

22 VAC 40-72-100 A – Incident reports

Question: *Would a pressure ulcer be considered “a major incident that has negatively affected or that threatens the life, health, safety or welfare of a resident” that has to be reported?*

Answer: Yes. Pressure ulcers (sometimes called pressure sores, bedsores or decubitus ulcers) are areas of injury to skin and tissue that develop as the result of periods of constant pressure that cuts off circulation to vulnerable parts of the body. Without sufficient blood flow to these areas, the affected tissue dies. The facility must report pressure ulcers to the licensing inspector by the next day after they are identified. As required in 22 VAC 40-72-100.C.7, the report should include as much descriptive information as possible.

All direct care staff should be vigilant in efforts to identify and report potential causes and take necessary measures to reduce the risk of any resident developing a pressure ulcer. The following information is provided as a guide to reporting a pressure ulcer as part of an incident report:

- It is not necessary to report Stage 1 pressure ulcers as an incident. These are areas where the skin is unbroken but is persistently pink or red and may look like a mild sunburn. The resident may complain that the area is tender, painful or itchy. Other direct care staff, supervisors and/or primary care physicians should be notified and plans developed to reduce the risk that more serious wounds may develop.
- Stage 2, 3 & 4 ulcers **must be reported as an incident** whenever identified on or after admission to the facility. For those residents whose wounds have not been seen by a licensed health care professional (physician, nurse, wound care specialist) qualified to assess the stage of a wound, the following are simple descriptions:
 - Stage 2 – skin is broken and the second layer of tissue is involved. The area is red and painful, and there may be some swelling and/or some drainage oozing from the wound. In the early development of these wounds, they may be very small. It is important to take action and report any broken skin that may be a developing pressure ulcer (not to be confused with skin tears or incontinence injury).
 - Stage 3 – skin has broken down and the wound extends through all three layers of the skin into soft tissue. The pressure ulcer is deeper and very difficult to heal. The site now has the risk for serious infection to occur. In order for the resident to remain in the assisted living facility, wound assessment and treatment must be in compliance with 22 VAC 40-72-340.G.2 and H. The wound must be healing and periodic observation and treatment must be provided, as directed in the written treatment plan from a physician or other licensed prescriber. This care and treatment must be provided by a licensed health care professional employed by or under contract with the facility, the resident, the responsible party or a home care agency licensed in Virginia.
 - Stage 4 – the wound extends into muscle and bone requiring extensive medical and/or surgical intervention and skilled observation and treatment due to the extreme risk of life-threatening infection. Because care of this

level of pressure ulcer is prohibited by law in assisted living, the resident cannot be admitted to or retained in assisted living and must be transferred to a setting where appropriate services can be provided. In those rare occasions where the resident is an enrolled Hospice recipient and wishes to stay in the assisted living facility, the Hospice program is responsible for the skilled services, including the care of any Stage 4 ulcers.

Note: necrotic or dead tissue may obscure the base of the wound making it difficult to differentiate a stage III from a stage IV wound. Necrotic tissue in the wound also predisposes a resident to infection.

- Clinical assessment is outside the scope of training and responsibility of unlicensed direct care staff, but they can report what they see. The acceptable description of the incident (the wound or wounds) as required at 22 VAC 40-72-100.C.7 will include, but is not limited to, the following:
 - Location of the wound(s) is usually, but not always, over a bony prominence
 - Shoulder
 - Hip
 - Tailbone
 - Buttocks
 - Heel and toes
 - Ankle
 - Elbow
 - Sides of knee
 - Ears, etc.
 - Approximation of size, width, length, depth even if a licensed health care professional has staged the wound.
 - Whether wound is draining/oozing.
 - Whether there is any unusual odor.
- Actions and outcomes as required at 22 VAC 40-72-100.C.9-10 will depend upon the extent of the clinical intervention, but at a minimum will include nurse and/or physician contacts, treatment orders, and any preventive measures undertaken as a result of the identification of any wound. (0613)