STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235518	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Woods Manor	13137 North Clio Road Clio, MI 48420

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This citation pertains to Intake Number MI00149458. Based on observation, interview and record review, the facility failed to operationalize policies and procedures for skin/wound assessments and prevent the development of pressure ulcers for three residents (Resident #1, Resident #2, and Resident #3) of three residents reviewed for wound and skin care, resulting in Resident #1's development of facility- acquired Stage III pressure ulcer to the coccyx area, five suspected deep tissue injuries on the right and left feet and pain; Resident #2's development of facility-acquired right buttock pressure wound stage II and right ischium pressure wound stage IV, and the potential for wounds to go undetected and untreated, pain and wound infection. Findings include: A review of the facility document titled Wound Measurement, revealed, .Suspected Deep Tissue Injury-Purple or maroon localized area of discolored intact skin or bold-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue . and .Stage III-Full thickness tissue loss, Subcutaneous fat may be visible but bone, tendon or muscle and not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling . Resident #1: A review of Resident #1's medical record revealed an admission into the facility on [DATE] and readmission on 1/12/25 with diagnoses that included Alzheimer's disease, weakness, obesity, pressure ulcer of sacral region stage 3 with onset date 11/24/24, pressure-induced deep tissue damage of right heel with onset date 11/21/24, and pressure-induced deep tissue damage of left heel with onset date 11/21/24. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident had severely impaired cognitive skills for daily decision making and was dependent on staff for oral hygiene, toileting hygiene, bathing, personal hygiene, transfers and needed partial/moderate assistance to roll left and right. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no unhealed pressure ulcers/injuries. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the MDS dated [DATE] revealed the Resident had one unhealed pressure ulcer/injury that was documented at a Stage 3 pressure ulcer and five current unhealed pressure ulcers/injuries at Unstageable-Deep tissue injury and zero of the number of these unstageable pressure injuries that were present upon admission/entry or reentry. A review of Resident #1's Wound Measurement documentation in the medical record revealed the following: -Date 11/21/24, Observations: Site: Right outer foot, Type: Pressure, Length 1.5 cm (centimeters), Width 1 cm, Stage: Suspected Deep Tissue Injury. Assessment notes included: (Resident #1's name) has an unstageable wound to her right outer foot. She is severely cognitively impaired due to dementia. She relies on staff for repositioning. Her appetite is fair. She is incontinent of her bladder and bowels. Staff assist her to reposition prn (as needed) -Date 11/26/24, Observations: Site: right heel, Type: Pressure, Length 2.9 cm, Width 3.3 cm, Stage Suspected Deep Tissue Injury; Site: left heel, Type: Pressure, Length 0.7 cm, Width 0.2 cm, Stage Suspected Deep Tissue Injury; Site: Right Small Toe, Type: Pressure, Length 0.7 cm, Width 0.4 cm, Stage Suspected Deep Tissue Injury; Site: Right outer foot, Type: Pressure, Length 1.6 cm, Width 1.1 cm, Stage Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 3.0 cm, Width 1.2 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) was assessed this morning while resting in bed. She has finished her breakfast (provided by staff) throughout the course of the assessment. During palpation over the areas of impairment (Resident's name) demonstrates brief symptoms of pain via facial grimacing, sharp intake of break (breath) and minor pulling away of the extremity. The right heel presents with a large, fluid filled blister and darkened tissue beneath. The discoloration on the outer edge presents as dark maroon in color and is flush with the skin. Similar presentation superior near the pinky toe. The left foot presents with a large area on the outside of the foot that is maroon around the edges and light in the center. This area is soft, boggy and retaining a small amount of fluid. The left heel also presents with a non-blanchable reddened area, boggy in nature. Since observing the discolorations (Resident name) has been provided with bilateral lower extremity prafo boots. She is using a pressure relieving mattress; however, a bariatric bed and air mattress have both been requested. She had recently been referred to skilled therapies for evaluation of her wheelchair positioning and a new wheelchair is in process of being obtained at the facility. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	-Date 12/6/24, Observations: Site: right heel, Type: Pressure, Length 2.9 cm, Width 3.3 cm, Stage Suspected Deep Tissue Injury; Site: left heel, Type: Pressure, Length 0.7 cm, Width 0.2 cm, Stage Suspected Deep Tissue Injury; Site: Right Small Toe, Type: Pressure, Length 0.7 cm, Width 0.4 cm, Stage Suspected Deep Tissue Injury; Site: Right outer foot, Type: Pressure, Length 1.6 cm, Width 1.1 cm, Stage Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 3.0 cm, Width 1.2 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) was assessed this morning while resting in bed. During palpitation over the areas of impairment. The right heel presents with a large, fluid filled blister and darkened tissue beneath. The discoloration on the outer edge presents as dark maroon in color and is flush with the skin. Similar presentation superior near the pinky toe. The left foot presents with a large area on the outside of the foot that is maroon around the edges and light in the center. This area is soft, boggy and retaining a small amount of fluid. The left heel also presents with a non-blanchable reddened area, boggy in nature. Since observing the discolorations (Resident's name) has been provided with bilateral lower extremity prafo boots. She is using a pressure relieving mattress, however, a bariatric bed and air mattress have both been requested. She had recently been referred to skilled therapies for evaluation of her wheelchair positioning and a new wheelchair is in process of being obtained at the facility. The bariatric bed and air mattress had not been initiated when mentioned they were requested on 11/26/24. -Date 12/12/24, Observations: Site: right heel, Type: Pressure, Length 3 cm, Width 2.5 cm, Stage Suspected Deep Tissue Injury; Site: Right Small Toe, Type: Pressure, Length 1.5 cm, Width 0.4 cm, Stage Suspected Deep Tissue Injury; Site: Right outer foot, Type: Pressure, Length 1.6 cm, Width 1.1 cm, Stage Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 3.0 cm, Width 1 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) has an unstageable wounds to her right outer foot, right foot near her small toe and Left foot. She is severely cognitively impaired due to dementia. She relies on staff for repositioning . -Date 12/19/24, Observations: Site: Coccyx, Type: Pressure, Length 4 cm, Width 3cm, Depth 0.1 cm Stage: III; Site: right heel, Type: Pressure, Length 2.9 cm, Width 3.3 cm, Stage Suspected Deep Tissue Injury; Site: left heel, Type: Pressure, Length 3 cm, Width 2 cm, Stage Suspected Deep Tissue Injury; Site: Right Small Toe, Type: Pressure, Length 0.7 cm, Width 0.4 cm, Stage Suspected Deep Tissue Injury; Site: Right outer foot, Type: Pressure, Length 1.6 cm, Width 1.1 cm, Stage Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 3.0 cm, Width 1.2 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) has multiple pressure wounds to her body. She relies on staff to reposition her. Her appetite is poor and she relies on staff to feed her. She is incontinent of her bladder and bowels . Treatments are completed as ordered. She is on an alternating air mattress. -Date 12/26/24, Observations: Site: Coccyx, Type: Pressure, Length 4.5 cm, Width 3cm, Depth 0.1 cm Stage: III; Site: right heel, Type: Pressure, Length 2.9 cm, Width 3.3 cm, Stage Suspected Deep Tissue Injury; Site: left heel, Type: Pressure, Length 30.5 cm, Width 20.5 cm, Stage Suspected Deep Tissue Injury; Site: Right Small Toe, Type: Pressure, Length 0.75 cm, Width 0.43 cm, Stage Suspected Deep Tissue Injury; Site: Right outer foot, Type: Pressure, Length 1.65 cm, Width 1.1 cm, Stage Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 3.0 cm, Width 1.2 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) has multiple pressure wounds to her body. She relies on staff to reposition her. Her appetite is poor and she relies on staff to feed her. She is incontinent of her bladder and bowels . Treatments are completed as ordered. She is on an alternating air mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Date 1/16/24, Observations: Site: Coccyx, Type: Pressure, Length 5 cm, Width 4cm, Depth 3 cm Stage: III; Site: Right outer foot, Type: Pressure, Length 1.5 cm, Width 1 cm, Stage: Suspected Deep Tissue Injury; Site: Left outer foot, Type: Pressure, Length 1 cm, Width 1 cm, Stage Suspected Deep Tissue Injury. Assessment notes included: (Resident's name) was readmitted with 3 pressure areas. She relies on staff to reposition her. She is now receiving tube feeding. She is incontinent of her bladder and bowels. She is at risk for further break down due to the diagnosis of Alzheimer's, depression, CKD (chronic kidney disease), HTN (hypertension) and hypothyroidism. Staff reposition her prn. Staff assist her to complete meals and fluids. Staff provide incontinence care upon rising, before and after meals, at HS (nighttime) and prn. Treatments are completed as ordered. She is on an alternating air mattress. Prafo boots are applied at HS and PRN. There was a description of the coccyx wound but not of the other wounds. A review of the progress notes revealed a lack of assessment of the other wounds. A review of Resident #1's medical