

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	

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)
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31424</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 2 sampled residents (Resident 1), who had a history of Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and amputation (surgical removal) of his right leg above the knee, received care consistent with nursing standards of practice and the resident's individualized care plan when:</p> <ol style="list-style-type: none"> 1) Licensed nursing staff did not document daily skin assessments (to identify skin injury) for Resident 1, as indicated in his Nursing Care Plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes); 2) Licensed nursing staff did not document the condition Resident 1's remaining foot (left) for a period of approximately one month prior to the identification of his necrotic (necrosis; death of body tissue; also known as necrosis) second toe. 3) Licensed nursing staff did not notify Resident 1's covering physician (via the on-call advice nurse) immediately when they identified his toe was black in color; they did not communicate Resident 1's potentially life-threatening condition during the initial phone call, they informed the physician in a subsequent phone call; and 4) Licensed nursing staff did not ensure Resident 1 was promptly transferred to the hospital once his emergent condition was discovered on the morning of 10/13/24, he was transported to the hospital hours later at 4:34 p.m.; the facility did not arrange transportation the hospital, an outside provider group (Provider Group F) called for ambulance transport. <p>These failures:</p> <ol style="list-style-type: none"> 1) Caused Resident 1's necrotic toe to go undetected until it had advanced to the wet gangrene (a type of necrosis when infection is present; can be fatal if left untreated) stage, when infection and sepsis (the body's extreme response to an infection; a life-threatening medical emergency) were already present, thereby placing him at risk of death and necessitating an emergent transfer to the hospital. 2) Prevented Resident 1's physician from knowing the declining status of his foot/toe, impairing his ability to intervene earlier in the disease process and order diagnostic testing and potential treatment to mitigate disease progression. <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3) Contributed to the amputation of Resident 1's left, second toe.</p> <p>4) Contributed to Resident 1 developing sepsis.</p> <p>5) Delayed his arrival to the Emergency Department, thereby delaying sepsis treatment (antibiotic [medication to treat infection] administration); and</p> <p>6) Contributed to Resident 1 experiencing foot pain he described as 6/10 (Pain Scale: a tool health care professionals utilize to help assess a person's pain: 0 is no pain and 10 is the worst pain imaginable).</p> <p>Findings:</p> <p>During a telephone interview with a confidential family member (CF) on 11/7/2024 at 11:54 a.m., CF stated her family member (Resident 1) called her on Sunday (10/13/2024) and told her he had pain in his left foot and his toe had been black for a while. CF stated a certified nurse assistant (CNA E) took a picture of Resident 1's foot and sent it to her; CF stated the photo showed his toe was black in color and nearly falling off. She stated the facility nurse, Licensed Nurse C (LN C), called Resident 1's provider group (Provider Group F; group of physicians covering for/working with Resident 1's physician, Physician D) and spoke to the on-call nurse. CF stated LN C told her the on-call physician had ordered Resident 1 to be given Gout (painful joint swelling) medication and have ice placed on his foot.</p> <p>During the same telephone interview on 11/7/24 at 11:54 a.m., CF stated she reviewed Resident 1's medical record (via computer access) after the call was made to Provider Group F and stated LN C had reported to them that Resident 1 had a painful and swollen left foot (not a black toe). CF stated she called the facility and told LN C that gout medication and ice would not help her father because he had gangrene. CF stated LN C became nervous and told her she would call Provider Group F again.</p> <p>During the same telephone interview on 11/7/24 at 11:54 a.m., CF stated she called Provider Group F herself (after speaking with LN C) and spoke to an on-call nurse; CF informed her that Resident 1's toe was black and nearly falling off, but LN C was not worried. CF stated the on-call nurse called a physician and told her Resident 1 needed to come by ambulance (to the hospital) right away. CF stated one hour later, Resident 1 was still at the facility (he had not been transported to the hospital). CF stated the on-call nurse (not a facility nurse) eventually called an ambulance for Resident 1. CF stated when Resident 1 arrived in the Emergency Department (ED), he was septic (sepsis; life-threatening infection) and his toe was subsequently amputated.</p> <p>Review of Resident 1's medical record facesheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was originally admitted to the facility 5/17/21 and had diagnoses that included, but were not limited to: Diabetes Mellitus, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), acquired absence (amputation) of right leg above the knee, and acquired absence (amputation) of the left great toe.