STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005904	A. BUILDING: _____ B. WING _____	C 12/20/2022

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ELEVATE CARE COUNTRY CLUB HILL	18200 SOUTH CICERO AVENUE COUNTRY CLUB HILLS, IL 60478

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S 000	Initial Comments Complaint Investigations: 2298949/IL153152, 2298984/IL153185, 2297391/IL151244, 2299051/IL153258, 2299392/IL153669, 2299584/IL153910, 2298439/IL152517 Facility Reported Incident Investigation of 11-06-2022/153378	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent an injury of unknown origin for 1 of 3 residents (R19) reviewed for abuse. This failure resulted in R19	S9999		

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S9999	Continued From page 2 having multiple unexplained bruises under the left eye, left shoulder and left forearm. Findings Include: On 11/30/22 at 10:16am, V67 (R19's family member) stated, R19 mouthed and pointed to V3 (certified nursing assistant/CNA), stating "you hit me" when V3 walked into the room on 11/24/22. R19 accused V3 (CNA) of hitting her in the face and pinching her. The incident had to happen on 11/23 when I didn't visit. I spoke to V3. V3 stated, I did not hit R19. I would never hit R19. I love R19. I would never hurt R19. V16 (respiratory therapist) told me, R19 eyes looked swollen. I reported it to V4 (nurse). V79 (emergency medical technician/EMT) stated, R19 had a black eye. I told R19 we couldn't prove the abuse but R19 keeps reporting the same thing. V3 is usually nice and takes care of R19 but something must have happened because R19 kept mouthing and writing V3 abused her. On 12/01/22 at 11:10pm, V69 (R19's family) stated, R19 had a black eye. V68 (R19's family member) stated, R19's right eye was red and puffy. R19 said, V3 did it. On 12/01/22 at 12:39 pm, V79 (EMT) stated, R19's face was bruised up on both sides. Right side face was bruised, left cheek circular 1cm bruise area. On 12/6/22 at 3:00pm, R19 was assessed to be alert and oriented to person, place and time. R19 stated V3 (CNA) started hitting(slapping) pinching me two weeks after I arrived at the facility. I didn't tell anyone because I was afraid V3 was going to retaliate. V3 would get upset because I would push the call light. V3 slapped	S9999		

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S9999	Continued From page 3 my hands, both sides of my face and pinched my stomach. R19 demonstrated where and how she was being hit and pinched by making a pinching motion over her stomach (lateral right side) and a slapping motion to the back of the hand and face on both cheeks with the front/palm-side of her hand. R19 was observed with two dissipating red circular spotted areas under R19's eye bags (puffy areas under R19's bilateral eyes on the lateral side). R19's left lateral eye was observed with a dissipating blue crescent area similar to the shape of a crescent moon under R19's left eye bag/puffy area. R19 had a bruised/dissipating blue irregular shaped area on the left shoulder the size of a 5-cent coin, and a larger blue dissipating area that covered R19's bicep with two circular dissipating blue circular area underneath the bicep just above the antecubital space and a dark irregular square shape on the posterior arm located at the base of the tricep above R19's elbow. Hospital paperwork dated 11/25/22 documents: Diagnosis: Suspect Elder Abuse. Skin: Bruising present. When asked if she (R19) felt scared to return to her nursing home. R19 nodded her head yes. Abuse Policy: Facility abuse prevention program policy revised 1/22/19 documents: It is the policy of the facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and crime against a resident in the facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental	S9999		

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S9999	Continued From page 4 psychosocial well-being. Willful, means the individual must have intended to inflict injury or harm. Physical abuse: hitting, slapping, pinching, kicking, etc. (B) Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1030a)1) 300.1210a) 300.1210b) 300.1210d)3)5)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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S9999	Continued From page 5 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1030 Medical Emergencies 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 6 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to immediately report and remove an elastic band from around one residents' legs which was placed by a family member. The facility	S9999		

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S9999	Continued From page 7 failed to monitor a resident in respiratory distress, notify the physician to obtain treatment orders for a critical high white blood cell count, failed to identify/notify the physician to obtain treatment orders for an alteration in skin around the implanted venous port and failed to implement interventions to prevent skin breakdown from moisture associated dermatitis. These failures affected 4 of 4 residents (R15, R4, R16, and R9) reviewed for quality of care. These failures resulted in R15 developing blisters to bilateral lower extremities, R4 being treated for elevated white blood cells for 3 days and being transported to the local hospital to be evaluated, diagnosed, and treated for sepsis. These failures also resulted in R16's implanted venous port dehiscence and R16 having to be transported to the local hospital and R9 developing full skin thickness skin loss. Findings include: R15 was admitted to the facility on 6/24/22 with diagnoses of Anoxic Brain Damage, Acute Respiratory Failure, Dysphagia, Gastrostomy, and Tracheostomy. R15's emergency service report dated 11/6/22: Emergency Medical Service (EMS) crew was dispatched to patient location for trouble breathing. Upon arrival the EMS crew found patient alone in room with no nursing staff present. Patient appeared to be aspirating on liquid food, heavy wheezing and posturing. Nursing home respiratory therapist came into the room and stated that patient was suctioned at approximately 4:00am this morning and patient was not in distress. The respiratory therapist suctioned R15, while suctioning was taken place EMS crew noticed R15's legs were bound by a	S9999		

