STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265764	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Dilworth	9645 Big Bend Blvd Saint Louis, MO 63122

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify three residents physician and the representative/appropriate family member after the residents had a change in condition (Resident #1, #2, and #3). The sample was 4. The census was 151. Review of the facility's policy, Reporting of Condition Changes, incidents and injuries, revised 1/23, showed: -Purpose: To provide an orderly process for reporting changes in condition, incident or injuries involving residents; -Responsibility: It will be the responsibility of the licensed nurses to know and follow this policy; -Policy: It is the facility policy to report condition changes, incidents or injuries involving residents; -Practice: When reporting changes in condition or incidents, the following procedure should be followed: -1. Evaluate symptoms and/or injury. Complete overall head to toe assessment including taking vital signs, temperature and neuro checks as indicated. Document assessment and findings on SBAR (communication tool- Situation, Background, Assessment, Recommendation); -3. Serious incidents, i.e., fractures, head injuries, uncontrolled bleeding or acute changes in resident conditions are reported to the physician at the time of occurrence. Be prepared, such as using SBAR format, to report to the physician results of the assessment, including pertinent information relative to items such as medications, lab results, etc. Per individual physician's order, any non-emergent issues may be reported to the physician at a later time, such as the next business day, if so specified within their order; -5. The resident representative/appropriate family member should be notified of any change in physician orders, including a change in diet, medications, treatments, etc.; -Documentation: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. If an incident occurred, chart the incident in the resident's medical record; -2. Document objective details of incident and nursing interventions/corrective measures taken; -4. All charting should include notification of doctor and resident representative/appropriate family member. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/25, showed: -admission date: 3/7/25; -Severe cognitive impairment; -Diagnoses included high blood pressure, weakness, acute kidney injury, and altered mental status. Review of the resident's face sheet, showed: -Emergency contact and next of kin (NOK) contact information including phone numbers. Review of the resident's skin assessment, dated 3/8/25 at 10:38 A.M., showed the coccyx (small triangular bone at the base of the spinal column) with erythema (redness of the skin). Review of the resident's medical record, dated 3/8/25, showed no notification to the physician or family member. Review of the resident's skin assessment, dated 3/13/25 at 12:49 P.M., showed the coccyx with pressure ulcer and blister to right heel. Review of the resident's medical record, dated 3/13/25, showed no notification to the physician or the family regarding coccyx pressure ulcer. Review of the resident's physician orders, dated 3/13/25 at 8:00 A.M., showed: -Pressure ulcer, coccyx, BID (twice a day), clean with soap water, apply Calvida (treats discomfort associated with wet skin, urine, and stool), BID and as needed (PRN) for soiling; -Blister, heel, right, BID, skin prep BID to heel. Please float (elevating the foot off the bed reducing or eliminating pressure on the heel to promote healing and protect from injury) heels at all times. During an interview on 4/9/25 at 10:19 A.M., Registered Nurse (RN) D said the SBAR he/she filled out for the resident on 3/13/25 listed the coccyx at the beginning of the SBAR, but in the appearance and evaluation findings, he/she only listed the finding of the blister to right heel and orders for skin prep BID to the right heel. RN D said he/she spoke to the Nurse Practitioner (NP) about the right heel. He/she stated the Nurse Manager (NM) was aware of the coccyx wound, and he/she asked RN D put in the order for the coccyx. RN D put the order in for BID so the nurses would look at the coccyx twice a day. RN D did not speak to a physician prior to entering the order for the coccyx. