STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00		G 0000		

This visit was for a post-condition re-visit survey of a home health agency, with 2 conditions of participation out of compliance (42 CFR 484.60 Care planning, coordination, quality of care, and 484.105 Organization and administration of services) during a recertification survey with exit date of 4-3-19.

Facility #: 013867

Survey dates: 5-28, and 5-29-19

Current Census:

Total
Skilled Services:

Home Health Aide only:

Personal Service only:
0

Total: 105

Record review only:
3

Active clinical records reviewed
3

Closed clinical records reviewed
0

Total clinical records reviewed:
3

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	During this visit, two (2) condition level deficiencies were found to have been corrected, and 17 standard level deficiencies were found to have been corrected and 1 standard level deficiencies were recited. No new deficiencies were cited. Together Homecare, Greenwood IN and Columbus IN, continues to be precluded from providing their own home health aide training and competency evaluation program for a period of 2 years beginning April 3, 2019, to April 2, 2021, for having being found out of compliance with the Conditions of Participation 42 CFR 484.60 Care planning, coordination, quality of care, and 484.105 Organization and administration of services.			
G 0942 Bldg. 00	Based on record review and interview, the governing body failed to ensure it authorized the adoption by the home health agency of wound care assessment, wound care management, and wound care documentation policy(ies) which met current accepted professional standards of practice for the operation of 1 of 1 home health agency skilled nursing service. The findings included: Review of an undated, two (2) page policy titled, "Wound Management Policy," evidenced the policy stated, "POLICY All patients are assessed for risk factors for impaired skin integrity, as well as the presence of any wound. Any identified	G 0942	**G 942** The Agency's Wound Management Policy, which was included in the Agency's Plan of Correction approved on May 6, 2019, has been modified to incorporate more detailed information as it pertains to professional standards of practice. Information from the websites noted by the state surveyor in the deficiency report has been incorporated into the policy to ensure that the contents are objective and reflect professional standards of practice. The Agency	06/25/2019

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	wounds will be assessed by the nurse and documented in the clinical record. Appropriate interventions will be added to the Plan of Care for any patient with active wounds. Patients determined to be at heightened risk for impaired skin integrity will have interventions addressed in the plan of care and on care plans as indicated. Risks, interventions, and effectiveness/goal progress will be documented in the patient record. PURPOSE To identify patients at risk for skin breakdown. To thoroughly document and track the presence and status of wounds. To collaborate with the managing Physician and other members of the interdisciplinary team for the promotion of wound healing and prevention. SPECIAL INSTRUCTIONS 1. The Registered Nurse will complete a Braden Scale assessment as a component of the comprehensive assessment for the Start of Care, Resumption of Care, and Re-Certification visits. 2. If a patient's Braden score indicates an increased risk for impaired skin integrity, appropriate interventions will be added to the Plan of Care as well as the Aide Care Plan. 3. Documentation of a wound will address location, size, drainage, appearance of wound be and peri-wound skin, odor, wound edges, wound care interventions performed during the visit (if applicable), and any additional information deemed pertinent by the assessing nurse. 4. The nurse will report assessment findings to the Physician and will request further orders or instructions to address any wound(s) as applicable. The nurse will continue to contact the Physician at frequent intervals until the Physician confirms receipt of the information, either by submitting an order for wound care to Together Homecare, or by referring the skilled care to another agency or facility, at the direction of the Physician. 5. If a Physician orders skilled nursing visits for wound care to be provided by Together		provided the Governing Body with a list of the websites from the deficiency report that the Agency referenced during the policy revision. The Governing Body reviewed and approved the policy, effective 6/25/2019. All RN Clinical Supervisors were educated on the new policy and its implications in patient care on 6/25/2019. All active nurses currently providing wound care for Agency patients have been educated on the Agency's Wound Management Policy. No wound care will be provided by any nurse who has not been educated on the Agency's Wound Management Policy. All new RN Clinical Supervisors will be in-serviced on the Wound Management Policy as part of their orientation process. The Director of Clinical is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur. Completion date: 6/25/19 and ongoing	