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S9999	Continued From page 8 rubber band across both legs. At no point during patient care at bedside did a nurse come into the room. The EMS crew only received information from the respiratory staff and face sheet. History and vital signs taken advanced life support (ALS) care started. After suctioning EMS crew bagged patient with bag valve mask and patient's oxygenation levels improved from 71% to 97%. ALS care continued. Patient loaded into ambulance where ALS care continued. On 11/9/22 at 11:15am, V26 (fire department personal) state he responded to 911 call for R15. V26 stated when they arrived to R15's room there were no staff monitoring or attending to R15. The respiratory therapist came in the room shortly after they arrived and assisted with suctioning the patient. V26 stated upon transferring R15 to the stretcher, EMS observed R15's lower legs were bound with a black elastic band on bilateral thighs above the knees. The band appeared to be indented into R15s skin. The elastic band was removed by EMS and reported to facility staff. R15's hospital record dated 11/6/22 documents: EMS stated that upon arrival, the patient's legs were bound with physical therapy band. They report the nurse did not show up when they arrived. Under Emergency triage notes: Per EMS upon arrival patient was in severe respiratory distress with oxygenation at 78% on trach collar. EMS states patient condition was extremely poor. EMS also states patient had a resistance band around her thighs binding them together. R15's legs observed with red welts with blistering from where patient was restrained. On 11/16/22 at 10:50am, R15 was observed in bed. Resident legs observed to be contracted in a butterfly pose. R15's Bilateral arms and hand	S9999		

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S9999	Continued From page 9	S9999		

contracted to the body. There were several small open and scabbed areas on right upper leg and one scabbed area noted to left upper leg.

On 11/17/22 at 11:11am, V65 (R15's family) stated she saw R15 around 10:00am on 11/5/22. V65 stated she placed the band around R15's legs to help exercise but her ride arrived early. V65 stated, there was a CNA on the other side of the room assisting with care to the roommate and she asked her to remove the band from R15. V65 stated she then left.

On 11/9/22 at 305PM, V21 (CNA) identified as CNA for R15 on 11/5/22 7:00am-3:00pm shift. V21 stated she did not observe the band on R15 when she provided morning care. V21 said she recalls family visiting R15 in the morning and after they left V21 said she observed the band on R15's legs when providing care. V21 said she did not report it to anyone because she thought it was supposed to be on R15. On 11/10/22 at 312PM, V21 said that no one asked her to remove the bands from R15.

On 11/9/22 at 3:48pm, V29 (CNA) stated she worked with R15 for the evening shift (3pm-11pm) and overnight shift (11pm-7aam on 11/5/22 into 11/6/22. V29 stated she observed the band on R15's legs during her shifts and stated she was able to provide incontinence care with no concerns. V29 stated she reported the band to V28 (nurse) at the end of her first shift and the nurse just said okay. V29 stated the nurse did not give any further instructions and assumed the band was meant to be there. V29 stated she assumed other people had seen the band. V29 stated she saw blisters on R15's knees.

On 11/22/22 at 2:26pm, V55 (CNA) stated she

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S9999	Continued From page 10 was the CNA working the 11pm-7am shift on 11/5/22 into 11/6/22 . V55 stated she heard V29 (CNA) asking the nurse about the bands on R15 and why were they there. V55 stated there was no response from the nurse. On 11/9/22 at 2:16pm, V28 (nurse) was identified as the nurse working with R15 11pm-7am shift on 11/5/22 into 11/6/22. V28 stated around 7am she went to give R15's morning medications and observed R15 in distress. R15 had emesis and pulse oxygenation was in the eighties. V28 stated she yelled for oncoming nurse who called 911 and the respiratory therapists, they were trying to clear R15's airway. V28 stated she stepped away to get R15's paperwork. V28 said she did not observe the band on R15 and said no one reported to her about the band on R15's legs. On 11/10/22 at 11:37am, V19 (Respiratory therapy, RT manager) identified as RT working with R15 on 11/5/22 into morning of 11/6/22. V19 stated she was performing change of shift report with V63 (RT) when she observed paramedics exiting the elevator on R15's floor. V19 stated she was not made aware that R15 was experiencing respiratory distress prior to EMS arrival. V19 said V28 (Nurse) was at the nursing station and reported that R15 was having a change in condition. V19 stated they went with EMS to R15's rooms. V19 stated she is unable to recall if any other facility staff were present in the room with R15 at time of EMS arrival to R15's room. V19 stated R15 was in distress and suctioning was performed. R15's oxygenation was 79% on 5 liters of oxygen. We increased oxygen to 15 liters and pulse ox went up to 91%. V19 denies seeing any bands on R15's legs. On 11/10/22 at 2:43pm, V34 (restorative aide)	S9999		