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eKare (a mobile wound measurement and documentation system collecting information at the point of care and supporting the management of wounds) wound assessment, coccyx pressure ulcer measurements, dated 3/26/25, showed: -Wound 2: Coccyx: -Etiology: Pressure injury: Stage 1 (Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable redness); -Onset date: 3/26/25; -Measurements: 4.5 centimeters (cm) x 2.4 cm x 0.6 cm; -Color: Red (R, granulated tissue, tissue that forms during the healing process of wounds): 29%, Yellow (Y, slough, yellow, tan, gray, green or brown): 43%, Black (B, eschar (thick, dry, and leathery crust of dead tissue that forms over a wound or burn. It is typically black, brown, or gray in color)): 28%; -Wound 3: Right buttock: -Etiology: Pressure injury: Stage 1; -Onset date: 3/26/25. Review of the eKare wound assessment, right buttock pressure ulcer measurements, dated 3/29/25 at 11:10 A.M., showed: -Wound 2: Coccyx (photo and measurements are of right buttocks): -Measurements: 4.0 X 3.0 X 0.3 cm; -Drainage: Minimum: Clear, thin watery (serous); -Odor: Malodorous (unpleasant smell) Review of the resident's medical record, dated 3/29/25, showed no notification to the physician or family. During an interview on 4/4/25 at 2:24 P.M., Licensed Practical Nurse (LPN) B said he/she worked on 3/30/25. He/She applied Calvida around the foam dressing. The resident had drainage and a foul odor. He/She did not contact the physician. 2. Review of Resident #2's admission MDS, dated [DATE], showed: -admission date: 2/20/25; -Moderate cognitive impairment; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included high blood pressure, hemiplegia (paralysis of one side of the body) or hemiparesis (weakness or paralysis on one side of the body), peripheral vascular disease (PVD, blood vessels outside the heart and brain narrow, become blocked, or spasm) or peripheral arterial disease (PAD, arteries in the arms and legs narrow due to the buildup of plaque, on the artery walls) and diabetes mellitus. Review of the resident's face sheet, showed: -Emergency contact and NOK contact information including phone numbers. Review of the resident's eKare Wound assessment reports, dated 3/3/25 - 3/11/25, showed: Wound 3: Left buttocks: -Etiology: Pressure injury, stage 1; -Onset date: 3/11/25; -Assessment: No odor or drainage; -Stage 2 (Partial thickness skin loss with exposed dermis. The wound bed is viable, pink, red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (dead tissue, typically appearing as a yellow, tan, or white fibrous material, that may be present in a wound bed) and eschar are not present); -Measurements: 3.7 cm x 2.3 cm x 0.1 cm. Review of resident's medical record showed no notification to the physician or family completed for Wound #3 that was identified on 3/11/25. Review of the resident's eKare Wound assessment reports, dated 3/18/25, showed: -Wound #4: Right heel, calcaneus (heel); -Etiology: Pressure injury, stage 1; -Onset date: 3/11/25; -Last assessment date: 3/18/25; -Assessment: -No odor; -Drainage minimum: Clear, thin, watery (serous); -Stage 2; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Measurements: 7.3 cm x 6.8 cm x 1.0 cm; -Wound #5: Left heel, calcaneus; -Etiology: Pressure injury, stage 1; -Onset date: 3/18/25; -Assessment: No odor or drainage; -Stage 2; -Measurements: 7.0 cm x 6.4 cm x 0.6 cm; Review of resident's medical record showed no notification to physician or family completed for Wound #4 and Wound #5 that were identified on 3/18/25. 3. Review of Resident #3's admission MDS, dated [DATE], showed: -admission date: 3/7/25; -Cognitively intact. Review of the resident's face sheet, showed: -Emergency contact and NOK contact information including phone numbers. Review of the resident's eKare wound assessment, dated 3/10/25, showed: -Wound #5: Coccyx: -Etiology: Pressure injury: Stage 1; -Onset date: 3/10/25; -Measurements: 3.7 cm x 6.0 cm x 0.1 cm. Review of the resident's medical record, dated 3/10/25, showed no notification to the physician or family. Review of the resident's medical record, showed: -3/11/25 at 4:26 P.M.: -Skin abnormalities general: None; -3/19/25 at 1:32 P.M.: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin integrity general: Intact; -Skin abnormalities general comment: reddened buttocks; Review of the resident's medical record, dated 3/19/25, showed no notification to the physician or family. 4. During an interview on 4/3/25 at 10:14 A.M., LPN E said if a resident has a new or worsening wound, he/she notifies the nurse manager (NM) and she will look at the wound and take photos of the wound. The NM then notifies the wound physician (WP) and/or the physician. Changes are documented on the SBAR and the nurse or the NM will complete the SBAR. LPN E said on the weekends, the nurse on the floor is responsible for making notifications and documenting any changes but during the week, the nurse manager takes care of it. During an interview on 4/3/25 at 9:41 A.M., the NM said she is responsible for the weekly wound report for her floor. While rounding with the wound physician, if a resident has a decline in a wound, he/she does not call and inform the resident's family. If an order is changed for a wound, he/she does not call and notify the resident's family. With new admissions and new consults, he/she contacts the wound physician so she can start