DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING ______ B. WING ______	C 02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALISADE HEALTHCARE CENTER	**920 4TH ST** **GARRETSON, SD 57030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS Surveyor: 16385 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/7/22 through 2/8/22. Areas surveyed included nursing services and pressure injuries. Palisade Healthcare Center was found not in compliance with the following requirement: F686.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled discharged resident (1) with a facility acquired pressure ulcer received ongoing assessments and interventions to prevent the pressure ulcer from worsening. *One of one sampled resident (2) with a facility acquired pressure ulcer received ongoing assessments and interventions to prevent the	F 686	1. Unable to correct deficient practice noted during survey. Resident 1 has discharged. Residents 2, 3, 4 and 5 plan of care has been reviewed and revised as appropriate. All residents have the potential to be affected. 2. The DNS or designee will educate all nursing staff on the skin policy by 2/28/22. This education to include identifying, implementing and reviewing interventions for residents that are at risk or have pressure ulcers, skin assessment that identifies risk, appropriate assessments are done timely and according to policy, identification and intervention of pain management of residents with pressure injuries, identification of interventions to prevent pressure injuries or prevent worsening of pressure injuries and how staff will be aware of these interventions, identification of treatment specific to the individual including initial start, review of effectiveness, change or continuation, review of documentation expectations, regarding physician orders, careplans, reporting, risk and skin assessments, and a review of all licensed staff and nursing assistants on their roles and responsibilities in preventing pressure injuries and preventing worsening of pressure injuries. All nursing staff not in attendance (see next page)	03/04/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lourdes Parker,
TITLE: Executive Director
(X6) DATE: 02/21/2022

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.

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F 686	Continued From page 1 pressure ulcer. *Three of three sampled residents (3, 4, and 5) admitted with pressure ulcers received ongoing assessments and interventions to prevent the pressure ulcers from worsening. Findings include: 1. Record review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 11/24/21 for skilled care. *She was transferred to the hospital on 12/8/21. -She had respiratory distress. *She was readmitted on 12/13/21 for skilled care. *She was discharged on 12/24/21. *She had two Braden Scale evaluations [used to determine the level of risk for a resident to develop skin issues] completed in her 26 days of admission. -On 11/24/21 her score was 17, indicating mild risk. -On 12/14/21 upon readmission her score was 18, indicating mild risk. *She should have had three completed per provider's skin integrity policy. -She would have had a Braden scale completed upon admission and weekly for 3 weeks. *She had received four weekly skin audits. -One in the month of November 2021 -Three in the month of December 2021 --Entry on 12/20/21 marked "n" [No] --Entry on 12/27/21 marked unknown notation. *Resident 1 had daily skilled charting completed 24 times. *Four times had a nonsurgical skin condition charted on: -11/24/21 bruising to the right eye, buttock, and lower back. -11/25/21 scattered bruising. -11/30/21 redness to peri area and buttock.	F 686	will be educated prior to their next working shift by the DNS or designee. 3. The DNS or designee will audit a random sample of 5 residents to ensure turning/repositioning in place if indicated, treatment provided as ordered by provider, documentation is accurate and done per policy, ensure a weekly skin assessment is completed and proper interventions are in place to prevent skin breakdown weekly times six weeks and monthly time three months. The DNS or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audit.	

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F 686	Continued From page 2 -12/2/21 redness to peri area and buttock. *Daily skilled charting had not documented for her skin issue identified on 12/14/21. *A pressure injury had been observed on 12/8/21 to her left buttock prior to her being transferred to the hospital. *No measurements had been documented for the left buttock pressure injury. *An order dated 12/14/21 to change the dressing to left buttock every 3 days and as needed until healed. Clean wound with wound cleanser, pat dry and apply foam dressing. *No documentation on the treatment administration record (TAR) had been completed indicating the dressing had been changed. Interview on 2/8/22 at 10:55 a.m. with licensed practical nurse (LPN)/wound nurse B revealed: *She had the first observation of pressure ulcer to her left buttock on 12/8/21. *Her pressure ulcer looked better after she returned from the hospital on 12/13/21. *On 12/14/21 a wound measurement of 2.8 centimeter (cm) x 4.2 cm x 0.2 cm. *On 12/21/21 a wound measurement of 5.2 cm x 4.2 cm. *Weekly skin evaluations were completed if a skin issue was noted. *Two weekly skin evaluations were completed. *Agreed a Braden score had been missed. *Nurses charting daily skilled notes should have documented any skin issues. Review of resident 1's care plan dated 12/14/21 revealed: *She had a pressure injury on her left buttock. *Intervention/task included: -Administer treatment as ordered and monitor for effectiveness.	F 686		

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F 686	Continued From page 3	F 686		

-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, and type of tissue and exudate.