</p> <p>Review of a hospital physician note, dated 10/13/24 at 10:02 p.m. indicated Resident 1 came to the hospital with, . necrotic left toe . the patient thinks the toe has been black for some time .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's medical record revealed a physician note by Physician D (Resident 1's doctor), dated 10/25/20 at 10:58 a.m., that indicated Resident 1 had been admitted to the hospital from 10/13/24 through 10/23/24. The progress note indicated Physician G (Resident 1's doctor at the hospital) documented Resident 1 . .presents (came to the hospital) with fever and necrotic left second toe . Blood culture (blood test that indicates infection) returned Strep pyogenes (bacteria was present in the blood culture; infection was present) . ID (infectious disease physician) consulted and agreed with continuing zosyn/vanco (antibiotics given to treat Resident 1's infection) . Taken to OR (operating room) on 10/15 (2024) and underwent amputation of 2nd toe .</p> <p>During an observation and concurrent interview on 11/8/24 at 11:30 a.m., Resident 1 was lying on his back in bed; his bed contained a foot cradle (device attached to the bed to keep blankets/sheets from touching and rubbing legs and feet). Resident 1 stated he had had four toes on his left foot but was now down to three; he stated the second toe had turned black. Resident 1 stated the second toe was getting green on Friday (10/11/24; two days prior to transport to the hospital) and on Sunday (10/13/24), an ambulance was called, and he was sent to the hospital. He stated he spent twelve days in the hospital. When asked about the wound (treatment) nurse at the facility, Resident 1 stated they take care of his heel now but, they missed the black toe.</p> <p>During an interview on 11/8/24 at 11:50 a.m., Certified Nursing Assistant E (CNA E) stated she had worked with Resident 1 a lot in the past and had seen him on Friday (10/11/24). She stated she had not noticed anything (unusual) Friday morning and LN B had not noticed anything, either. CNA E stated Resident 1's toe had turned black on Saturday and he was sent out (to the hospital) on Sunday.</p> <p>During an interview on 11/8/24 at 1:52 p.m., Licensed Nurse B (LN B) stated she was the facility's wound (treatment) nurse and had been working with Resident 1. LN B stated she had seen Resident 1 Friday and Saturday (10/11/24 and 10/12/24) prior to his hospital transfer but she did not work on Sunday (10/13/24). LN B stated Resident 1 had had back lesions (prior to 10/13/24) that were kind of infected and she had been applying ointment to them. She stated she had taken photos of his back lesions. She stated Resident 1 also had super dry skin and she had put lotion on his leg. LN B stated she had not seen a black toe when she had applied the lotion.</p> <p>Review of Resident 1's medical record revealed a nurse progress note from the LN B (dated 10/15/24 at 4:14 p.m.- two days after Resident 1 was sent to the hospital) that indicated, Performed wound care on patient Friday and Saturday October 11, and 12 (sic) to his lower back when turning patient and helping him roll over and take blankets down (sic). I used moisturizer lotion to patients dry left leg. Patient wasn't noted with any black discoloration to left foot.</p> <p>Review of Resident 1's medical record indicated LN B documented a skin assessment titled, Evaluated on [DATE] - 13:05 (1:05 p.m. - over six weeks prior to his left/second toe amputation) that indicated Resident 1 had an open lesion (tissue injury) on his right scapula (shoulder blade); she documented its size and photographed the lesion. No additional wound evaluations were located in Resident 1's medical record until 10/25/24 (after amputation of his second toe on 10/15/24,) when LN B documented and photographed a diabetic lesion located on his left heel. No photo of Resident 1's necrotic toe, reportedly taken on 10/13/24, was in his medical record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's medical record revealed a Change of Condition (An acute change of condition is a sudden clinically important deviation from a patient's baseline in physical, cognitive [mental], behavioral, or functional domains [physical ability]) evaluation, dated 10/13/24 at 2:50 p.m., that indicated, .Edema (swelling) . Change in skin color .Nursing observations, evaluation, and recommendations are: Noted swelling and discoloration on left foot. Pain level 6/10 (severe pain). Noted discoloration on 2nd toe of left foot. Called (Provider Group F) after hours and spoke to advice Nurse (name) and received orders from MD . Stat X ray (immediate timeframe; photographic or digital image of the internal composition of something, especially a body part) left foot. stat CBC (blood test) and Stat uric acid level (blood test for gout). New orders Colchicine (medication for gout) twice daily for 5 days . Apply ice on left foot three times a day for 3days (sic) .</p> <p>During a telephone interview on 11/18/2024 at 4:20 p.m., LN C stated she was a newly graduated registered nurse who had been working at the facility a total of four months. LN C stated she was Resident 1's nurse the day he was sent to the hospital; she stated her shift began at 6:45 a.m. and a CNA told her in the morning that Resident 1 had swelling of his left foot. LN C stated she went to Resident 1's room right away and he was complaining of foot pain that was 6/10. When asked what time the CNA notified her about Resident 1's foot and she went to the room, LN C stated she did not remember. When asked what Resident 1's foot looked like, LN C stated it was swollen with discoloration. She stated the left second toe was a little bit blackish.