to follow the resident. On 4/3/25 at 2:19 P.M., the NM said if a resident has a new or worsening wound, the CNA reports it to the nurse. The nurse completes an assessment, fills out an SBAR and is responsible for notification to the physician and family. During an interview on 4/9/25 at 8:37 A.M., the Administrator and Director of Nurses said they expected staff to notify the physician and family if a resident has a new or worsening wound and for it to be documented in an SBAR. They expected the physician to be notified if a treatment needed to be changed because that is a change in condition and an SBAR should be completed. They expected staff to be knowledgeable of and follow the facility's policy and procedures. MO00252102 MO00252195

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure an acceptable skin management program was maintained to prevent pressure injury development and to report changes timely to the physician. The facility failed to complete wound assessments, including assessment and documentation of the location, stage, size, wound characteristics, periwound (the area around the wound) and wound edge description for two residents. (Residents #1 and #2). In addition, the facility failed to follow their policy for wound photographs and measurements for three residents (Resident #1, #2, and #3). The facility failed to contact Resident #1's physician prior to entering an order for a treatment. Additionally, the facility failed to follow their policy and complete a Situation, Background, Assessment, and Recommendation (SBAR) when new and/or worsening wounds were observed and failed to notify the physician and family for three residents (Resident #1, #2, and #3). Resident #1's pressure ulcer worsened, developing drainage and a foul odor. The resident required emergency surgery and was diagnosed with sepsis. Treatment orders were not followed for two of four sampled residents (Residents #1 and #2). The sample was 4. The census was 151. The Administrator was notified on 4/9/25 of an Immediate Jeopardy (IJ), which began on 3/29/25. The IJ was removed on 4/9/25 as confirmed by surveyor on-site verification. Review of the facility's policy, Wounds: Treatment of Pressure and Non-Pressure Injuries, including Staging and Documentation, revised 10/23, showed: -Purpose: To provide guidelines for use in wound assessment, treatment, and documentation; -Responsibility: It is the responsibility of the Director of Nursing (DON) to oversee this policy and procedure; -Policy: The facility Wound Product Selection Guide will be used as guidelines to determine appropriate treatments. A physician's order is required for all wound treatment; -A. General Principles of Wound Care: -1. Before choosing an intervention or treatment for a wound, it is important to identify the type of wound. Review the following documentation (attached) to determine the wound type and treatment protocol: -Pressure Injuries; -2. Keep the wound clean. Cleanse with wound cleanser or normal saline. Wound cleanser is preferable since it has the necessary pressure (8 pounds per square inch (psi)) to cleanse the wound properly. Use of betadine or hydrogen peroxide on open wounds is not recommended as they have been shown to be toxic to wound tissue; -3. For dry wounds add moisture and for wet wounds add absorbent dressing; -4. Protect the wound with appropriate dressing (See attached facility Health Group Wound Product Selection Guide. If the integrity of the dressing is compromised either by (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	drainage/exudates or movement, it should be changed; -5. Maceration (softening and breakdown of skin tissue due to prolonged exposure to moisture) - Protect peri wound with products that prevent moisture to wound edges such as skin prep, cavilon, zinc oxide. Refer to facility formulary; -6. Interventions should be taken to reduce edema and pressure related to the wound such as offloading heels and repositioning; -7. Individualize turning schedule; -8. Evaluate mattress type and add specialized mattress if indicated. Refer to Support Surfaces Algorithm; -B. Assessment/Documentation: -1. Any wound is to be assessed by a licensed nurse or licensed practitioner. The location, stage, size, odor, undermining (separation of wound edges from the surrounding healthy tissue, creating a space or pocket under the wound surface), tunneling (channel or passageway that extends from a wound or ulcer deep into the underlying tissues), exudates (fluid that leaks out of blood vessels into nearby tissues), necrotic tissue (tissue that is dead or dying), and presence of absence of granulation tissue (tissue that forms during the wound healing process), peri-wound and wound edge description should be noted and documented in the resident's medical record at least weekly. Wound assessment documentation should be completed for pressure