Interview on 2/8/22 at 12:50 p.m. with administrator A revealed:
*She was not aware a Braden score had not been completed weekly.
*All mattresses in the facility are pressure redistributing.
*They utilized an algorithm and for stage 3 or above pressure ulcers residents received an air mattress to their bed.
*Residents received a wheelchair gel cushion from the facility.
*LPN/wound nurse B completed all the measurements of wounds weekly.
*If a resident had a skin issue it was not always documented daily.

Review of provider's policy dated August 2009 regarding skin integrity revealed:
*Resident's skin integrity should have been evaluated using the Braden Scale Evaluation.
*Nurses would complete the Braden Scale Evaluation on admission and then weekly for three weeks, annually, and with a significant change of condition.
*Skin impairment identified upon admission should have been measured for color, presence of odor, exudate, and presence of pain associated with skin impairment should have been documented.
*The medical provider was notified and staff implemented any treatment orders received.
*Implemented interventions should have been documented on the resident's care plan.
*If skin impairment was noted after admission, the nurse initiated alert charting.

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-Resident 1 did not have any alert charting related to skin integrity.

Surveyor: 16385
2. Observation on 2/7/22 at 1:45 p.m. of resident 2 during tour revealed:
*She was lying in bed on her right side with a positioning pillow tucked under her left side.
*She had an air mattress on her bed.
*There was a pressure redistribution cushion in her wheelchair.

Review of resident 2's medical record revealed:
*She had been admitted on 1/5/22.
*Daily skilled evaluations had been completed from 1/7/22 through 1/29/22.
-All daily skilled evaluations had indicated, "Resident does not have other non-surgical skin conditions."
*A skin/wound note on 1/31/22 stated, "Resident has small open area on coccyx, mepilex [absorbent foam dressing] was applied, and barrier cream [physical barrier between skin and contaminants]. No other concerns at this time."

Review of resident 2's Braden Scale for Predicting Pressure Sore Risk revealed:
*On 1/5/22:
-She had a score of 14.0 indicating she was at moderate risk for developing a pressure ulcer.
*On 2/2/22:
-She had a score of 13.0 indicating she was at moderate risk for developing a pressure ulcer.
*No other weekly Braden Scale assessments had been completed.
*Braden Scale assessments had not been done weekly per facility policy.

Review of resident 2's weekly skin evaluations

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revealed:
*On 2/2/22, a weekly skin evaluation had been completed indicating she had a stage 2 pressure ulcer on her coccyx [one at the base of spine] that measured 1.1 cm x .5 cm. No depth was documented.
*On 2/8/22, a weekly skin evaluation had been completed indicating the stage 2 pressure ulcer on her coccyx measured 1.2 cm x .5 cm. Depth was less than .1 cm.

Review of resident 2's physician's orders revealed:
*An order on 2/2/22 for the pressure ulcer "Cleanse with wound cleanser, pat dry, apply duoderm dressing. Change every 3 days or prn [as needed] if loose or soiled."
*On 2/2/22, an order for hospice care.

Review of resident 2's 2/2/22 revised care plan for pressure ulcers revealed:
*"I have a pressure injury on my coccyx r/t [related to] Immobility."
*Interventions included:
-"Administer treatments as ordered and monitor for effectiveness.
-Avoid laying on my back, encourage me to lay on my side.
-I have a pressure redistribution mattress on my bed and a pressure redistribution cushion in my wheelchair.
-The resident requires assistance to turn/reposition at least every 2 hours, more often as needed or requested.
-Weekly treatment documentation to include measurement of each area of skin breakdown's width length, depth, type of tissue and exudate."

Surveyor: 06365

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3. Observation and interview on 2/7/22 at 2:30 p.m. with resident 3 revealed:
*She was in bed with the head of her bed raised up to about 75 degrees with pillows propped behind her head/shoulders.
*Her head was tilted forward and turned slightly to the right.
*She responded "Yes" when asked if she was comfortable.
*She was hard of hearing, and her daughter sitting in a chair beside her bed carried on the remaining conversation.
*The daughter reported the resident had current skin concerns on her bottom and her ankle.

