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	095034	A. BUILDING _____ B. WING _____	09/25/2012

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F 281	Continued From page 20 suicidal thoughts and his/her high level of anxiety ... " A telephone interview with Employee # 28 was conducted on October 10, 2012 at 3:17 PM. He/she stated, " It happened on August 13, 2012 around 6:00 PM, it was a scheduled therapy visit and I always did the treatment in the resident ' s room, but he/she was in distress. I wanted to calm him/her. He/she was screaming at the top of his/her voice, screaming like in labor and deliver and I wanted to get him/her out of pain. He/she complained of her back hurting. I informed the nurse came in and medicated the resident for pain. I spent a good amount a time calming him/her down. The resident was going on and on and the resident was agitated. I don ' t recall him/her saying that [that he/she wanted me to help her to kill him/herself]. I didn ' t have concerns when I left that day; it was an emotionally draining experience. I was not listening to him/her directly. It [the suicidal ideation] was an afterthought. I left the building and did not have concerns. He/she made a health care choice that was a terminal choice for him/her. When queried as to why the note wasn ' t written on the day of the incident. He/she stated, " It was late. I am a professor, a student and a mother. It [the resident ' s suicidal ideation] was not clear to me when I was working with the resident. It hit me when I was coming back to work [August 15, 2012]. It was not an atypical visit with this resident. I was focused on the resident ' s functional treatment. I wish I had come to a mental awareness sooner. Based on the residents physical ability he/she was no able to carry out the plan that he/she verbalized. This	F 281		

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F 281	Continued From page 21 resident could not move or roll in bed." When queried about would what would be your customary practice if someone verbalized a desire to harm themselves? He/she replied, " I would go to the nurse and let the nurse know. "When I came back to work I spoke with the social worker who told me to write down what happened so that he/she could follow up. " A period of 2 days lapsed from the time the resident verbalized suicide ideations to the time the facility was notified. Employee #28 (physical therapist) failed to act with timeliness in conveying to the healthcare team, a resident's verbalization of suicidal ideation. The record was reviewed September 21, 2012.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 33 sampled residents, it was determined that facility staff failed to follow-up on a recommendation for a neurology evaluation for one (1) resident and act with timeliness on an	F 309		

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F 309	Continued From page 22 order for psychiatric consultation for one (1) resident. Residents #138, and #376. The findings include: 1. Facility staff failed to follow-up on a recommendation for a neurology evaluation for Resident #138. According to a " Physician ' s Interim Order " dated January 18, 2012 at 0850 [AM] directed: " Transfer to [hospital] secondary to [Status Post] fall; left hip pain; vomiting x1t [times one]. " A review of an " Interdisciplinary Progress Note " dated January 20, 2012 revealed, " Medical Attending - Readmit- [follow-up] hospitalization s/p unwitnessed fall. [Hemodynamically] stable; no acute issues. Fall precautions- meds reviewed and resumed. Doctor ' s signature. " A review of a nurse practitioner " Interdisciplinary Progress Note " dated January 30, 2012 revealed: " Resident observed at [name of hospital] [times] 24 hours with fall unwitnessed. All diagnostic studies- Within Normal Limits. " According to a " Multidisciplinary Discharge Orders/Instructions " dated January 19, 2012 directed, " Follow-up: Neurology Clinic for syncope work up. Patient has appointment with Neurology on February 1, 2012 at 1 PM for EEG (Electroencephalogram). A further review of the resident ' s clinical record lacked evidence that a neurology evaluation was	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. 1. Resident #138 was evaluated by the neurologist on 10/1/2012 2. All residents requiring follow up recommendation for neurology evaluation have been identified. It has been determined that all consults have been completed. 3. All licensed staff have been in-serviced on following up on recommendations for neurology evaluations. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	10/1/12 11/9/12 11/9/12 Ongoing