</p> <p>During the same telephone interview on 11/18/2024 at 4:20 p.m., LN C stated she called Provider Group F's after-hours advice nurse (who subsequently called the on-call physician). When asked what she told the advice nurse when she called, LN C stated she told her Resident 1's foot had, swelling and discoloration. When asked if she told the advice nurse the toe was blackish, LN C stated, no. When asked why she did not notify the nurse of the black color, LN C stated she told her in a subsequent call; she stated she called and spoke to the advice nurse two separate times. During the first call, she stated she reported Resident 1 had discoloration of the toe but did not tell the on-call nurse it was black. She stated a physician from Provider Group F ordered ice (to the foot) and gout medication. During the second call, LN C stated she told the advice nurse the toe was discolored and, I think I told it was blackish. She stated a photo had been taken of Resident 1's foot and she showed the photo (to the advice nurse) during the second call. LN C stated a stat xray was ordered after the second call and Resident 1's family member requested he be sent to the hospital. When asked what the length of time between calls to the advice nurse was, LN C stated she did not remember. When asked when 911 (emergency medical responders) was called (to transport Resident 1 to the hospital), LN C stated she did not remember. LN C stated Resident 1 was still in the facility at 2:30 p.m., when her shift ended.</p> <p>Review of Resident 1's medical record revealed a nurse's progress note, dated 10/13/2024 at 10:58 p.m. that indicated, Res (Resident 1) was P/U (picked up) at 1634 (4:34 p.m.) to (Hospital Name) via gurney with 2EMT's (two emergency medical technicians).</p> <p>During the same telephone interview on 11/18/2024 at 4:20 p.m., LN C was asked how nurses documented resident skin assessments and she stated nurses perform skin assessments after resident showers and then documented in the (nurse) progress notes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/18/2024 at 4:45 p.m., the Director of Nursing (DON) stated Resident 1 was a very high risk for necrosis and deep tissue injury (damage to the soft tissue beneath the skin caused by pressure). She stated he had a history peripheral vascular disease and had had an amputation of the first toe on the left foot. When asked if she knew the timeframe of events on 10/13/24, the day Resident 1 was sent to the hospital, the DON stated she did not know the conversations (that occurred). When asked if she was aware LN C did not notify the advice nurse that Resident 1's toe was blackish in the initial conversation (rather than the follow-up, second call), the DON again stated she did not know the conversations. When asked what a nurse should do when she/he discovers a resident has a black toe, the DON stated they should evaluate for pain and infection and call the doctor right away. She stated necrotic toes could have bad outcomes like amputation, bleeding, infection, sepsis and even death.</p> <p>Review of Resident 1's medical record document titled, Braden Scale For Predicting Pressure Sore (pressure ulcer/injury: localized, pressure-related damage/injury to the skin and/or underlying tissue) Risk, dated 8/19/24, indicated he had a score of 15 (at risk of developing pressure ulcers). [The Braden Scale is an assessment tool reflecting a person's risk of developing pressure ulcers/pressure sores].</p> <p>Review of Resident 1's medical record revealed multiple nurse progress notes, prior to Resident 1's hospital transfer on 10/13/24; the nurse progress notes did not indicate nursing staff were monitoring the status of his foot. A nurse's noted dated 9/10/24 at 3:27 p.m. indicated, .monitoring for skin tear on left hand . still have rashes (sic) on his back and dressing on his wound on left upper back . On 9/12/24 at 6:39 p.m., LN C documented, .Resident has recurrent rash on back. Resident got shower . LN C's note did not indicate she conducted a skin assessment after the shower. On 9/17/24 at 8:24 p.m., nursing staff documented that Resident 1 was sent to a podiatry medical appointment but did not document any skin assessments. On 9/21/24 at 10:06 p.m., LN C documented Resident 1 was complaining of, itching; she documented he had a shower but did not document a skin assessment. On 9/25/24 at 9:10 p.m., LN C documented Resident 1 received a shower, had redness and rash around the groin area, but did not document a skin assessment of his foot. The next documented nurse's progress note was dated 10/9/24 at 10:07 p.m. (reflecting a two-week period with no documented nurse progress notes). In the 10/9/24 nurse's note, LN C indicated Resident 1 received a shower, was complaining of itching, staff applied cream to arms, leg, knee and chest and an abrasion was located on the knee; LN C did not document the status of his foot. On 10/12/24 at 10:06 p.m. (the day before he was sent to the hospital), LN C documented Resident 1 refused his shower; she did not document any skin assessment. On 10/13/24 at 3:24 p.m., LN C documented, Resident (1) is alert and oriented (not confused). Noted swelling and discoloration on left foot. Pain level 6/10. Noted discoloration on 2nd toe of left