Injuries and recommended for any other skin issues of concern; -a. Location: Describe the precise location of the wound in anatomical terms; -b. Staging: (Pressure Injuries): (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-1. Suspected Deep Tissue Injury (DTI): Persistent non-blanchable (skin condition where redness or discoloration does not fade or disappear when pressed upon) deep red, maroon, or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic (tissue that is dead or dying) tissue, subcutaneous (area below the skin) tissue, granulation (process of forming new tissue and blood vessels as part of the healing process of a wound) tissue, fascia (connective tissue that surrounds and connects various structures within the body, including muscles, bones, nerves, and organs), muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable (Slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined), Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) or Stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (thick, dry, and leathery crust of dead tissue that forms over a wound or burn. It is typically black, brown, or gray in color) may be present on some parts of the wound bed. Often includes undermining or tunneling.). Do not use deep tissue pressure injury to describe vascular, traumatic, neuropathic, or dermatologic conditions; -2. Stage 1 Pressure injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable redness which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes. Color changes do not include purple or maroon discoloration as these may indicate deep tissue pressure injury; -3. Stage 2 Pressure Injury: Partial thickness skin loss with exposed dermis. The wound bed is viable, pink, red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (dead tissue, typically appearing as a yellow, tan, or white fibrous material, that may be present in a wound bed) and eschar are not present. These injuries commonly result from adverse microclimate (specific climatic conditions, including temperature, humidity, and airflow, immediately surrounding the skin's surface) and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), This stage should not be used to describe skin tears, tape burns, abrasions, perinea l dermatitis (inflammation of the skin in the perineal area, the region between the anus and genitals), maceration, or excoriation (abrasion or wearing away of the skin's surface, resulting in raw, irritated, or red patches); (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-4. Stage 3 Pressure Injury: Full thickness tissue loss. Full-thickness loss of skin in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity (having excess body fat or being obese) can develop deep wounds. The bridge of the nose, ear, occipital (posterior, or back, region of the head) and malleolus (bony protuberance (bulge, lump, or projection on a body surface) on either side of the ankle joint) do not have subcutaneous tissue and Stage 3 Injuries can be shallow. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury; -5. Stage 4 Pressure Injury: Full thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable (capable of being felt by touch) fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury; -6. Unstageable Pressure Injury: Visualization of the wound bed is necessary for accurate staging. Full thickness tissue loss in which the base of the injury is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. However, stable (dry, adherent, intact without erythema or fluctuance (wave-like sensation or movement that is felt when palpating (examining by touch) a fluid-filled area of the body)) eschar on the heels serves as the body's natural (biological) cover and should not be softened or removed; -c. Size: -Measure the wound in centimeters (cm) including the length, width, and depth. Measure wound from healed margins to healed margins vs. edge to edge. Use clock coordinates when measuring depth with 12 o'clock representing toward the head. Using clock coordinates measure and document any tunneling or undermining using a cotton tip applicator. Tunneling is a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound. Undermining is the destruction of tissue or injury extending under the skin edges (margins) so that the pressure injury is larger at its base than at the skin surface; -d. Odor: Describe the odor of the wound as none, mild, or foul (after cleaning); -e. Color: Describe the color of the involved area. Note options for documentation here include describing the wound bed (including granulation tissue, slough, or eschar) in terms of color such as pink, red, yellow, white, black, or brown and estimate percentage of colors; -f. Surrounding tissue (Periwound): Assess the surrounding tissue and document the involved areas i.e., inflammation, maceration or wet wound edges, tenderness, warm or cool to touch, skin turgor, hypertrophic (abnormally enlarged)/callused/thickened, or any other finding; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-g. Drainage: Describe the type, amount, and color of the drainage (exudates). Examples: yellowish green, gray, serosanguinous (fluid that contains both serum (clear, watery part of blood) and blood typically appears as a pinkish-red or yellowish fluid), etc.