pink skin surrounding the wound.

On December 4, 2018 at 11:04 AM, V15 (R172's father) said his son developed the pressure ulcers after coming to the facility.

On December 5, 2018 at 2:30 PM, V16 Assistant Director of Nurses (ADON) said R172 was admitted to the facility with no pressure ulcers.

On December 6, 2018 at 10:52 AM, V6 LPN said when a new wound is found the nurse is do an assessment, give the information to the wound care nurse and that person will obtain orders for treatment. V6 said frequent repositioning and off loading pressure areas are important to prevent pressure sores.

On December 6, 2018 at 10:36 AM, V9 CNA said to prevent pressure sores you have to reposition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

the residents frequently and use pillows to off load pressure to certain areas.

On December 6, 2018 at 1:04PM, V20 Licensed Practical Nurse (LPN) said she thinks the bunny boots were started a few weeks after coming to the facility.

On December 6, 2018 at 1:11 PM, V21 Certified Nursing Assistant (CNA) said the bunny boots were started after the pressure ulcers started to his foot.

On December 6, 2018 at 9:38 AM, V2 Director of Nurses (DON) said the wounds should have been found and treated before they became unstageable.

R172's care plan shows the increased risk for alteration in skin integrity was initiated on July 20, 2018. The interventions are to reposition frequently and off load heels as needed.

The facility policy for pressure ulcer and skin condition assessment dated 9/14 shows the purpose is to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented. #4 shows each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the initial assessment.
#7 at the earliest sign of a pressure ulcer... a skin assessment form will be initiated. The initial observation of the ulcer or skin breakdown will also be described in the clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

2. On 12/04/18 at 9:32 AM, R28 states she has wound on left foot and has been going to the wound care doctor for 6-8 weeks. R28 states she thinks the wound was caused by the strap on footrest of her wheelchair. R28 stated she is taking an antibiotic for infection of wound. A strap was in place at the back of the left foot rest on her wheelchair. R28 was not wearing any offloading boots or shoes. A gauze bandage was observed on R28 left foot.

The physician notes for R28 dated 10/16/18, shows R28 had a superficial left heel ulcer and increased edema to lower extremity. No measurement or additional wound description is recorded.

The initial wound note by nursing dated 10/22/18 shows the wound is on the left heel, stages as a deep tissue injury, measured 2.8 x 3.0 CM, with a moderate drainage. The treatment includes use of an off loading boot and foam dressing. The assessment did not include a description of the wound bed.

On 12/06/18 at 10:25 AM, V18 (Licensed practical nurse/wound care nurse) stated, "I think R28 self reported the heel wound to me on 10/22/18. She is not on scheduled skin checks. I referred her to the wound doctor on the same day because he was here making wound rounds. R28 does her own shower." V18 stated she was not sure, but the wound could have been caused from the strap on the foot rest of her wheelchair and she doesn't wear shoes." V18 confirmed there were no nursing notes of the new wound for R28 before 10/22/18. V18 stated the treatment included off loading the wound on 10/22/18. V18 stated R28 uses a sponge boot at times. She does not use the correct one but she is free to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

choose which boot to wear. R28's legs are swollen. V18 has not observed R28 walking, but thought she could transfer herself to the toilet. V18 described R28's wound as a deep purple color, and drainage was leaking from the wound, but it was not open. V18's initial wound assessment did not contain any information regarding the precipitating factors that may have caused the deep tissue injury of R28's heel or measures used to alleviate the pressure.

R28's care plan states she requires assistance with ADL's to maintain the highest possible level of functioning AEB the following limitations and potential contributing factors: General weakness, use of psychotropic medications, Bipolar, Anxiety, COPD, Type II diabetes, and Epilepsy. She is mostly independent but needs some assistance with dressing and transfers. The care plan shows R28 has an alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues related to Type II diabetes, epilepsy and allergic rhinitis. Deep tissue injury 10/22/18 Interventions include to skin check during routine care on a daily basis and during the weekly/biweekly bath or shower schedule. Other interventions related to deep tissue injury of the left heel were to administer wound care treatments per physician orders. No interventions to relieve pressure to the left heel are identified in the care plan for R28.

The December 2018 physician order sheet lists Santyl ointment to left heel, Arginaid to wound bed and offloading boot at bedtime. Fentanyl patch every 72 hours for pain. On 11/28/18 an antibiotic order was started for treatment of infection to left heel wound.

The wound physician note on December 3, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 measured the wound size 1.7 cm x 3.0 cm x 0.3 cm with moderate serous drainage and 40% cover with thick adherent devitalized necrotic tissue. The wound was surgically excised of devitalized tissue. R28's Diagnosis list in electronic record includes Bipolar, Cellulitis of left lower limb. Cellulitis of right lower limb, COPD, chronic embolism and thrombosis of deep veins of lower extremity, GERD, alcoholic cirrhosis of liver without ascites, heart failure, anemia, spondylosis without myelopathy or radiculopathy, insomnia, edema, anxiety, OA, HTN, idiopathic peripheral autonomic neuropathy. R28's Minimum data set of 09/17/18 shows R28 has brief interview of mental status score of 15 (cognitively intact) and she does not walk, uses a wheelchair for mobility. R28 is at risk for pressure ulcer and had no unhealed pressure ulcer, or other wound or skin problem. (B)	S9999		