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	Homecare, the Administrator and Director of Clinical Services shall be notified immediately. 6. If the Physician determines that a Medicare episode must begin for skilled nursing and any other therapy service(s), the Physician will be notified that the referral must be made to a Medicare agency. Together Homecare [Medicaid agency] will assist with this referral process at the request of the Physician and will coordinate care with any additional agency. 7. Any would that does not appear to be improving with skilled intervention will be brought to the attention of the managing Physician, as well as the agency Director of Clinical Services. 8. Any difficulty in obtaining orders or contacting the Physician and/or other service providers related to wound care will be brought to the attention of the Administrator and Director of Clinical Services immediately. A review of available sources from an internet search evidenced the following current accepted professional standards of practice in relation to the identification, categorization, monitoring, measuring, care, and management of patient wounds)/integumentary impairment(s). A. http://www.homehealthquality.org/Education/Best-Practices/BPIPs/Wound-Mgmt.aspx [Home Health Quality Improvement] "Types of wounds include: · Pressure ulcers/injuries · Venous, arterial, and neuropathic lower-extremity wounds · Surgical wounds · Skin tears · Burns · Ostomies			

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	The utilization of an interdisciplinary approach to wound care improves care." Review of the adopted policy failed to evidence the policy was based on current accepted professional standards of practice to include determination and documentation of the type of wound identified, and the need for an interdisciplinary approach to wound care. B. https://www.hopkinsmedicine.org/gec/series/wound_care.html [Johns Hopkins Medicine] "Wound Assessment An assessment of the wound should be done weekly and be used to drive treatment decisions. Wound assessment includes: location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection. Location Documentation of the location indicating which extremity, nearest bony prominence or anatomical landmark is necessary for appropriate monitoring of wounds. (Hess 2005) Class/Stage Pressure ulcers are classified by stages as defined by the National Pressure Ulcer Advisory Panel (NPUAP). Originally there were four stages (I-IV) but in February 2007 these stages were revised and two more categories were added, deep tissue injury and unstageable. Pressure Ulcer Staging Stage I - Intact skin with non-blanchable redness			

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	of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Stage III - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining/tunneling. Stage IV - Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. (Suspected Deep) Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-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. (NPUAP 2/07) Class There are a number of classification and grading systems used in wound care but the simplest method uses the terms partial thickness or full thickness · Partial thickness wound (PTW): damage to			

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	epidermis and/or dermis only · Full thickness wound (FTW): damage to subcutaneous layer or deeper Size / Measurement · Length - from top edge to the bottom edge (head to toe) at longest point · Width - from edge to edge perpendicular to the length at widest point · Depth - straight in, perpendicular to the base, at deepest point Undermining/Tunneling · Using the "clock concept" (12 o'clock is in the direction of the patient's head and 6 o'clock is toward the feet) · Where does it start and where does it end (clockwise direction) · Tunnel depth is at it's deepest point · Location of deepest point Base Tissues Assessing the appearance of tissue in the wound bed is critical for determining appropriate treatment strategies and to evaluate progress toward healing. (Keast et al. 2004) Necrosis/Eschar - Black, brown or tan devitalized tissue that adheres to the wound bed or edges and may be firmer or softer than the surrounding skin. Slough - Soft, moist avascular tissue that adheres to the wound bed in strings or thick clumps; may be white, yellow, tan or green. Granulation - Pink/red moist tissue comprised of new blood vessels, collagen fibers and fibroblasts. Typically the surface is shiny and moist with a granular appearance. Epithelium - New pink and shin tissue/skin that grows in from the edges or as islands on the			