record revealed a lack of documentation of the resident being repositioned and a lack of documentation regarding the application of the Parfo boots. A review of Resident #1's Short Term Care Plan Wound and Skin, revealed a care plan on 11/20 for the problem Potential for infection as evidence by: Redness and Tenderness was indicated, handwritten 1.5cmx (by) 0.8 cm deep tissue injury to outer R (right) foot. The Approaches included, Medication as Ordered, Ensure culture ., Document presence of S/S (signs and symptoms) of infection ., Assess nutritional needs ., Ensure availability of fluids, Notification of authorized representative PRN, Assess pain level within EMAR, TX (treatment) as ordered, Document compliance with TX and response to TX prn, Consult Health Care Practitioner PRN, Weekly/prn measurement of the area, Positioning guidelines/other indicated approaches for this resident: (no items documented). No further guidelines or approaches were identified on this care plan for positioning or other indicated approaches. The Short Term Care Plan had documentation for vital signs, drainage, odor, surrounding warmth, surrounding edema and compliant with positioning guidelines. A review of Resident #1's Short Term Care Plan Wound and Skin, revealed a care plan on 11/24 for the problem Potential for infection as evidence by: Symptoms: Stage I pressure injury coccyx with similar approaches as listed above with approach #10. Add indicated additional approaches to protect the residents skin to the permanent plan of care: (no other approaches were listed.) Further documentation was requested of the Short Term Care Plans (STCP) after the Resident returned from the hospital but was not received prior to the exit of the survey. A review of Resident #1's care plan revealed a Focus (Resident's name) is at risk for altered functional mobility and ADL's . Intervention for Skin, after the onset of pressure ulcers, included: Skin Impairment Location: both feet, sacrum revision on 11/27/24 Heels elevated in bed as tolerated; Inspect heels with care and report to charge nurse as indicated **Parfo boots to be worn ATC (around the clock) as tolerated, with a revision date on 11/27/24. The care plan and STCP-for potential for infection, lacked the identification of the multiple facility acquired pressure ulcers, and STCP for each individual wound with a lack of person centered approaches/interventions for the prevention and healing of the wounds and updated as wounds developed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #1's weekly nursing skin assessments revealed a skin assessment done on 8/28/24 and then on 9/11/24, 14 days apart; 11/27 skin assessment completed then not completed until 12/9 which was 12 days since the last skin assessment completed, then completed on 12/18 which was 9 days since the previous skin assessment completed; skin assessment completed on 12/18 from which the Resident was discharged to the hospital on 12/30 which was nine days between the completed skin assessments and transfer to the hospital. On 1/17/25 at 11:25 AM, an observation was made of Resident #1 lying in bed. The Resident did not engage in conversation but nodded yes for surveyor to watch dressing change completed with Clinical Care Coordinator, Nurse E and Nurse K. The old dressing was removed from the coccyx wound, area opened, reddened. The old dressing had packing that was covered by a foam dressing. When asked about the packing, Nurse K indicated that the order was not for a packing but both Nurses indicated it was a good idea and Nurse E indicated she would have the treatment order changed. The area was cleansed and Santyl applied to the wound bed and covered with a border foam dressing. An observation was made of the air mattress on the bed with settings of normal pressure, #3 comfort level and float. On 1/21/25 at 10:34 AM, an observation was made with Clinical Care Coordinator (CCC), Nurse E of Resident #1's feet and heels. An observation was made of Resident #1's feet and legs with dry flaking/peeling skin on bilateral feet and lower legs. The right heel where the blister had been, had pink skin and was not open, the outer foot areas had a brownish area in the middle of the wound bed and were not open. An observation was made with Nurse E of the air mattress machine. The settings were on 3-harness/comfort level and the air circulation was on float. When asked why the air mattress was on float, the CCC reported that she was not aware of the difference between float and alternating, but indicated she thought it was the air flow through the mattress. The Nurse indicated that they put all the air mattresses on alternating, and it should not be on float. The Nurse switched it to alternating. Resident #2: A review of Resident #2's medical record revealed an admission into the facility on [DATE] and readmission on 3/20/23 with diagnoses that included diabetes, Alzheimer's disease, weakness, Fournier gangrene and pressure ulcer of right buttock with onset date 11/21/24. A review of Resident #2's MDS dated [DATE] revealed the resident had one Stage 2 pressure ulcer that was not present upon admission/re-entry, had a Brief Interview of Mental Status score of 11/15 that indicated moderately impaired cognition, was dependent on staff for transfers and needed partial/moderate assistance with mobility to roll left and right. A review of the MDS dated [DATE] for Significant change revealed the Resident had two Stage 2 pressure ulcers that were not present upon admission/re-entry and had one Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) that was not present upon admission/re-entry. