STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235356	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge at the Shore	900 S Beacon Blvd Grand Haven, MI 49417

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake: MI00144606 Based on interview and record review, the facility failed to 1.) assess and monitor pressure injuries/wounds, 2.) ensure pressure injury/wound assessments were complete, accurate, and documented in the resident record, 3.) notify the provider and the DPOA (Durable Power of Attorney) of new and deteriorating pressure injuries/wounds, and 4.) provide ordered wound treatments and ensure treatments were in place for pressure injuries/wounds for 1 of 3 residents (Resident #2) reviewed for alterations in skin integrity/pressure ulcers, resulting in incomplete and inaccurate wound assessment and a delay in wound treatment. Findings: Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke with Review of R2's hospital documentation Wounds-Active Wounds Moisture Associated Skin Damage Gluteal dated 4/10/24 and Toe Right Anterior dated 4/13/24 .Unclear wound on his abdomen, appears chronic. Wound care to see him . During an interview on 05/29/2024 10:37 AM, Family Member (FM) C stated R2's abdominal wound was due to an abscess they had to drain by his peg tube site. FM C reported there were no other wounds or pressure injuries other than the ones documented by the hospital at the time of R2's admission to the facility. Review of R2's Minimum Data Set (MDS) Section M-Skin Conditions dated 4/23/24 revealed, A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/devise-YES .Does the resident have one or more unhealed pressure ulcers/injuries? NO .Surgical wound care-YES .Other open Lesion(s) on the foot-YES .Moisture Associated Skin Damage (MASD)-NO Confirming there was no pressure injury identified during the admission assessment. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Care Plan revealed, Resident has an ADL (activities of daily living) self-care performance deficit related to hx. (history) of CVA (stroke), encephalopathy (change in brain function), non-verbal, mostly unresponsive, impaired mobility, B&B (bowel and bladder) incontinence .Date Initiated: 04/18/2024 Revision on: 04/30/2024 . AMBULATION: N/A .BATHING: 2 person assist in bed .BED MOBILITY: 2 person assist . TRANSFERS: with 2 person assist AND use of mechanical hoyer lift. Indicating R2 was fully dependent on staff assistance for all care including repositioning. During an interview on 05/29/2024 10:00 AM, Minimum Data Set Nurse (MDSN) A reported that A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/devise was documented as YES because R2 had scar tissue present over a bony prominence but did not have an active pressure injury. Review of R2's Nursing Admission Evaluation-Part 1 Section V-Skin dated 4/17/24 revealed excoriation on the sacrum and scrotum and a pink blanchable area on right outer ankle (no measurements), Right toe(s) unstageable (no specific toe identified), bilateral legs scars, open area on abdomen, and soft heels. There was no treatment ordered for the reddened area on the right outer ankle or bilateral heals to prevent the worsening of the skin injuries. (Only an intervention to wear heel boots while in bed was initiated). Review of R2's Skin & Wound Evaluation dated 4/17/24 (with a lock date of 5/10/24) revealed a wound on the coccyx measuring 6.5cm x 0.7 cm (no depth). Type (pressure, abrasion, etc) was blank. In house or present on admission was blank, length of time the wound had been present was blank, all wound descriptions were blank, and there was no treatment plan documented. Review of R2's Skin & Wound Evaluation dated 4/17/24 (with a lock date of 5/9/24) revealed a stage II pressure injury to R2's scrotum documented as Present on Admission measuring 5.5 x 3.7 cm (no depth). Review of R2's Electronic Health Record revealed no documentation that the physician and DPOA (Durable Power of Attorney) were notified of the skin injuries/wounds. Review of R2's Order Summary with a start date of 4/18/24 revealed, Cleanse bottom and scrotum with soap and water and apply Triad cream. every shift for excoriation. This was to be done three times a day. Review of R2's April Treatment Administration Record revealed the above order was not completed 2 times on 4/19/24, 1 time on 4/20/24, 1 time on 4/22/24, 1 time on 4/28/24, and 1 time on 4/29/24. (There was no documentation that R2 would refuse treatment.) Review of R2's Electronic Health Record revealed no documentation for a rationale for the lack of wound care. Review of R2's Provider Note dated 4/19/24 revealed Erythema (superficial reddening of the skin) on his buttocks was present. No other skin concerns were identified. Review