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	wound surface. Exudates Amount · None - base and dressing dry · Slight - small amount in center of dressing · Moderate - contained within the dressing · Copious - extends beyond dressing onto clothing or bed linen Type · Serous - thin, watery, clear or straw colored · Serosanguineous - thin, pale red to pink · Purulent - thick, opaque, tan, yellow to green and may have an offensive odor · Consider treatment modality and frequency of dressing changes Odor Assess after cleansing (Garcia & Thomas 2006). Extreme malodor, especially if accompanied by purulent exudates is suggestive of infection. Most wounds do have an odor. The type of dressing can affect odor as well as hygiene and the presence of nonviable tissue (Keast et al. 2004). Edge/Perimeter · Describe wound edges (approximated, rolled, calloused) · Describe periwound skin (indurated, erythematous, macerated, healthy) · Describe presence of excoriation, denudement, erosion, papules, pustules or other lesions Induration - Abnormal hardening of the tissue caused by consolidation of edema, this may be a sign of underlying infection. Erythema - Redness of surrounding tissue may be normal in the inflammatory stage of healing.			

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	However, if accompanied by an increase in temperature of tissue, exudates or pain may also be a sign of infection. Maceration - Caused by excessive moisture, Tissue loses its pigmentation (appears lucid or turns white) and becomes soft and friable. Pain A critical aspect of local wound assessment both from the perspective of the patient and as a clinical indicator of infection. (Reddy, Keast, Fowler & Sibbald 2003) Include location, type/cause, rating (use validated scale), patient description and nonverbal signs. Evaluation of infection Infection - Signs and Symptoms: · Redness, warmth and induration of adjacent tissues · Pain or tenderness · Dysmorphic and/or friable granulation · Unusual odor · Purulent exudates · Systemic signs (fever, chills, sweats) When to Culture: (Dow 2003) · When signs of infection are present or when a clean wound fails to heal · Always cleanse wound first · Semi-quantitative swab collection is acceptable · Quantitative biopsy is "gold standard" but expensive and invasive Additional Assessment for Lower Extremity Wounds (WOCN 2002) Physical Exam · Edema -extent and persistence of pitting (1+ - 4+)			

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	· Color changes - dependent rubor (purple-red discoloration) or elevation pallor (paling of the skin when leg raised to a 60° angle for 15 -60 seconds) · Distal pulses -amplitude on palpation (0 - 4+) · Neuropathy - skin changes (dryness, cracking), structural abnormalities, and loss of protective sensation (10gm monofilament exam - testing 10 points) Wound Healing · Phases of Wound Healing · Optimization of Wound Environment The healing process varies depending on the stage of the pressure ulcer. Stage I & II pressure ulcers and partial thickness wounds heal by tissue regeneration. Stage III & IV pressure ulcers and full thickness wounds heal by scar formation and contraction. Data indicate a 20% reduction in wound size over two weeks is a reliable predictive indicator of healing. (Flanagan 2003) Optimization of Wound Environment · Manage comorbid conditions · Adequate nutrition & hydration · Remove nonviable tissue · Maintain moisture balance · Protect the wound and periwound skin · Eliminate or minimize pain · Cleanse · Prevent and manage infection · Control odor Manage comorbid condition · Optimize cardiovascular and pulmonary functioning · Support tissue oxygenation · Maintain blood glucose control			

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	Adequate nutrition & hydration (Harris & Frasier 2004) · Encourage protein, calorie-dense foods and fluids, unless contraindicated · Monitor intake, weight and skin turgor · Assess and address impairments in dentition and swallowing · Assist patients with meals if needed · Dietary consult Eliminate or Minimize Pain · Address the cause (remove the source if external, treat the infection or medicate based on physiological stimulus) · Pharmacological strategies -long acting drugs preferable, use breakthrough doses and prevent adverse effects · Incorporate psycho-social, spiritual and culturally sensitive support · Appropriate dressing selection, gentle removal and "Time out" during treatment administration Cleanse · Normal saline is the recommended solution · Cavity wounds or tunnels may be irrigated · Apply 4-15 (psi) pressure/force to remove debris without harming healthy tissue Protect Wound and Periwound Skin · Use barrier products to protect from adhesives and moisture · Change dressings at appropriate intervals to avoid pooling of exudates Prevent and Manage Infection Critical colonization can result in failure to heal, poor quality tissue, increased friability and increased drainage (Frank, Bayoumi & Westendorp 2005). Determining whether the			