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #2's Short Term Care Plan Wound and Skin, revealed a care plan on 11/21 for the problem Potential for infection as evidence by: Purulent Drainage was indicated, handwritten unstageable wound to right buttock. The Approaches included, Medication as Ordered, Ensure culture ., Document presence of S/S (signs and symptoms) of infection ., Assess nutritional needs ., Ensure availability of fluids, Notification of authorized representative PRN, Assess pain level within EMAR, TX (treatment) as ordered, Document compliance with TX and response to TX prn, Consult Health Care Practitioner PRN, Weekly/prn measurement of the area, Positioning guidelines/other indicated approaches for this resident: (no items documented). No further guidelines or approaches were identified on this care plan for positioning or other indicated approaches. The Short Term Care Plan had documentation for vital signs, drainage, odor, surrounding warmth, surrounding edema and compliant with positioning guidelines. A review of Resident #2's Wound Measurement documentation in the medical record revealed the following: -Dated 11/25/24, Observations: Site: Left heel, Type: Pressure, Length, 1.8 cm, Width 0.6, Depth 0.1, Stage: II; Site: Right Ischium, Type: Pressure, Length 3 cm, Width 4.2 cm, Depth 0.1, Stage: II, Right Ischium irregular shaped similar to a star. Assessment notes: There is a wound on resident's right ischium in the skin fold which is believed to be some pressure likely but also moisture excoriation based on the shape of the wound. The wound has several thin areas that stretch away from the center base [due to skin folds] giving it a star like shape. It is superficial at this time. His heel continues to heel slowly and is better when he is compliant with elevating his legs. There are no s/s of infection. The wound bed remains beefy red. -Dated 1/20/25, Observations: Site: Right buttock, Type: Pressure, Length 1 cm, Width 3 cm Depth 0.2 cm, Stage II; Site: Left buttock, Type: denuded blister, Length 1 cm, Width 1cm, Stage II; Site: Right Ischium, Type: Pressure, Length 1 cm, Width 1 cm, Depth 0.1 cm, Stage IV. Assessment notes: [assessment completed today for 1/17/2025] Wound on his right ischium [also labeled as right gluteal fold in the treatment orders] continues to heal slowly 2' (secondary) to poor oral intake especially poor protein intake despite protein supplement . He wound edges are healed to a more round shape [from original star-like shape]. There is scant drainage noted on previous dressing and no drainage noted during cleansing. The wound edges are flush with wound bed which remains pink. The peri wound area is appropriate for ethnicity and remains intact. There is no slough or s/s of infection. He has been more compliant with bed rest however he has been requesting that staff position him with pillows to help float his sacrum coccyx are but not actually lying on his side. Resident encouraged and tolerated lying on his side with pillows behind his back and supporting his leg for a short period of time. His heels remains pink and intact [free from pressure of breakdown]. New pressure area observed over the weekend to the right of his gluteal fold/right buttock/sacrum. The area is unusually shaped linear curve. The wound bed is beefy red with scant sanguineous drainage noted. Left Buttock across the gluteal fold [from right buttock wound] is a denuded blister [skin firm and slightly gray from blister stretching out skin and reabsorbing] Peri wound is pink and intact also. A review of the wound measurement documentation revealed wound measurements and assessments completed on 11/25/24 and then on 12/6/24, 11 days apart. A review of Resident #2's Skin Assessments from 8/26/24 to present revealed the following: 8/26/24 completed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	9/15/24, 20 days past the last skin assessment completed on 8/26/24. 10/13/24 and then after 14 days, skin assessment completed on 10/27/24. 11/3/24 and then after 14 days, skin assessment completed on 11/17/24. 11/21/24 and then after 10 days, skin assessment completed on 12/1/24. 