Use this pathway for a resident having, or at risk of developing, a pressure ulcer (PU) or pressure injury (PI) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

Revie	ew the following in Advance to Guide Observations and Intervie	ews:
	e most current comprehensive and most recent quarterly (if the com-	prehensive isn't the most recent) MDS/CAAs for Sections C, GG, H, J, K
M.		
Phy	ysician's orders (e.g., wound treatment) and treatment record (TAR)).
Per	tinent diagnoses.	
Car	re plan (e.g., pressure relief devices, repositioning schedule, treatme	nt, scheduled skin/wound inspection, or pressure injury history).
Obse	rvations:	
	bserve wound care and assess the wound (observe as soon as ossible)	 Does staff use appropriate infection control practices such as hand hygiene and PPE while providing wound care and
0	Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan?	 other high-contact care activities? Are precautions taken to not unnecessarily contaminate the
0	Is there pain during wound care? If so, what did the nurse do?	wound or clean equipment and supplies during resident care?
0	Does the wound look infected?	o Are reusable dressing care equipment (e.g., bandage
0	Use of clean gloves, <i>gown</i> , and clean technique for each resident. When treating multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (e.g., in the perineal region).	scissors) cleaned or reprocessed if shared between residents? Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing wet or soiled? What did
0	Remove gloves <i>and gown</i> and decontaminate hands between residents.	staff do? How are care planned interventions being implemented?
0	Staff ensure that if perineal or incontinence care is performed gloves <i>and gown</i> are used, then visibly soiled dressing is removed, hand hygiene is performed, and clean gloves are donned before clean dressing is applied.	How are staff following the care plan? Is the resident repositioned timely and in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI?
0	Clean wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications such as ointments, creams should be dedicated to one resident).	 Use of proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction. Pressure relief devices are in place and working correctly and are used per the manufacturer's instructions.
	,	☐ Does the resident show signs of PU/PI related pain?

	Are ordered nutritional interventions implemented (e.g., supplements and hydration)?
Resident, Resident Representative, or Family Interview:	
Did your wound develop in the facility? If so, do you know how it occurred?	☐ How did the facility ensure you had a choice in how your wound would be treated?
Has staff talked to you about your risk for the wound and how they	☐ How often are dressings changed or treatment applied?
plan to reduce the risk?	Does your wound hurt? Do you have pain with wound care or when
How are they treating your wound?	the dressings are changed? If so, what does staff do for your pain?
Is the wound getting better? If not, describe.	What types of interventions are done to help heal your wound? Ask
How has your wound caused you to be less involved in activities you enjoy?	about specific interventions (e.g., positioned q2h, use of pressure redistribution devices or equipment).
How has your wound caused a change in your mood or ability to function?	If you know the resident refused care: Did staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?
Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner	r):
☐ What, when, and to whom do you report changes in skin condition?	☐ What do you do if the resident refuses care?
Does the resident have a PU? If so, where is it located?	☐ Is the PU/PI improving?
☐ How are you made aware of the resident's daily care needs?	☐ How is pain related to the PU/PI assessed? And how often?
☐ What PU interventions are used?	☐ How do you inform other staff and the MD about the PU/PI status?
Does the resident have pain? If so, how is it being treated?	☐ How do you monitor staff to ensure they are implementing care
Has the resident had weight loss, dehydration, or acute illness? If	planned interventions?
so, what interventions are in place to address the problem?	How do you determine the appropriate interventions?
Is the resident currently on any transmission-based precautions?	If there are systemic concerns: What are the facility's policies and
Has there been a change in the resident's overall function and mood?	procedures regarding care, treatment, prevention, and interventions for pressure ulcers?
Ask about any observation concerns.	Is the resident's treatment effective? Have you been contacted with
☐ Is the resident at risk for the development of PU/PI?	any changes in the PU/PI?
How and how often is the resident's skin assessed and where is it	How do you monitor the resident's wound progress?
documented?	How is the effectiveness of wound care or pressure ulcer prevention
☐ When did the current PU/PI develop? What caused the PU/PI?	measures evaluated? And how often and by who?

so, describe.				
Record Review:				
t been evaluated for as appropriate and/or as in reflect the condition of the sing, frequency of dressing in, measurement, in treatment measures the risks correctly identified and ling practitioner? In and procedures with regard to ion, care, treatment, and PU/PI if concerns are identified. The resident's condition (i.e., will on by staff or by implementing the erventions; impacts more than the riew or revision of the care go comprehensive assessment.				

Critical Element Decisions:

- 1) Did the facility ensure that a resident:
 - Receives care, consistent with professional standards of practice, to prevent pressure ulcers; and
 - Does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable; and
 - Receives necessary treatment and services to promote the healing of a pressure ulcer, prevent an infection, and prevent new ulcers from developing?

If No, cite F686

- 2) Did the physician evaluate and assess medical issues related to the resident's skin status and supervise the management of all associated medical needs, including participation in the comprehensive assessment process, development of a treatment regimen consistent with current standards of practice, monitoring, and response to notification of change in the resident's medical status related to pressure ulcers? If No, cite F710
- 3) Did the facility use appropriate *infection control practices*, *such as* hand hygiene and PPE when providing wound care *and other high-contact care activities*?

If No, cite F880

- 4) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
 - If No. cite F655
 - NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
- 5) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
 - If No, cite F636
 - NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.
- 6) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
 - If No, cite F637
- NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not require OR

the resident did not have a significant change in status.

- Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)? If No, cite F641
- 8) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences? If No, cite F656
 - NA, the comprehensive assessment was not completed.
- 9) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
 If No, cite F657
 - NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be informed F552, Notification of Change F580, Abuse (CA), Neglect (CA), Choices (CA), Admission Orders F635, General Pathway (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), QAA/QAPI (Task).