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	wound has a bacterial imbalance (critical colonization and infection) is of primary importance to healing (Sibbald, Woo & Ayello 2006). · Superficial increased bacterial burden - topical agent with low toxicity, not likely to cause allergy and not associated with bacterial resistance · Surrounding skin compartment infection - topical agent, swab culture and appropriate oral antibiotic agent (Sibbald 2003) · Deep wound infection or osteomyelitis - parenteral antibiotics. Also consider tissue culture and additional lab tests (Frank et al. 2005) · Dressings with a high moisture vapor transmission rate will allow moisture to escape and evaporate in minimally exudative wounds · Moderate to heavily draining wounds require absorptive dressings Control Odor · Appropriate frequency of dressing changes · Cleanse with each dressing change · Debridement and antimicrobials as indicated · Charcoal dressings ... " Review of the agency adopted policy failed to evidence the policy was based upon current accepted professional standards of practice to include identification and documentation of the class/stage of wound; measurement of the length, width, and depth of each wound, presence or absence of tunneling or undermining; presence or absence of pain, presence or absence of signs and symptoms of infection; presence or absence of co-morbid conditions (diabetes, inadequate nutrition/hydration, etc.); and failed to objectively define how wound healing/or failure of the wound to heal, was to be assessed, e.g. "Any wound that			

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	does not appear to be improving with skilled intervention will be brought to the attention of the managing Physician, as well as the agency Director of Clinical Services." Review of governing body meeting minutes, dated 4-24-19, evidenced the governing body approved and adopted the new "Wound Management Policy," for the agency, at this meeting. The meeting minutes failed to evidence any discussion or directives for revision of the policy prior to adoption. During interview with nursing supervisor on 5-29-19 at 2:25 PM, the nursing supervisor stated the governing body had approved the above policy without any questions, concerns, or directions for amendment. The nursing supervisor stated not having based the newly adopted agency policy on wound management on current accepted professional standards of practice. The nursing supervisor inquired if the surveyor would provide an example of a professional standard of practice. When queried how nurses would be instructed to assess wound healing/or failure of the wound to heal, using the standard "any wound that does not appear to be improving ... " the nursing supervisor replied the policy language used a subjective, rather than an objective, determination of the progress/status of patient wound(s).			
N 0000 Bldg. 00	This visit was for a state licensure re-visit survey of a home health agency,with exit date of 4-3-19. Facility #: 013867	N 0000		

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	Survey dates: 5-28, and 5-29-19 Current Census: Total Skilled Services: Home Health Aide only: Personal Service only: 0 Total: 105 Record review only: 3 Active clinical records reviewed 3 Closed clinical records reviewed 0 Total clinical records reviewed: 3 During this visit, 14X standard level deficiencies were found to have been corrected and 1 deficiency recited. No new deficiencies were cited.			
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility			

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	for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the governing body failed to ensure it authorized the adoption by the home health agency of wound care assessment, wound care management, and wound care documentation policy(ies) which met current accepted professional standards of practice for the operation of 1 of 1 home health agency skilled nursing service. The findings included: Review of an undated, two (2) page policy, "Wound Management Policy," evidenced the policy stated, "POLICY All patients are assessed for risk factors for impaired skin integrity, as well as the presence of any wound. Any identified wounds will be assessed by the nurse and documented in the clinical record. Appropriate interventions will be added to the Plan of Care for any patient with active wounds. Patients determined to be at heightened risk for impaired skin integrity will have interventions addressed in the plan of care and on care plans as indicated. Risks, interventions, and effectiveness/goal progress will be documented in the patient record. PURPOSE To identify patients at risk for skin breakdown. To thoroughly document and track the presence and status of wounds. To collaborate with the managing Physician and other members of the interdisciplinary team for the promotion of wound healing and prevention. SPECIAL INSTRUCTIONS 1. The Registered	N 0442	**N 442** The Agency's Wound Management Policy, which was included in the Agency's Plan of Correction approved on May 6, 2019, has been modified to incorporate more detailed information as it pertains to professional standards of practice. Information from the websites noted by the state surveyor in the deficiency report has been incorporated into the policy to ensure that the contents are objective and reflect professional standards of practice. The Agency provided the Governing Body with a list of the websites from the deficiency report that the Agency referenced during the policy revision. The Governing Body reviewed and approved the policy, effective 6/25/2019. All RN Clinical Supervisors were educated on the new policy and its implications in patient care on 6/25/2019. All active nurses currently providing wound care for Agency patients have been educated on the Agency's Wound Management	06/25/2019