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F 309	Continued From page 23 performed in accordance with the discharge order/instructions. A face-to- face interview was conducted with Employee #11 on September 24, 2012 at approximately 2:00 PM. After reviewing the clinical record; he/she acknowledged the record lacked documentation that the resident had a neurology evaluation. Stated he/she would follow-up with the doctor. On September 21, 2012, the physician wrote an order for a neurology consult (re: Syncopal episodes, frequent falls). " the record was reviewed September 24, 2012. 2. Facility staff failed to act with timeliness on an order for psychiatric consultation for Resident #376. A review of progress notes for Resident #376 included the following: July 14, 2012 at 23:12 ...call by the front desk secretary to go and see resident in [his/her] room because of [his/her] pain. He/she stated that resident has been calling that if [he/she] did not get relief from his/her pain, he/she is going to hurt him/herself. Upon getting to his/her room I observed [multiple] open areas on the resident ' s hip/thigh area with bright red blood. Skin tears measured about 0.7cm x 0.8cm some of them unmeasurable. [Primary Attending] made aware and family also made aware. Calmoseptine [ointment] to be applied [every] shift. Resident remains alert, confused and stable.	F 309	2. 1. Resident #376 was evaluated by the Psychiatrist on 8/9/2012. 2. All residents with an order for psychiatric consultation have been identified. All consultations are up to date. 3. All licensed staff have been in – serviced on obtaining psych consults in a timely manner. 4. Monthly audits will be completed by the Nurse Manager or designee. Results will be presented at the quarterly QA/QI meeting.	8/9/12 11/9/12 11/9/12 Ongoing

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F 309	Continued From page 24 July 24, 2012 at 17:21 ...[Social worker] visited with resident in a quiet corner in the living room and resident expressed unhappiness at being in LTC (long term care) setting. [Social worker] explored ADL [activities of daily living] needs with resident, and resident asserted, " [he/she] can do everything for [him/herself] and doesn ' t need any help. " Resident stated [he/she] feels like he/she is " in prison " and " just look at these people. " Per resident his/her sleep and appetite have improved. He/she would prefer to be at home " doing everything [he/she] use to do " . Resident showed little insight about his/her current health status ...[Social Worker] reminded resident of the circumstances surrounding his/her admission (multiple intubations) and resident agreed he/she almost died-and said he/she sometimes " Wishes God would take [him/her]. " Resident denied [suicidal] and hallucinations or delusions. He/she quickly added that " suicide is a sin and God forgive me. " [Social worker] will share this with IDT [interdisciplinary team] and recommend psychiatric consult for depressive symptoms. " July 31, 2012 at 11:09 ...[Social Worker] met with resident in his/her room after CNA (certified nurse aide) reported resident has been irritable. Resident said, " Get me outta here. " Social Worker discussed discharge planning resources and need for 24-hour care. Resident expressed firm belief that he/she was " walking and well " when he/she came into this place, " and now he/she keeps being told, " You ' re sick " and can ' t leave. [Social Worker] reviewed resident ' s rights and explored discharge options. Resident continues to believe that [facility name]	F 309		

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F 309	Continued From page 25 and [hospital] staff wish to keep his/her here. He/she expressed anger, frustration and disbelief about his/her current health status. He/she said he/she wished he/she was dead but denied suicidality, stating " Suicide is a sin. " Resident did not respond to supportive counseling or redirection but did say he/she understood that someone would need to care for him/her at his/her home. [Social Worker] to share his/her thoughts of death with [nursing] and pastoral care. A review of Interdisciplinary Progress Notes dated August 15, 2012 [no time indicated] revealed, " Late entry note for tx [treatment] given August 13, 2012, Pt [patient] extremely agitated. c/o [complain of] pressure abdomen with pain LB [lower back]. Pt discussed wanting to commit suicide by throwing [his/herself] out of the 2nd flr (floor) window. [He/she] c/o being concerned about meds [medication] causing confusion. [He/she] says he/she asked for the meds to help decrease his/her anxiety but he/she regrets it. Pt said the doctors and nurses were trying to kill him/her because he/she did not accept dialysis. She then said, " If they can treat me then why won ' t they send me somewhere where they can treat me. " Pt discussed main reasons for these emotions with me. His/her pain was [unable to read]. Encouraged Pt to try moist heat ...However when PT went to leave she stated, " Don ' t leave me alone he/she followed by stating you care about me won ' t you help me kill myself. Pt then fell asleep. Pts statements reported to social services upon RTW (return to work) by therapist today. Spoke further with [pastoral representative] and Employee # 23 who	F 309		

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F 309	Continued From page 26 interviewed this therapist re: above. Pt seen by MD ... " The Physician ' s Interim Orders revealed the following: July 20, 2012, " Psych consult for decision making capacity. " August 8, 2012, " Psych Consult [second] to wt (weight) loss. " August 15, 2012, " Psych follow up in 2-weeks for mood disorder. " The clinical record revealed that the physician ' s request for psychiatric consultation was acted on greater than two (2) weeks (approximately 19 days) following the initial order. The psychiatric consult was conducted on August 9, 2012 following a second physician ' s order (August 8, 2012) requesting psychiatric consultation. Additionally, a directive for a psychiatric " 2-week " follow-up visit from August 15, 2012 was not conducted until September 20, 2012. Facility staff failed to act with timeliness on a physician ' s request for psychiatric consultation. A face-to-face interview was conducted on September 21, 2012 at 10:30 AM with Employee #13. He/she acknowledged the findings. The record was reviewed on September 21, 2012.	F 309		
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	F 314		