of R2's Skin & Wound Evaluations revealed no evaluation was completed on 4/24/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Skin assessment dated [DATE] revealed, Left iliac crest (front) dressing intact .right toe(s) great toe .Sacrum red . There were no measurements or descriptions of the pressure/skin injuries. There was no documentation that the physician or DPOA were notified of the skin injury. There was no treatment in place regarding dressing intact and no new treatments were initiated at that time. Review of R2's Provider Note dated 4/29/24 revealed no documentation that they were aware of and/or assessed R2's wounds. Review of R2's Skin Assessments revealed no skin assessment was completed on 5/1/24. Review of R2's Skin & Wound Evaluation dated 5/1/24 revealed that R2 had a Stage III pressure injury on his coccyx that was in house acquired with the Exact Date: 5/1/24. The wound measured 8.1 x 5.9 cm with no depth measured with the progress of the wound New. A pain score of 3/10 was documented and grimaces with cleansing and care. The treatment documented was to cleanse the wound with normal saline/generic wound cleanser and cover with a foam dressing. Review of R2's Electronic Health Record revealed no documentation that the physician and DPOA were notified of the deterioration of the wound (increased pain) or that the DPOA was notified of a treatment change. Review of R2's Transfer Form dated 5/2/24 section G. Skin/Wound Care 1. Pressure ulcers (stage, location, appearance, treatments) revealed, sacral stage 2. There was no additional documentation related to the sacral pressure injury. There were no other pressure injuries/wounds documented. R2 was admitted to the hospital on 5/2/24-5/6/24. Review of R2's Hospital Wound Consult dated 5/3/24 revealed, WOC (wound, ostomy, and continence) nurse consulted for multiple pressure injuries and other wounds present on admission to hospital. Patient nonverbal, dependent for care. Incontinent of bowel and bladder. He was assessed with the assistance of another WOC nurse. *Over the coccyx there is a large wound with a necrotic (death of tissue) base. The edges are purple and non attached. Surrounding skin non blanchable. Wound measures approximately 10x10 cm but has poorly defined borders. Triad paste applied. Impression: Evolving deep tissue injury, already full thickness with necrosis. *On the left hip there is an open wound with a pink smooth base. Wound edge purple and non attached. Minimal drainage. Wound measures 4.2x2.7 cm. Wound dressed with xeroform and a foam dressing. Impression: Evolving deep tissue injury, currently appears partial thickness . *BLE (bilateral lower extremities) with multiple areas of pressure injury and a wound on the right great toe with eschar present. Pressure injuries include: Right anterior ankle evolving deep tissue injury (identified on the admission assessment with no treatment ordered at that time). Left lateral pretibial area deep tissue injury (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left anterior ankle deep tissue injury Left lateral foot and left lateral ankle deep tissue injuries Right Achilles deep tissue injury Right medial foot deep tissue injury . Review of R2's Order Summary revealed there was no wound treatment ordered for R2's [NAME] lateral ankle, Left lateral pretibial area, Left anterior ankle, Left lateral foot, left lateral ankle, Right Achilles deep tissue injury, or Right medial foot upon return to the facility. Review of R2's Electronic Health Record revealed no documentation that the physician and DPOA were notified of the multiple new wounds. Review of R2's Nursing Evaluation Summary dated 5/6/24 revealed, Resident readmitted from acute facility . Moisture related wound to sacrum 8.4x10.2x0.1 cm., moderate SS (serosanguinous) drainage, no odor or pain, irreg. (irregular) edges, TX (treatment) in place. Posterior scrotum has a moisture related area 2x1x0.1 cm., house barrier cream applied . There were no other pressure injuries/wounds documented. Review of R2's Nursing Readmission Evaluation-Part 1 dated 5/6/24 revealed R2 had Moisture Associated Skin Damage to his scrotum and his sacrum. There were no other pressure injuries/wounds documented. Review of R2's Care Plans on 5/28/24 revealed they had not been updated to reflect R2's multiple pressure injuries following skin assessments, wound assessments, or the hospitalization from (5/2/24-5/6/24). The Care Plans did not reflect the wound consultant's recommendations from 5/8/24 of Elevate leg(s) .Limit sitting to 60 minutes/day .Turn in bed at least once every 2 hours if able .: Resident has impaired skin integrity as evidenced by: Wound to R (right) great toe Surgical wound to L (left) lower abdomen