12/1/24 and then after 35 days, skin assessment completed on 1/5/25. On 1/21/25 at 1:15 PM, an observation was made with Resident #2 of the dressing change to the buttock and ischial pressure wounds completed by Nurse J. The Resident was lying in bed, answered questions and engaged in conversation. Nurse J had removed the old dressings from the three areas, right buttock, left buttock and ischial wound. The dressing on the right buttock had drainage, the Nurse had used a 4 x 4 to cleanse the wound than folded the 4 x 4 over and cleansed the wound on the left buttock. The Nurse used the same 4 x 4 to cleanse both wounds and had not changed gloves and performed hand hygiene between the cleansing of the two wounds. The old dressing on the left buttock did not have any drainage. The Nurse got another 4 x 4 and started to clean the wound on the right ischial prior to changing gloves and performing hand hygiene. The Nurse stopped and leaving the 4 x 4 at the ischial wound, changed his gloves. It was noted that a small open area was observed by the Nurse of the Residents scrotum. The area was cleansed, and ointment was applied. Resident #3: A review of Resident #3's medical record revealed an admission into the facility on [DATE] and discharged on [DATE] with diagnoses that included enterocolitis due to Clostridium difficile, rhabdomyolysis, diabetes, heart failure and kidney failure. A review of Resident #3's Skin Assessments revealed a skin assessment completed on 12/4/24 and then completed next 12 days later on 12/16/24 and then not completed again until 12/30/24, 14 days after. On 1/21/25 at 11:46 AM, an interview of conducted with the Director of Nursing (DON) regarding the lack of skin assessments for Resident #1 and 2 and lack of assessment of the wound for Resident #1. The DON indicated that CCC, Nurse E might have her wound notes from week to week that are not in the electronic medical record. The lack of consistent skin assessments on a weekly basis was reviewed. The DON stated, Yes, I can see that the documentation is a concern. When asked about the air mattress alternating versus float, the DON indicated that it should be alternating and when addressed that the care plan did not have the machine settings, the DON indicated that they put the settings on the pump and can add alternating to the sticker. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/21/25 at 2:30 PM, an interview was conducted with CCC, Nurse E regarding Resident #1's development of the facility acquired pressure ulcers. When asked about facility policy on doing weekly skin assessments, a review was conducted of the lack of consistent weekly skin assessments. The Nurse indicated skin assessments were to be completed weekly. The Short Term Care Plan (STCP) for wounds were reviewed. The Nurse indicated that there should be a STCP for each wound. A review of the STCP revealed there was not a care plan for each individual wound. The Nurse indicated that the Nurses look at the wounds daily, and document on the STCP. A review of the STCP revealed that documentation had not occurred daily, and the documentation was not available for all wounds. The documentation would be for that specific wound with one STCP for each wound. Resident #2's wounds were reviewed with CCC, Nurse E. The Nurse reported that the left buttock origination was 1/19/24 and stated, I followed up on it yesterday, a denuded blister. A review of progress notes revealed that the wound had not been documented on 1/19/24 and the Nurse stated, I don't know why she didn't mention it in her note. The ischium was reported as started 11/21/24. A review of the STCP dated 11/21/24 listed Unstageable wound to right buttock, but the wound measurement documentation revealed two wounds at that time to the left heel and right ischium. The Nurse reported that each wound should have their own care plan, and the nurses were to document daily on the wounds. A review of the documentation of symptoms revealed that they were not done daily. The Nurse indicated that they are kept in a binder and once the page is filled, it is uploaded into the medical record. A request for the STCP's for Residents #2 and #1 were requested. The Nurse reported that our expectations are daily for the dressing and short term care plan documentation, and that there should be one for each wound. When asked who sets up the STCP, the Nurse reported the charge nurses or who ever discovers it, they should be adding a STCP in. A review of Resident #2's medical record revealed not all wounds identified with a care plan. The dressing change completed on Resident #2 with Nurse J was reviewed. The concern of professional standards of care for infection prevention was discussed with CCC, Nurse E. Review of the facility policy Skin at Risk Assessment Documentation, Staging & Treatment last revised January 2020 revealed, Policy: It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity .It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries .9. Re-assess and measure a pressure ulcer a minimum of weekly .10. Document the appearance of the wound with considerations to the physical characteristics as applicable to the resident: a. Location b. Stage c. Size d. Color e. Peri-wound condition f. Wound edges g. Sinus tracts or tunneling h. Exudate i. Odor .