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F 314	Continued From page 27 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 record review and staff interview for three (3) of 33 sampled residents, it was determined that facility staff failed to ensure that Resident #3, who had an alteration in skin integrity, classified by the facility as a " denuded " area to the coccyx (November 11, 2011) received necessary treatment and services in a timely manner to promote healing; Subsequently on March 1, 2012 the wound progressed to an Unstageable pressure ulcer. Additionally, facility staff failed to consistently assess the characteristics and monitor the progression of pressure sores for two (2) other residents. Residents #3, #16 and #289. The findings include: 1.Facility staff failed to ensure that Resident #3, who had an alteration in skin integrity, classified by the facility as a " denuded " area to the coccyx (11/11/11). The area progressed to "Unable to accurately Stage" (according to the facility's documentation) on March 1, 2012. There was no evidence that facility staff consistently provided necessary treatment and	F 314	F314 483.25(c) TREATMENT /SVCS TO PREVENT/HEAL PRESSURE SORES 1. A. 1. Resident #3's wound was assessed and treatment is in progress. 2. All residents with alteration with skin integrity have been identified. Necessary treatment and services to promote wound healing are in place. 3. All licensed staff have been in-serviced on facility's wound care protocol. 4. Monthly audits will be completed by wound nurse or designee. Results will be submitted to DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 314	Continued From page 28 services to promote wound healing. Subsequently, the wound progressed to an Unstageable pressure ulcer. According to the facility ' s policy entitled; " Pressure Ulcer Management; Policy No: 1215; Revised Date: 08/10/12 " stipulated the following: " II. Procedure: 2. Weekly rounds are made on residents with new or difficult to manage pressure areas. On these rounds, the present treatment modality is evaluated for effectiveness. Changes in treatment may be suggested at this time. 5. Wound care Nurse or designee will observe application of dressings to ensure proper technique. 6. The CNA [Certified Nursing Assistant] will report any changes in the skin and turn in the report to their Team Leader that shift. The Team Leader will observe the skin, document wound status, treatment and measurement on the Skin and Wound update section of the EMR [Electronic Medical Record], and notify the Nurse Manager/Designee or Supervisor for that shift of the changes. 7. The Team Leader will follow up the physician for orders as needed and notify the responsible party; and 9. The Nurse Manager/Designee will make weekly skin assessment rounds and the RN [Registered Nurse] will ensure that the wound status, treatment and measurements on the " Skin and Wound " section on the EMR is correct. " Denuded skin is defined by a John Hopkins; " Wound Care Assessment and Documentation Treatment " slide presentation on February 18, 2011 as " Loss of superficial epidermis. "	F 314		