Excoriation of scrotum and buttocks. Date Initiated: 04/18/2024 Revision on: 04/30/2024 . Administer treatment(s) per orders Date Initiated: 04/18/2024 . Assist resident with turning and repositioning as needed Date Initiated: 04/18/2024 .Notify Physician/NP/PA of noted worsening skin condition or any new areas of skin impairment Date Initiated: 04/18/2024 . Resident is at risk for impaired skin integrity related to impaired mobility, decreased mobility, dependence on staff for mobility, B&B (bowel and bladder) incontinence Date Initiated: 04/18/2024 Revision on: 04/30/2024 . Assist resident with turning and repositioning as needed Date Initiated: 04/18/2024 . Complete skin inspection weekly and as needed Date Initiated: 04/18/2024. A consent for a wound consultant provider to evaluate and treat R2 was completed on 5/6/24. Review of R2's Skin & Wound Evaluation dated 5/7/24 revealed R2 had a Stage III pressure injury on his coccyx that measured 8.9 x 5.9 cm with no description of the wound bed or treatment completed and/or implemented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Skin & Wound-Total Body Skin assessment dated [DATE] revealed 4 new wounds were identified. No further descriptions documented. Review of R2's Pertinent Charting Initial-Skin dated 5/7/24 revealed, 1. Date skin issue occurred: 5/6/24. 2. Location of skin area being documented: Coccyx, scrotum, right dorsum foot and 1st metatarsal phalangeal, left lower quad previous surgical site .Schedule for wound round PA (Physician Assistant) on 5/8/24 . Review of R2's Provider Note dated 5/7/24 revealed no documentation that they were aware of and/or assessed R2's newly identified wounds. Review of R2's Skin & Wound Evaluation dated 5/8/24 revealed R2 had a Stage III pressure injury on his coccyx that measured 9.9 x 5.9 with no depth measured. The wound bed was 40 % necrosis and 60 % granulation tissue. The treatment provided was cleansing the wound with normal saline and applying Honey Alginate cover (with) Silicone Bordered Gauze. Review of R2's Electronic Health Record revealed no documentation that the physician and DPOA were notified of the deterioration of the wound. Review of R2's Skin & Wound Evaluation dated 5/8/24 revealed R2 had a Stage III pressure injury on his Left lateral thigh documented as new and measuring 3.8 x 2.0 cm with no depth measurements. Review of R2's Wound Consultant Evaluation dated 5/8/24 revealed: (Wound) Location: left hip, right foot, scrotum, coccyx, abdomen Duration: since admission (5/6/24) Context: pressure Associated Signs and Symptoms: Complaints of increased pain [AGE] year old male admitted to Medilodge Facility on 5/6/24. Wound specialist asked to evaluate and treat . *Wound #4 Posterior Scrotum is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 3cm length x 1cm width x 0.1 cm depth . *Wound #5 Sacral is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 7.6 length x 9.8cm width x 0.1 cm depth . *Wound #6 Left Hip is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 3.5cm length x 1.5 cm width x 0.1 cm depth . *Wound #7 Right, lateral Calf is a Stage 2 Pressure injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 16cm length x 3.5cm width with no measurable depth . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/2024 at 11:26 AM, Corporate Clinical Nurse (CCN) B confirmed the Left Hip and Left Lateral thigh were the same pressure injury documented by the wound consultant and facility staff. Review of R2's Provider Note dated 5/8/24 revealed, .Skin .Perineum small pelvic partial-thickness wound. Right great toe with dry eschar dorsal aspect. Bilateral lower extremities multiple areas of pressure injury. Right anterior ankle involving deep tissue injury. Left lateral foot and left lateral ankle deep tissue injury. Right Achilles deep tissue injury. Right medial foot deep tissue injury . Review of R2's Skin & Wound Evaluation dated 5/10/24 revealed R2 had a Stage II pressure injury to his scrotum documented as Present on Admission and had been present for 1 week. The wound measured 3.7 x 2.6 cm with no depth documented. (Note: no other Skin & Wound Evaluations for his scrotum since 4/17/24). There were no locations, measurements, or descriptions of the pressure injuries/wounds. Review of R2's Electronic Health Record revealed no documentation that the DPOA was notified of scrotal wound or of any new treatments ordered. Review of R2's Skin assessment dated [DATE] revealed there were no new areas of breakdown identified. Review of R2's Wound Consultant Evaluation dated 5/15/24 revealed: (Wound) Location: left hip, right foot, scrotum, coccyx, abdomen Duration: since admission Context: pressure Associated Signs and Symptoms: Complaints of increased pain *Wound #4 Posterior Scrotum is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.9cm length x 0.9cm width x 0.1 cm depth .The wound is improving *Wound #5 Sacral is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 8.5 length x 9cm width x 0.1 cm depth .The wound is deteriorating .