Observation and interview on 2/8/22 at 9:40 a.m. with resident 3 revealed:
*She was positioned in bed as she had been when observed on 2/7/22.
*Her son was sitting in a chair beside her bed.
*She responded "Yes" that she had a sore on her ankle but did not agree she had a sore on her bottom.
*The son confirmed she still had open areas on both her ankle and bottom. They would be going to see a doctor about them.

Review of the EMR for resident 3 revealed:
*On 1/24/22, the day of admission:
-The admission progress note documented the resident had "an ulcer to her right lower leg with a dressing that is changed q [every] 3 days and open areas to her coccyx."
-The admission-readmission nursing evaluation documented skin issues included:
--A right outer ankle vascular open area that measured 7.3 cm length by 5.5 cm width by 0.7 cm depth that was covered with Optifoam dressing.

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F 686	Continued From page 7 --A stage 3 pressure ulcer to her coccyx that measured 4.0 cm length by 0.5 cm width by 0.1 cm depth. -The Braden Scale was scored at 15 indicating she was at risk for the development of pressure ulcers related to: --Having slightly limited sensory perception. --Having occasionally moist skin. --Being chairfast with slightly limited mobility. --Needing moderate to maximum assistance with movement that could lead to friction and shear problems. *On 1/25/22, the daily skilled progress note (PN) documented: -Other skin observations included wounds to the arm, leg, and coccyx. -The same observations on 9 subsequent daily skilled PNs through 2/6/22 except the PN on 1/29/22, and two daily skilled PNs were missed on 2/3/22 and 2/6/22. *On 1/26/22: -The skin integrity issues section was blank on the admission care conference record. -The care plan included pressure injury on the coccyx and venous ulcer to right lateral ankle related to immobility, atrial fibrillation, weakness, and heart disease with the interventions for: --Treatments as ordered. --Turn and reposition at least every 2 hours. --Weekly treatment documentation to include measurement of each skin breakdown's width, length, depth, the type of tissue, and exudate. --Pressure redistribution cushion in the wheelchair and air mattress on the bed were added on 2/1/22. *The 1/28/22 admission and 5-day Minimum Data Set (MDS) assessment documented: -The resident's mental status was scored 8 meaning her cognitive function was moderate to	F 686		

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F 686	Continued From page 8 severely impaired. -She needed extensive to total weight-bearing assistance of two staff for bed mobility, transferring between surfaces, and toileting. -The presence of one stage 3 pressure ulcer but no venous ulcers. -Skin treatments checked included pressure reducing device for chair and bed, turning and repositioning program, pressure ulcer and injury care, application of ointments/medications. "Application of dressings" was not checked. *The 1/28/22 pressure ulcer care area assessment (CAA) that was signed on 2/2/22 documented: -The presence of an existing pressure ulcer but there were no notes related to the location, size, presence or type of drainage or odors, nor the condition of the surrounding skin. -The need for a special mattress and seat cushion, and a regular schedule of turning. *The TAR revealed: -A treatment order dated 1/24/22 to apply foam dressing to pressure ulcer on coccyx every 72 hours. This was checked as completed on 1/24/22, 1/27/22, and 1/30/22. -There was no order on the January 2022 TAR to complete a weekly skin audit, which should have been completed on 1/31/22. -A treatment order dated 2/7/22 for a weekly skin audit every night shift every Monday. *A 2/1/22 weekly skin evaluation, 9 days after admission, documented measurements of the two ulcers: -The right ankle was noted as an arterial ulcer measured at 7.0 cm length by 3.0 cm width by 0.4 cm depth with an irregular shape, a pink/beefy red and yellow color with minimal drainage and no odor. "No" was checked in response to if the ulcer was "noted on admission" and the wound	F 686		

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status was noted as "unchanged."
-The stage 3 pressure ulcer on the coccyx was an irregular shape that measured at 1.6 cm length by 0.5 cm width without a depth measurement, with a pink/beefy red color, no drainage or odor, was noted on admission and was improving.
*The 2/2/22 Braden Scale, 10 days after admission, was scored at 12 indicating high risk related to slightly limited perception, very moist, chairfast, very limited mobility, probably inadequate nutrition, and friction/shear problem.
*The February 2022 task record directed staff to monitor the presence of the pressure-relieving mattress and cushion in the wheelchair. The task for the turning and repositioning program was not listed.