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	Nurse will complete a Braden Scale assessment as a component of the comprehensive assessment for the Start of Care, Resumption of Care, and Re-Certification visits. 2. If a patient's Braden score indicates an increased risk for impaired skin integrity, appropriate interventions will be added to the Plan of Care as well as the Aide Care Plan. 3. Documentation of a wound will address location, size, drainage, appearance of wound be and peri-wound skin, odor, wound edges, wound care interventions performed during the visit (if applicable), and any additional information deemed pertinent by the assessing nurse. 4. The nurse will report assessment findings to the Physician and will request further orders or instructions to address any wound(s) as applicable. The nurse will continue to contact the Physician at frequent intervals until the Physician confirms receipt of the information, either by submitting an order for wound care to Together Homecare, or by referring the skilled care to another agency or facility, at the direction of the Physician. 5. If a Physician orders skilled nursing visits for wound care to be provided by Together Homecare, the Administrator and Director of Clinical Services shall be notified immediately. 6. If the Physician determines that a Medicare episode must begin for skilled nursing and any other therapy service(s), the Physician will be notified that the referral must be made to a Medicare agency. Together Homecare [Medicaid agency] will assist with this referral process at the request of the Physician and will coordinate care with any additional agency. 7. Any would that does not appear to be improving with skilled intervention will be brought to the attention of the managing Physician, as well as the agency Director of Clinical Services. 8. Any difficulty in obtaining orders or contacting the Physician and/or other service providers related to wound		Policy. No wound care will be provided by any nurse who has not been educated on the Agency's Wound Management Policy. All new RN Clinical Supervisors will be in-serviced on the Wound Management Policy as part of their orientation process. The Director of Clinical is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur. Completion date: 6/25/19 and ongoing	

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	care will be brought to the attention of the Administrator and Director of Clinical Services immediately. A review of available sources from an internet search evidenced the following current accepted professional standards of practice in relation to the identification, categorization, monitoring, measuring, care, and management of patient wounds)/integumentary impairment(s). A. http://www.homehealthquality.org/Education/Best-Practices/BPIPs/Wound-Mgmt.aspx [Home Health Quality Improvement] "Types of wounds include: · Pressure ulcers/injuries · Venous, arterial, and neuropathic lower-extremity wounds · Surgical wounds · Skin tears · Burns · Ostomies The utilization of an interdisciplinary approach to wound care improves care." Review of the adopted policy failed to evidence the policy was based on current accepted professional standards of practice to include determination and documentation of the type of wound identified, and the need for an interdisciplinary approach to wound care. B. https://www.hopkinsmedicine.org/gec/series/wound_care.html [Johns Hopkins Medicine] "Wound Assessment			

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	An assessment of the wound should be done weekly and be used to drive treatment decisions. Wound assessment includes: location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection. Location Documentation of the location indicating which extremity, nearest bony prominence or anatomical landmark is necessary for appropriate monitoring of wounds. (Hess 2005) Class/Stage Pressure ulcers are classified by stages as defined by the National Pressure Ulcer Advisory Panel (NPUAP). Originally there were four stages (I-IV) but in February 2007 these stages were revised and two more categories were added, deep tissue injury and unstageable. Pressure Ulcer Staging Stage I - Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Stage III - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining/tunneling.			