(A debridement-removal of dead tissue-was completed at the bedside at that time. Post Debridement Measurements: 8.5cm length x 9cm width x 0.2cm depth .) *Wound #6 Left Hip is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 1.1cm length x 1.5 cm width with no measurable depth . the wound is improving . *Wound #7 Right, lateral Calf is a Stage 2 Pressure injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 11.5cm length x 2.5cm width with no measurable depth .The wound is improving . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NEW WOUNDS *Wound #8 Right, Lateral Ankle is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 3.7cm length x 3cm width x 0.1 cm depth .(This area was documented on admission as a pink blanchable area. No wound treatment was initiated when first identified. A treatment order was not initiated until 5/16/24.) *Wound #9 Right, Distal, Anterior Calf is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 0.4cm length x 0.5cm width x 0.1ccm depth . Review of R2's Electronic Health Record revealed no documentation that the physician and DPOA were notified of the new wounds. There was no documentation that the DPOA was notified of any new treatments ordered. Review of R2's Electronic Health Record revealed there were no Skin & Wound Evaluations completed on R2's coccyx or left lateral thigh on 5/15/24 or on 5/17/24 on R2's scrotum (1 week from previous assessment per the facility policy). There was no documentation and/or pictures of the newly identified wounds on R2's Right, Lateral Ankle or Right, Distal, Anterior Calf. Review of R2's IDT-Interdisciplinary Progress Note dated 5/16/24 revealed, IDT meeting- readmission 5/6/24 for a Cerebral Infarction and is LTC - He does not have any new wounds . Confirming the lack of communication from the licensed nurses to management and providers. Review of R2's May Medication Administration Record revealed: *Cleanse sacrum with normal saline or wound cleanser. Apply honey and Ca/Alginate and cover with Silicone Bordered foam. Change daily and as needed. This treatment was not completed on 5/13/24 or 5/16/24. (R2 was sent out of the facility for a procedure on 5/16/24 but the wound treatment was not completed upon his return). * Left Hip: cleanse with Normal saline or Wound Cleanser Apply collagen sheet to promote autolytic debridement; cover with Silicone Bordered Foam and change daily and as needed . This treatment was not completed on 5/13/24 or 5/16/24. *Posterior Scrotum: Cleanse with Normal Saline or Wound Cleanser, apply DermSeptin Ointment to scrotum and inner creases daily and as needed . This treatment was not completed on 5/13/24, 5/16/24, or 5/17/24. *Right, lateral Calf: Cleanse with Normal Saline or Wound Cleanser, Apply skin prep daily and as needed . This treatment was not completed on 5/13/24, 5/16/24, or 5/17/24. Review of R2's Electronic Health Record revealed no documentation that the provider was notified the treatments were not completed or a rationale for the lack of wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Nurses' Note dated 5/18/24 at 7:38 PM revealed, While doing my med pass, residents son asked me if I was his nurse, I explained that I was and I will be until 6 a.m., He said he would like his father sent to the ER ASAP, as he is running a temp and his wound on his coccyx is worse than it was yesturday (sic), I went and called (nurse practitioner name omitted) and explained the situation and request by the family, she agreed to send him to the ER .the daughter in law asked to see me, she was very nice, yet very concerned, and questioned me in great detail about the worsening of his wound and new tunneling she said she observed, she voiced many complaints and concerns of which I attempted to dis spell (sic) as well as assured her he is being checked and repositioned hourly, but could only speak for my 12 hours night shifts, she was very reluctant to believe me and appears to be very dis satisfied (sic) with his care .EMS arrived to transport resident . Review of R2's Emergency Department Progress Notes beginning on 5/18/24 at 9:06 PM revealed, .ED (Emergency Department) Course as of 5/18/24 2244 (10:44 PM) Patient seen examined. Patient is a [AGE] year-old male presenting to emergency department complaint of likely infected decubitus ulcer .Severe decubitus ulcer see picture .Patient's CT scan does result as described below. No evidence of osteomyelitis however there is noted some soft tissue emphysema. I did