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F 314	Continued From page 29 www.slideshare.net/nektovaleri/wound-care-6976123. According to the quarterly MDS dated October 9, 2011 revealed that Resident #3 was coded for requiring extensive assistance in Bed Mobility, Transferring, Dressing, Toileting, Personal Hygiene under Section G (Functional Status); Section H (Bladder and Bowel) the resident was coded, Urinary and Bowel as always incontinent; and Section M (Skin Conditions) was coded as at risk of developing pressure ulcers and Section M was coded as none of the above for the presence of Skin impairment of any type. Section I the resident ' s diagnoses included: Hypertension, Hyperlipidemia, Alzheimer ' s disease, Cerebral Vascular Accident, Hemiplegia, Depression, Psychotic Disorder. The annual MDS dated January 1, 2012 revealed that Resident #3 was coded for requiring extensive assistance in Bed Mobility, Dressing, Personal Hygiene and total dependence in transferring, and toileting under Section G (Functional Status); Section H (Bladder and Bowel) the resident was coded, Urinary as always incontinent and frequently incontinent of Bowel; and Section M (Skin Conditions)-M0150 was coded as at risk of developing pressure ulcers and M1040 was coded as none of the above were present. However, the resident had alteration in skin integrity to his/her coccyx. The care plan entitled, " Problem #41, Hx (history) of Interruption in Skin Integrity "	F 314	B. 1. Resident #3's alteration in skin integrity was coded correctly in significant change MDS assessment dated 3/11/2012. All subsequent MDS's have been coded correctly. 2. All residents with altered skin integrity have been identified. All MDS's are coded correctly. 3. All MDS staff have been in-serviced on proper coding of section M. 4. Random audits will be conducted my MDS coordinator. Results will be submitted to DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 314	Continued From page 30 initiated 01/24/11 revealed, and " Goal-wound will be free of infection and healing gradually within 90 days. Approach: ...1. Turn and position every 2 hours. 2. Measure and document size of wound. 3. Reassess wound every 7 days and PRN. 4. Notify Wound nurse of new wound. 5. Treat wound as ordered ... " On 11/11/11 the care plan was updated to included " Interruption in Skin Integrity related to Coccyx area " . At this time facility staff failed to provide a written description of the wound on the care plan. On February 29, 2012 the care plan was updated to include, " wound nurse staged coccyx ulcer as Stage 3 " On March 1, 2012 the care plan was updated to include, " Coccyx ulcer unstageable " Braden Scale or Predicting Pressure Sore Risk dated October 17, 2011=14 mod (moderate) risk; 13-14= moderate risk. For scores below 18 institute Carroll Manor Pressure Ulcer Prevention Protocol Laboratory Results- A review of the laboratory results dated November 9, 2011 revealed that Resident #3 ' s albumin level was 3.0 Low, reference range 3.2-5.0g/dl. The laboratory results dated March 4, 2012 revealed that the Albumin level was 2.6 Low (range 3.2-5.0). Physician ' s Interim Orders	F 314	C. 1. Resident #3's care plan was updated to include written description of her wound. 2. All residents with wounds have been identified. Care plans have been updated to include written description of wound. 3. All licensed staff have been in-serviced to provide written description of wound on care plan. 4. Monthly audits will be conducted by wound nurse or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 314	Continued From page 31 " November 11, 2011 at 2035 ...Clean open pink on coccyx area with Bedside Care Foam (Bedside Care Foam) and pat dry. Apply Calmoseptine Ointment (multipurpose skin barrier cream) twice daily x (times) 14 days ... " " November 29, 2011 at 1030 ...Clean denuded area on the Coccyx with Bedside Care Foam, apply Saf-Gel (Hydrating Dermal Wound Dressing), cover with 4x4 gauze and secure with Tegaderm (Transparent Film Dressing). Change dsg (dressing) daily x 14 days. D.C. (discontinue) Calmoseptine Ointment to Coccyx open area ... " " December 7, 2011 at 1123 ...Cleanse denuded area on the Coccyx with Bedside Care Foam, apply Mepilex Sacral Boarder (an all-in-one foam dressing that effectively absorbs and retains exudate and maintains a moist wound environment). Change every 3 days and PRN. D.C Saf-Gel dsg to Coccyx. " " December 28, 2011 at 1100 ... Cleanse denuded areas on the Sacro-Coccyx area with Bedside Care Foam, apply Stomadhesive powder (Helps form a protective barrier for excoriated or weeping skin) and Calmoseptine and Baza Clear (aids in the treatment & prevention of diaper dermatitis & protects skin from wetness and moisture), apply BID (twice daily). D.C. Rx (medical prescription) with Mepilex Border ... " " December 30, 2011 at 1430 ...Vitamin C 500mg by mouth twice daily for wound healing x	F 314		

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F 314	Continued From page 32 14 days. Zinc Sulphate 220mg by mouth daily for wound healing x 14 days ... " " February 7, 2012 at 1100 ...Sacro-Coccyx Ulcer: Cleanse with normal saline, apply Santyl Ointment (a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP), cover with 4x4 gauze; Secure with Tegaderm. Change dsg daily x 14 days. Keep the heels floated while in bed with the help of pillows ... " " February 15, 2012 at 1710 ...Increase Ensure to TID [three times a day] (Provides 1050 Kcal, 39 g protein). Give Zinc Sulfate 220mg p.o. daily x 14 day(s) for wound. Give Vitamin C 500 mg p.o. daily for wound x 14 days ... " " February 22, 2012 at 1040 ...D.C. previous Rx order dated 2/15/2012. Cleanse Sacro-Coccyx Ulcer with Normal Saline. Fill the wound bed with 2x2 gauze saturated with ¼th strength Dakin's Solution (antiseptic solution containing sodium hypochlorite and developed to treat infected wounds). Cover with 4x4 gauze, secure with tape. Change dsg Q (every) shift/PRN x 7 days. " " February 28 [2012] at 1300 ...D.C. previous Rx order for Sacro-Coccyx Ulcer dated 2/22/12. Cleanse Sacro-Coccyx Ulcer with Normal Saline; apply/sprinkle Polysporin pwd (powder). Fill the wound with gauze saturated with Santyl Ointment. Cover with 4x4 gauze, secure with Tegaderm. Change dsg daily x 21 days. "	F 314		