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	Stage IV - Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. (Suspected Deep) Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-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. (NPUAP 2/07) Class There are a number of classification and grading systems used in wound care but the simplest method uses the terms partial thickness or full thickness · Partial thickness wound (PTW): damage to epidermis and/or dermis only · Full thickness wound (FTW): damage to subcutaneous layer or deeper Size / Measurement · Length - from top edge to the bottom edge (head to toe) at longest point · Width - from edge to edge perpendicular to the length at widest point · Depth - straight in, perpendicular to the base, at deepest point Undermining/Tunneling · Using the "clock concept" (12 o'clock is in the direction of the patient's head and 6 o'clock is toward the feet)			

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	· Where does it start and where does it end (clockwise direction) · Tunnel depth is at it's deepest point · Location of deepest point Base Tissues Assessing the appearance of tissue in the wound bed is critical for determining appropriate treatment strategies and to evaluate progress toward healing. (Keast et al. 2004) Necrosis/Eschar - Black, brown or tan devitalized tissue that adheres to the wound bed or edges and may be firmer or softer than the surrounding skin. Slough - Soft, moist avascular tissue that adheres to the wound bed in strings or thick clumps; may be white, yellow, tan or green. Granulation - Pink/red moist tissue comprised of new blood vessels, collagen fibers and fibroblasts. Typically the surface is shiny and moist with a granular appearance. Epithelium - New pink and shin tissue/skin that grows in from the edges or as islands on the wound surface. Exudates Amount · None - base and dressing dry · Slight - small amount in center of dressing · Moderate - contained within the dressing · Copious - extends beyond dressing onto clothing or bed linen Type · Serous - thin, watery, clear or straw colored · Serosanguineous - thin, pale red to pink · Purulent - thick, opaque, tan, yellow to green and may have an offensive odor · Consider treatment modality and frequency			

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	of dressing changes Odor Assess after cleansing (Garcia & Thomas 2006). Extreme malodor, especially if accompanied by purulent exudates is suggestive of infection. Most wounds do have an odor. The type of dressing can affect odor as well as hygiene and the presence of nonviable tissue (Keast et al. 2004). Edge/Perimeter · Describe wound edges (approximated, rolled, calloused) · Describe periwound skin (indurated, erythematous, macerated, healthy) · Describe presence of excoriation, denudement, erosion, papules, pustules or other lesions Induration - Abnormal hardening of the tissue caused by consolidation of edema, this may be a sign of underlying infection. Erythema - Redness of surrounding tissue may be normal in the inflammatory stage of healing. However, if accompanied by an increase in temperature of tissue, exudates or pain may also be a sign of infection. Maceration - Caused by excessive moisture, Tissue loses its pigmentation (appears lucid or turns white) and becomes soft and friable. Pain A critical aspect of local wound assessment both from the perspective of the patient and as a clinical indicator of infection. (Reddy, Keast, Fowler & Sibbald 2003) Include location, type/cause, rating (use validated scale), patient description and nonverbal signs. Evaluation of infection			

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	Infection - Signs and Symptoms: · Redness, warmth and induration of adjacent tissues · Pain or tenderness · Dysmorphic and/or friable granulation · Unusual odor · Purulent exudates · Systemic signs (fever, chills, sweats) When to Culture: (Dow 2003) · When signs of infection are present or when a clean wound fails to heal · Always cleanse wound first · Semi-quantitative swab collection is acceptable · Quantitative biopsy is "gold standard" but expensive and invasive Additional Assessment for Lower Extremity Wounds (WOCN 2002) Physical Exam · Edema -extent and persistence of pitting (1+ - 4+) · Color changes - dependent rubor (purple-red discoloration) or elevation pallor (paling of the skin when leg raised to a 60° angle for 15 -60 seconds) · Distal pulses -amplitude on palpation (0 - 4+) · Neuropathy - skin changes (dryness, cracking), structural abnormalities, and loss of protective sensation (10gm monofilament exam - testing 10 points) Wound Healing · Phases of Wound Healing · Optimization of Wound Environment The healing process varies depending on the stage of the pressure ulcer. Stage I & II pressure			