discuss this with the radiologist further and there is only this noted in the soft tissue area nothing deeper that be suggestive of a deeper space necrotizing fasciitis .Patient has numerous medical comorbidities and seeing the progression of the patient's wounds over the last couple of weeks the General surgery team feels that having wound care in person would be more appropriate for this patient thus requesting transfer to [NAME] Hospital .DIAGNOSIS at time of disposition: 1. Severe sepsis 2. Pressure injury of buttock, stage 4, unspecified laterality .ED Disposition: TRANSFER TO ANOTHER FACILITY . Review of R2's Hospital Inpatient Progress Notes beginning on 5/19/24 revealed: General Medicine History and Physical dated 5/19/24 at 4:39 AM revealed, .Severe sepsis d/t (due to) infected sacral decubitus and Concern for concurrent foot wounds .He went to Medilodge after his last admission and has since developed multiple pressure ulcers. He was admitted for this wound and concern for infection given fevers .He was transferred from (city) to (hospital) for wound evaluation. There was concern on the CT for subcutaneous emphysema in the wound and concern for necrotizing process. The wound has many little tunneling pockets under the eschar . Infectious Disease Consultation dated 5/21/24 revealed, .Plan: At this time, unclear source of sepsis/SIRS but likely from infected sacral decubitus ulcer . During an interview on 05/28/2024 at 3:03 PM, R2's DPOA confirmed that he had not been notified by the facility staff of R2's new and worsening pressure injuries and was made aware of the new and deteriorated wounds when R2 was admitted to the hospital from 5/2/24-5/6/24 and again on 5/18/24-current. During an interview on 05/28/2024 at 1:06 PM Licensed Practical Nurse (LPN) D reported that until the last 3 weeks there was no designated wound nurse for the facility and the floor nurses had been responsible for Skin Assessments and Skin & Wound Evaluations for their residents for the shift. LPN D reported that there were now Unit Managers that were responsible for ensuring all documentation was complete, wounds were measured, orders were implemented, treatments were completed as ordered, and would round with the wound consultant. LPN D reported it was working much better to have consistent staff following resident wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/2024 at 11:26 AM, CCN B reported that facility management team had identified concerns with the wound management program which included late Skin Assessments and Skin & Wound Assessments, wound assessments being incomplete (no depth measurements and pictures) and/or late, wound assessments inconsistent with the wound consultant's assessment/measurements, and orders not implemented. CCN B reported that beginning on 5/7/24 facility licensed nurses and unit managers were educated on the skin and wound policies and procedures of the facility and systemic changes to the wound management program were initiated. Review of the facility policy Pressure Injury Prevention and Management last reviewed/revised 1/1/22 revealed, .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3.Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury risk assessment, using the [NAME] or Braden tool on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly. b. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. c. Assessments of pressure injuries will be performed by a licensed nurse and documented in the medical record .4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care. f. Interventions will be documented in the care plan and communicated to all relevant staff. 5. Monitoring a. The attending physician will be notified of i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. iii. Any complications (such as infection, development of a sinus tract, etc.) as needed. b. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified. 6. Modifications of Interventions .b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i. Changes in resident's degree of risk for developing a pressure injury. ii. New onset or recurrent pressure injury development. iii. Lack of progression towards healing . (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Wound Treatment Management last reviewed/revised 10/26/23 revealed, .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise, or is wet. 4. Dressings will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage .b. Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size - including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of peri-wound skin. c. Location of the wound. d. Goals and preferences of the resident/representative. 6. The effectiveness of treatments will be monitored through ongoing assessment of the wound.