4. Observation and interview on 2/8/22 at 9:50 a.m. with resident 4 revealed:
*She was seated in her wheelchair on a cushion in her room.
*She reported she did not have any skin concerns or open areas other than a bruise she pointed out on her left wrist.
*The mattress on her bed was a standard pressure-relieving mattress.

Review of the EMR for resident 4 revealed:
*On 1/25/22:
-The admission PN noted her report of intermittent left hip and knee pain with a recent weakness.
-A skin/wound PN revealed she had a stage 2 pressure wound to her upper right gluteal cleft that measured 2 cm and blanched well.
-The admission-readmission nursing evaluation noted a stage 2 pressure ulcer to her right buttock with no measurements listed and no treatment.

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F 686	Continued From page 10 -The Braden Scale was scored at 18 indicating she was at risk related to having no sensory impairment, rarely moist skin, being chairfast, having slightly limited mobility, consuming adequate nutrition, and having a potential problem with friction and shear during movement. -The daily skilled PN noted "Other skin condition" included a stage 2 right buttock pressure sore and a right iliac crest scab. Subsequent daily skilled PNs through 2/6/22 did not note that skin condition. The daily skilled PNs for 1/26/22 and 1/31/22 were not done. *The baseline plan of care initiated on 1/25/22 included: -"Skin at risk" with the interventions of barrier cream, pressure-reducing mattress, and wheelchair cushion. -A goal was added on 1/28/22 to "have no skin breakdowns." *On 1/26/22, skin integrity issues were blank on the care conference record. *On 1/28/22, the admission/5-day MDS revealed: -The resident's mental status was at 12 meaning her cognitive function was moderately impaired. -She needed extensive weight-bearing assistance of one to two staff for bed mobility, transferring between surfaces, and toileting. -The presence of one stage 2 pressure ulcer. -Skin treatments checked included pressure reducing device for chair and bed, turning and repositioning program. -Pressure ulcer and injury care, application of ointments/medications, and application of dressings were not checked. *The 1/28/22 pressure ulcer CAA that was signed on 2/2/22 documented: -The presence of an "existing pressure ulcer/injury" but there were no notes describing the location, size, presence or type of drainage or	F 686		

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F 686	Continued From page 11 odors, nor the condition of the surrounding skin. -The need for a "special mattress and seat cushion," and a "regular schedule of turning." -The rationale for care planning pressure ulcers included: --The "licensed nurse assesses skin each week," caregivers asses skin "with each bath and each time the resident is dressed." --"Caregivers assist with repositioning at least every two hours and as needed for comfort." *The January 2022 TAR revealed no order for treatment or weekly evaluation. *On 2/1/22 (8 days after admission): -The care plan was revised to address a "pressure injury on my lower right buttock" with interventions of "pressure redistribution" mattress and cushion in the wheelchair, "monitor dressing to right buttock," assist to "turn/reposition at least every two hours," and weekly documentation "to include measurement...type of tissue and exudate." -The weekly skin evaluation noted a "first observation" of a stage 2 pressure ulcer on resident's right buttock that was "noted on admission," that was irregular and measured 1.2 cm length by 1.0 cm width without a depth measurement, and that had a pink/beefy red color, with a "superficial" wound bed, normal wound edges, and no drainage or odor. -A skin/wound PN noted the resident was admitted with a stage 2 pressure ulcer to lower right buttock and had skin irritation that was extremely red to the resident's left abdominal area. A fax was sent to the physician for orders. *The 2/2/22 Braden Scale (9 days after admission) was scored at 17 indicating she was at risk related to no sensory impairment, occasionally moist skin, chairfast, slightly limited mobility, adequate nutrition intake and potential	F 686		

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problems with friction/shear.
*The February 2022 TAR included orders:
-On 2/3/22, (10 days after admission) for weekly skin audit every night shift every Thursday, which was marked as "N" indicating no new impairment.
-On 2/4/22, then discontinued on 2/5/22, (11 days after admission) for wound treatment to the right buttock, cleanse with wound cleanser, pat dry, and apply foam dressing every shift every three days, which was checked as completed on 2/4/22.
-On 2/5/22 for wound treatment to right buttock to cleanse, dry, and apply Poop Goop two times per day every three days, which was marked as completed on 2/5/22.
*The February 2022 task record did not include directions for monitoring the presence of the pressure-relieving mattress and wheelchair cushion, nor for turning and repositioning every two hours.