foot. Called (Provider Group F) after hours and spoke to advice Nurse (name) and received orders from MD (name). Family notified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview and concurrent medical record review on 11/22/24 at 1:40 p.m., the DON was asked to review the nursing progress notes, wound nurse notes, and photos located in Resident 1's medical record. When asked about the photos of his toe, reportedly taken on the morning of 10/13/24, the DON stated they had not been uploaded (into the electronic medical record) and stated, I don't know about the photos. The DON confirmed the medical record did not contain documentation of wound nurse progress notes or foot/toe photos after August 2024 and prior to 10/13/24. The DON was asked to clarify if Resident 1's medical record contained documentation of licensed nursing staff monitoring Resident 1's toe/foot the month prior to the identification of his necrotic toe. The DON stated and confirmed she could not locate foot/toe monitoring documentation in the nurse's progress notes or the treatment administration record (TAR, location of wound care and treatment notes). When asked if nursing staff should have been monitoring Resident 1's foot daily, as indicated in the Nursing Care Plan, the DON stated, yes.</p> <p>Review of Resident 1's nursing care plan (date initiated 02/17/2023, revised 07/03/2024) indicated, Skin: at risk for skin breakdown . The care plan goal was, Will have no skin breakdown daily x3 (for three) months . The interventions to reach the goal indicated, Daily body assessments to monitor for any skin injury . Notify MD for any skin breakdown .</p> <p>During an interview on 11/22/24 at 2:30 p.m., Physician D was asked about the development and outcome of Resident 1's necrotic toe. Physician D stated LN B (treatment nurse) told him she had seen Resident 1's foot on Friday (10/11/24, two days prior to being sent to the hospital) and his foot at that time was really good. When asked if he thought the necrosis could have developed quickly (between Friday and Sunday), Physician D stated it was, conceivable, but it may have taken longer. He stated everyone (medical staff) thought it was occurring (progressing) longer than a few days.</p> <p>During the same interview on 11/22/24 at 2:30 p.m., Physician D stated the nurse (LN C) was concerned about the change in Resident 1's toe on Sunday (10/13/24) and at some point, reported it looked black. He stated in the first call to Provider Group F, the LN C reported swelling and treatment for gout (ice and medication) was ordered. Physician D stated there was no mention of the toe's color (being black) in the first call to his provider group. Physician D stated Resident 1's family member (CF) reached out to the facility and also made a second call to an unofficial call center (related to Provider Group F) and spoke to the on-call nurse manager; Provider Group F's on-call nurse manager then arranged ambulance transfer for Resident 1 to the hospital.</p> <p>During the same interview on 11/22/24 at 2:30 p.m., when Physician D was asked if the failure of nursing staff to monitor Resident 1's left foot daily and notify the physician timely of any changes contributed to his necrotic toe being found (identified) at an advanced stage, he stated, yes. He stated the necrosis was found at the wet gangrene stage and was infected. When asked if Resident 1 was septic (had sepsis) when he arrived in the emergency room , Physician D stated, he met sepsis criteria. (a combination of findings/set of criteria - such as exams, tests, etc.- that providers use to identify/confirm the presence of sepsis). He stated if the issue was found when the toe was dusky (gray color; less advanced disease), he would have ordered and performed a vascular study (to assess circulation of the foot) and monitored the foot. When asked if nursing staff should have been monitoring Resident 1's toe/foot, Physician D stated, yes.</p> <p>Online review of the National Library of Medicine website indicated gangrene is associated with a high incidence of mortality (death), and in patients that survive, it can have a massive impact on the quality of life. (https://www.ncbi.nlm.nih.gov/books/NBK560552/).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	
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)		
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Online review of John Hopkins website indicated, Gangrene is a dangerous and potentially deadly health problem . Gangrene can spread quickly over a large area of the body .Wet gangrene is often life-threatening . (https://www.hopkinsmedicine.org/health/conditions-and-diseases/gangrene)</p> <p>Online review of the Mayo Clinic website indicated diabetes increases the risk of gangrene. Symptoms include changes in skin color including pale gray to blue, purple, black and red; swelling, blisters and severe pain can be present. (https://www.mayoclinic.org/diseases-conditions/gangrene/symptoms-causes/syc-20352567).</p> <p>Online review of the Center for Disease Control and Prevention (CDC) website indicated, Sepsis . is a life-threatening medical emergency . almost any infection can lead to sepsis . sepsis happens when an infection you already have triggers a chain reaction throughout your body . Infections that lead to sepsis most often start in the . skin . Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure and death . (https://www.cdc.gov/sepsis/about/index.html).</p>		