-amount: zero, small, moderate, and large; -h. Pain: Describe pain related to the wound and incorporate interventions to reduce pain in the care plan. Document interventions and outcomes in the medical record. -C. Monitoring of Wounds: Weekly wound rounds will be made by the DON or designee to assess all wounds (Pressure and Non-Pressure Injuries); -Monitor wounds for signs and symptoms of infection such as purulent (containing or producing pus) exudates, peri-wound warmth, swelling, induration, or erythema (erythema may not be easily determined in residents with dark skin pigmentation), increased pain or tenderness around the site or delayed wound healing. Findings such as elevated white blood cell (WBC), bacteremia, sepsis, or fever may signal an infection related to a pressure injury area or co-existing infection from a different source. -If any of the above symptoms develop, intervene appropriately, including notification of the physician and obtaining orders. Update the Plan of Care as appropriate; -If the wound fails to show some evidence of progress toward healing within 2 weeks, the wound and the resident's overall clinical condition should be reassessed, and the treatment plan reevaluated. The decision to change, modify or remain with the same treatment plan should be documented. Rationale for continuing with the same treatment should be well documented; -When a wound is present monitoring should include the following: -An evaluation of the injury if no dressing is present: -An evaluation of the status of the dressing, if present (whether it is intact, if there is drainage, is it or is it not leaking). If the dressing is leaking, it must be changed; -The condition of the area surrounding the injury can be observed without removing the dressing; -The presence of complications, such as signs of increasing area of ulceration or soft tissue infection, increased redness or swelling around the wound or increased drainage from the wound; -If pain is present, and if so, assess it is being adequately controlled; -See Assessment section of this policy and procedure regarding weekly assessment and documentation; -Although the above information refers to pressure injury monitoring, the same should apply for all wounds, including heels with eschar; -In addition, it is recommended monitoring be completed on all healed wound sites and documented weekly during skin assessments. Remember that the skin of healed (continued on next page)

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	265764	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Dilworth	9645 Big Bend Blvd Saint Louis, MO 63122

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wounds and surrounding area are always more susceptible to breaking down again; -Based on assessment, the resident's clinical condition, choices and identified needs, basic or routine care should include: -Turning and positioning, protecting heels; -Keep clean and dry; -Provide appropriate support surface; -Monitor and maintain nutrition and hydration status, where feasible; -Evaluate drug regimen; -Incorporate interventions into Plan of Care and revise as condition of the resident indicates; -F. Documentation: -It is critical that all caregivers document their observations and activities. For example, CNAs are critical to the process by reporting abnormal skin observations, documenting nutrition and hydration aspects, turning and positioning, peri-care, etc.; -Nurses also have a variety of documentation responsibilities as indicated throughout and are critical to the process of documenting interventions that have been taken to avoid pressure injuries; -G. Use of Wound photography: Photography will include wounds that are pressure injuries, arterial or venous wounds. -Wound photographs will be taken upon admission or readmission to the community, weekly, upon discovery, as needed and upon discharge; Review of the facility's policy, Skin integrity, Assessment and Prevention of Wounds/Other Skin Conditions, revised 9/22, showed: -Purpose: To prevent avoidable skin breakdown and pressure injuries, provide guidelines for the treatment of impaired skin and guidelines for documentation; -Policy: All residents will be assessed for the risk of skin breakdown. Risk factors identified will be evaluated. Interventions will be developed and implemented to minimize or stabilize the risk. Interventions will be care planned; -I. Assessment: (continued on next page)

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