Interviews on 2/8/22 at 9:35 a.m. with CNA C and at 9:55 a.m. with CNA D revealed they:
*Monitored for skin concerns while assisting with daily care and during baths.
*Reported any concerns to the nurse right away.
*Could document a care concern or alert in the computer.

5. Observation and interview on 2/7/22 at 2:40 p.m. with resident 5 revealed:
*She was in bed on a standard pressure-relieving mattress.
*Her husband, sitting on a chair beside the bed, explained she needed help to transfer.
*The resident reported she had "something going on with my butt."

Observation and interview on 2/8/22 at 10:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING ______ B. WING ______	C 02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALISADE HEALTHCARE CENTER	**920 4TH ST GARRETSON, SD 57030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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a.m. with resident 5 revealed:
*She was sitting on a cushion in her wheelchair in her room.
*She confirmed her previous statement that there was a skin condition on her butt and agreed to show it to the surveyor.
*The director of nursing (DON) E assisted the resident stand while the surveyor observed the resident's bottom and found deep purple areas on both buttocks.

Review of the EMR for resident 5 revealed:
*On 11/16/21:
-The admission PN noted both buttocks were red and purplish and slow to blanch, with no measurements. Barrier cream was applied.
-The admission-readmission nursing evaluation noted stage 1 pressure ulcers to both buttocks with no measurements.
-The Braden Scale, the only one listed in the EMR since admission, was scored at 12 indicating the resident was at high risk related to limited sensory perception, very moist skin, chairfast, very limited mobility, and friction & shear problem with movement.
*On 11/18/21, the daily skilled PN, the first one in the EMR since the resident's admission on 11/16/21, noted she had "red buttocks with barrier cream applied."
-There were no daily skilled PNs on 11/19/21 through 12/1/21.
-The skin condition on her buttocks was not listed on any daily skilled PNs after 12/1/21.
-Daily skilled PNs were not completed on 6 days in December 2021, including 12/11/21, 12/15/21, 12/17/21. 12/23/21, 12/28/21, and 12/30/21.
*On 11/19/21, the admission/5-day MDS revealed:
-The resident's mental status was scored at 15

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meaning her cognitive function was intact.
-She needed extensive weight-bearing to total assistance of two staff for bed mobility, transferring between surfaces, and toileting.
-The presence of one stage 1 pressure ulcer.
-Skin treatments checked included pressure-reducing devices for chair and bed.
-Turning and repositioning program, pressure ulcer and injury care, application of ointments/medications, and application of dressings were not checked.
*The 11/19/21 pressure ulcer CAA documented:
-The presence of an "existing pressure ulcer/injury" but there were no notes related to the location, size, presence or type of drainage or odors, nor the condition of the surrounding skin.
-The need for a "special mattress or seat cushion to reduce or relieve pressure."
-The resident "requires staff assistance to move sufficiently to relieve pressure over any one site."
*The November 2021 TAR included an order for weekly skin audit and noted:
-On 11/23/21 (8 days after admission), the order was marked with "Y" [yes], meaning a new skin impairment.
-On 11/30/21, the order was marked with "N" [no], meaning no new skin impairment was found.
-The weekly skin audits on the TARs for December 2022 through 2/8/22 were all coded as "N."
*On 12/5/21 (20 days after admission and 17 days after the MDS was completed), the care plan noted:
-Problem statements for "Limited physical mobility" related to "weakness and RLE [right lower extremity] injury" and "at risk for pressure ulcer development."
--Interventions to use a wheelchair for mobility with staff assistance, extensive assistance for

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daily care, mechanical lift for transfers, "encourage small frequent position changes," and "weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate."
-On 2/8/22, the intervention for pressure-relieving cushion and bed were added.
*The February 2022 task record noted:
-Monitor for pressure relieving surface on the bed and in the chair.
-No direction was related to a turning or repositioning program.

Interview on 2/8/22 at 12:51 p.m. with administrator A revealed:
*After the observation at 10:00 a.m. of resident 5's buttocks with the surveyor and DON E, three staff (LPN/wound nurse B, DON E, and administrator A) observed resident 5's buttocks after 20 minutes of offloading.
*There was no purple area observed by the three of them at that time.
*She found a foam cushion with a plastic cover on resident 5's wheelchair that the husband brought to the facility.
*She replaced that cushion with a facility cushion.
*She had been taught that a red area is a stage 1 ulcer and there should have been weekly evaluations after that until resolved.