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	ulcers and partial thickness wounds heal by tissue regeneration. Stage III & IV pressure ulcers and full thickness wounds heal by scar formation and contraction. Data indicate a 20% reduction in wound size over two weeks is a reliable predictive indicator of healing. (Flanagan 2003) Optimization of Wound Environment · Manage comorbid conditions · Adequate nutrition & hydration · Remove nonviable tissue · Maintain moisture balance · Protect the wound and periwound skin · Eliminate or minimize pain · Cleanse · Prevent and manage infection · Control odor Manage comorbid condition · Optimize cardiovascular and pulmonary functioning · Support tissue oxygenation · Maintain blood glucose control Adequate nutrition & hydration (Harris & Frasier 2004) · Encourage protein, calorie-dense foods and fluids, unless contraindicated · Monitor intake, weight and skin turgor · Assess and address impairments in dentition and swallowing · Assist patients with meals if needed · Dietary consult Eliminate or Minimize Pain · Address the cause (remove the source if external, treat the infection or medicate based on physiological stimulus) · Pharmacological strategies -long acting drugs preferable, use breakthrough doses and			

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	prevent adverse effects · Incorporate psycho-social, spiritual and culturally sensitive support · Appropriate dressing selection, gentle removal and "Time out" during treatment administration Cleanse · Normal saline is the recommended solution · Cavity wounds or tunnels may be irrigated · Apply 4-15 (psi) pressure/force to remove debris without harming healthy tissue Protect Wound and Periwound Skin · Use barrier products to protect from adhesives and moisture · Change dressings at appropriate intervals to avoid pooling of exudates Prevent and Manage Infection Critical colonization can result in failure to heal, poor quality tissue, increased friability and increased drainage (Frank, Bayoumi & Westendorp 2005). Determining whether the wound has a bacterial imbalance (critical colonization and infection) is of primary importance to healing (Sibbald, Woo & Ayello 2006). · Superficial increased bacterial burden - topical agent with low toxicity, not likely to cause allergy and not associated with bacterial resistance · Surrounding skin compartment infection - topical agent, swab culture and appropriate oral antibiotic agent (Sibbald 2003) · Deep wound infection or osteomyelitis - parenteral antibiotics. Also consider tissue culture and additional lab tests (Frank et al. 2005) · Dressings with a high moisture vapor			

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	transmission rate will allow moisture to escape and evaporate in minimally exudative wounds · Moderate to heavily draining wounds require absorptive dressings Control Odor · Appropriate frequency of dressing changes · Cleanse with each dressing change · Debridement and antimicrobials as indicated · Charcoal dressings ... " Review of the agency adopted policy failed to evidence the policy was based upon current accepted professional standards of practice to include identification and documentation of the class/stage of wound; measurement of the length, width, and depth of each wound, presence or absence of tunneling or undermining; presence or absence of pain, presence or absence of signs and symptoms of infection; presence or absence of co-morbid conditions (diabetes, inadequate nutrition/hydration, etc.); and failed to objectively define how wound healing/or failure of the wound to heal, was to be assessed, e.g. "Any wound that does not appear to be improving with skilled intervention will be brought to the attention of the managing Physician, as well as the agency Director of Clinical Services." Review of governing body meeting minutes, dated 4-24-19, evidenced the governing body approved and adopted the new "Wound Management Policy," for the agency, at this meeting. The meeting minutes failed to evidence any discussion or directives for revision of the policy prior to adoption. During interview with nursing supervisor on 5-29-19 at 2:25 PM, the nursing supervisor stated the governing body had approved the above			

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	policy without any questions, concerns, or directions for amendment. The nursing supervisor stated not having based the newly adopted agency policy on wound management on current accepted professional standards of practice. The nursing supervisor inquired if the surveyor would provide an example of a professional standard of practice. When queried how nurses would be instructed to assess wound healing/or failure of the wound to heal, using the standard "any wound that does not appear to be improving ... " the nursing supervisor replied the policy language used a subjective, rather than an objective, determination of the progress/status of patient wound(s).			