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	095034	A. BUILDING _____ B. WING _____	09/25/2012

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F 314	Continued From page 33 A review of the Treatment Administration Records (TAR) revealed: According to the TAR the resident received Calmoseptine Ointment as ordered from November 11 - 25, 2011. It was noted that treatment/dressing change on November 25, 2011 (the second dressing) and November 26, 27 and 28, 2011 were blank indicating (that the treatment was not signed as being done). The resident received Bedside Care Foam with Mexiplex Sacral Border as ordered on December 10, 14, 17, 19, 21, 24, 26, and 28, 2011. It was noted that treatment/dressing change on December 8 and 9, 2011 were blank indicating (that the treatment was not signed as being done). According to the documentation on the TAR, February 16 thru 22 and 29, 2012 the resident received a treatment to cleanse Sacro-Coccyx ulcer with Normal Saline, sprinkle Polysporin powder; apply pack 2x2 gauze saturated with poly Santyl ointment, cover with 4x4 gauze; secure with Tegaderm. However, there is no documented evidence of a physician ' s order to direct this treatment. In summary, there was no evidence that facility staff administered the wound treatment in accordance with the physician ' s orders as evidenced by the aformentioned blanks on the TAR. Additionally, from February 16 thru 22, 2012 facility staff conducted a wound treatment	F 314		

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F 314	Continued From page 34 to the resident ' s sacro-coccyx in the absence of a physician ' s order (application of Polysporin adn Tegaderm). Skin Condition Report -Unhealed Daily Wound Assessment revealed: " 11/11/2011 Present on the Coccyx is a denuded area. The following findings were documented, length in cm=0.8, width in cm=0.5, no odor is present, no drainage is apparent, recent changes were made to the treatment orders for this site, no itching or discomfort, General comments: At 2020 reported by CNA resident noted open pink area on coccyx measuring 0.8cm x 0.5cm, [physician] notified and gave order to clean the area with bedside care foam and pat dry, apply Calmoseptine ointment twice daily x14 days. " " 11/15/2011 Present on the Coccyx is a denuded area: The following findings were documented, General comments: Resident denuded area on coccyx assessed this morning, area measures 0.5 x 0.5 appearance is pink, no drainage noted. Treatment continues to cleanse with bedside foam and apply Calmoseptine bid x14 days. " " 11/23/2011 Present on the Coccyx is a denuded area: The following findings were documented, Length 0.2 x width 0.2, skin is not blanchable, no odor is apparent, no drainage is apparent, This wound was not present on admission, wound baseline visible, pink wound base = 100%, granulation tissue type = 100%, no itching, or discomfort, condition is flat, color is	F 314	D. 1. Resident #3's wound treatment was administered according to physician order dated 2/15/12 for Polysporin administration and Tegaderm. 2. All residents with wound treatments have been identified. There are corresponding physician orders for the treatments. 3. All licensed staff have been in-serviced on administering wound treatments in accordance with physician orders. 4. Random audits will be conducted by wound nurse or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	2/15/12 11/9/12 11/9/12 Ongoing

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pink, wound has no pattern -scattered, no foreign bodies , surrounding tissues is normal, The affected area has an absence of hair, skin tissue temperature is warm to touch, margins are regular, resident has no pain. Skin turgor is fair, General comments: Denuded area on coccyx healing well, site dry and pink in color, site improvement noted. "

" 11/24/11 Present on the coccyx is a denuded area. The following findings were documented, PA, NP, MD were notified of the present status of site. No changes in site condition, no recent changes were made to the treatment orders for this site, antibiotics are not currently in use. General Comments: Open area on coccyx assessed, cleanse with bedside foam as ordered and Calmoseptine applied to site, no bleeding or odor at site. "

" 11/28/2011 Present on the coccyx is a denuded area. The following findings were documented Length in cm=0.5, width in cm=0.5, depth in cm= 0, no odor is apparent, no drainage is apparent recent changes were made to the treatment orders for this site, the wound was not present on admission, General comment: pale pink dry wound bed, also noted moist areas in the gluteal fold and in the periwound area, current applying Safgel ointment and covering with gauze and Tegaderm, change dressing daily14 days, wound base is visible, pink wound base = 100%, condition is flat, color pink, no foreign bodies present, surrounding tissue hyper pigmented, skin tissue temperature is consistent with surrounding tissue, margins are regular, mucus membranes are dry, mucus membranes are pink, skin turgor is fair, no change in site

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condition, recent changes were made to the treatment orders for this site, Antibiotics are not currently in use: pressure reducing or relieving devices are in place, devices used on the bed surface, extremity device or shoes used, turning and repositioning program being implemented. Nutrition update: protein supplemental administered other nutritional programs in Ensure. Risk factor: Decreased mobility, inactivity. "

" 11/29/2011 Present on the coccyx is a denuded area. The following findings were documented General comments: Residents Coccyx area assessed this morning is pink and dry and new treatment orders received to cleanse with bedside foam and apply Safgel daily, no pain at site. "

" 12/07/2011 Present on the coccyx is a denuded area. The following findings were documented Length in cm=0.5, width in cm=0.5, depth in cm=0, no odor is apparent, no drainage is apparent, The wound was not present on admission, General comments: dark pink wound bed with very scant drainage, recommend applying Mepilex sacral border to the dressing, wound base is visible, pink wound base = 100%, no foreign bodies present, surrounding tissue is normal, skin tissue temperature is consistent with surrounding tissue, margins are irregular, mucus membranes are moist, mucus membranes are pink, skin turgor is fair ... "

" 12/13/2011 Present on the coccyx is a denuded area. The following findings were documented General comments: Sacral coccyx area assessed this shift and appearance pink and

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moist, treatment done as ordered with Mepilex sacral border, no drainage was noted, no odor "

" 12/14/2011 Present on the coccyx is a denuded area: Length 0.5cm x width 0.5cm, skin is not blanchable, no drainage, wound base is visible, pink wound base = 100%. "

" 12/21/2011 Present on the coccyx is a denuded area: Length 1cm x width 1cm, depth 0.1cm, drainage consistency is thin, scant drainage is present, color is clear, red area on the edges with pale pink area in the center, wound base is visible, pink wound base = 15%, red wound base = 85%, surrounding tissue is moist, continue applying Mepilex sacral dressing. "

" 12/27/2011 Present on the coccyx is a denuded area.: Length 0.5cm x width 0.3cm, depth 0cm, skin is blanchable, no odor, no drainage, red in color, is red and moist, treatment cleanse with bedside foam and with Mepilex sacral border every third day. "

" 12/28/2011 Present on the coccyx is a denuded area.: Length 3cm x width 6cm, depth 0cm, drainage consistency is thin, scant drainage is present, color is clear, denuded superficial dark pink ... with irregular borders, wound base visible, red wound base = 100%, Apply Stomadhesive powder, Calmoseptine and baza clear as moisture barrier ointment, Nutrition: zinc and vitamin C, protein supplement. "

" 01/06/2012 Present on the coccyx is a denuded area ...Length 2cm x width 4.5cm. depth 0cm, no drainage , wound base visible, red

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F 314	Continued From page 38 wound base = 100%, Epithelial tissue type =100%, wound red, margins are irregular, treatment no changes, continue pressure reducing or relieving devices, Nutrition zinc, vitamin C and protein supplement. " " 01/09/2012 Present on the coccyx is a denuded area.: Length 2cm x width 4cm, depth 0cm, no odor, no drainage, wound base visible, red wound base = 100%, Epithelial tissue type =100%, wound red, margins are irregular, treatment no changes, continue pressure reducing or relieving devices, Nutrition Zinc, Vitamin C. " " 01/17/2012 Present on the coccyx is a denuded area ... Length 1.5cm x width 0.8cm, depth 0cm, wound base visible, red wound base = 100%, Epithelial tissue type =100%, wound red, margins are irregular, treatment no changes, continue pressure reducing or relieving devices, Nutrition zinc, vitamin C and protein supplement. " " 01/23/2012 Present on the coccyx is a denuded area ...no measurements, drainage consistency is thin, minimal drainage is present, color is red-tinged, noted in the center mildly ecchymotic area, Denuded area from tape toward distal area, wound base visible, red wound base = 100%, surrounding tissue is macerated, margins are irregular, treatment no changes, continue pressure reducing or relieving devices are in place, turning and repositioning program implemented. " " 01/24/2012 Present on the coccyx is a denuded area. The following findings were	F 314		