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S9999	Continued From page 11 stated R15's family showed her the bands back in October. V34 stated she told the family the bands were not appropriate and no further discussion. V34 said she reported it to V35 (restorative nurse). On 11/10/22 at 238pm, V35 (restorative nurse) stated she spoke to R15's family in October. V35 stated family had inquired about placing bands on R15's legs due to contractures. V35 said she told family facility could not place bands on R15 because it would be a restraint and family said okay. There was no further discussion about the bands. V35 stated the conversation was documented on a on grievance form. Review of R15's medical record did not document any education or discussion with family about the use of bands around her legs. Review of facility grievance binder for September and October did not document any grievance related to R15. R15's wound assessment report dated 11/12/22 documents: right lateral knee; blister measuring 18x13x0.10cm; left anterior thigh; blister measuring 1x1xunknown cm. R4 was admitted to the facility on 9/15/22 with a diagnoses of Respiratory Failure, Protein-Calorie Malnutrition, Chronic Kidney Disease, type II Diabetes, Pressure Ulcer and Anemia. R4's progress note dated 10/19/22 at 11:36am documents: Spoke local hospital who stated that resident was evaluated, and they found no emesis when assessed. Resident noted to have elevated white blood count and chest x-ray was clear per emergency room (ER) nurse. Resident	S9999		

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S9999	Continued From page 12 will not be admitted and will return back to facility. R4's progress note dated 10/20/22 at 1:19pm documents: R4 had emesis times(x)3. Vital signs stable. New orders for x-ray. R4's Physician order sheets documents order 10/20/22 referral for Gastroenterologist and stat KUB for vomiting. R4's laboratory results dated 10/21/22 documents: white blood count of 28.7. Results phoned and faxed on 10/21/22 at 1:47pm. Normal white blood cell count range is 4.8-10.8. R4's laboratory results dated 10/18/22 document white blood cells 14.7. R4's progress note 10/22/22 documents: Writer called patient's primary doctor to relay critical labs; could not reach MD; writer will pass labs onto the next shift nurse to recontact MD. R4's progress note 10/23/22 at 5:58pm documents: This writer left message with the on-call number to relay labs, awaiting call back. R4's progress note 10/23/22 at 8:05pm documents: Note Text: Lab results were relayed; MD gave orders to monitor. R4's progress note 10/24/22 at 3:56pm documents: V61 gave orders for patient to be seen by infectious disease for elevated white blood count. R4's Physician order sheets documents order on 10/24/22 referral for infectious disease. There were no other orders documented related to high White blood count.	S9999		

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S9999	Continued From page 13 R4's medication administration record for October 2022 does not document any new treatments after 10/19/22. R4's vital signs were monitored once a day. R4's hospital record dated 10/24/22 documents: White blood count of 46.7. Under clinical impression documents: Sepsis due to unspecified organism and pneumonia due to infectious organism in part of the lung. R4's care plan dated 9/16/22 documents R4 has potential to exhibit signs and symptoms of infection related to chronic leucocytes. History of C.Auris fungemia, Enterococcal Bacteremia and Klebsiella; recent history of urinary tract infection. Interventions: assess for signs and symptoms of infection. Notify the physician as indicated; notify physician of change in condition; obtain laboratory results as ordered. Report abnormal reports to physician; obtain vital signs as ordered. On 11/23/22 at 9:45am, V60 (MD) and V61 (NP) stated they both do not recall being notified of any abnormal lab results for R16. V60 stated if he was notified of results, they would have monitored the patient. When asked to explain what monitor means, V60 said he would expect the staff to monitor R4's vital signs every shift and report any changes or abnormal values. V60 said any further interventions would depend on how the patient was presenting clinically and if no changes presented, they would just continue to monitor the patient. When V60 was asked if any additional diagnostic test should have been ordered, V60 replied that it was too soon to reorder CBC and he has never had any issues with laboratory results in the past. V60 said he may have ordered a blood culture but that takes a few days so it would have been easier to send the patient to the	S9999		

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S9999	Continued From page 14 hospital at that point. V60 stated they did order KUB to be performed due to emesis and there were no findings. V61 stated she referred R16 to infectious disease on 10/24/22 prior to hospital transfer. On 11/22/22 at 2:53pm, V2 (DON) stated facility staff should notify the physician immediately for any critical lab results. If doctor is not available, they would reach out to the medical director to report results. On 11/23/22 at 9:39pm, V25 (Medical director) stated If she or her staff would have been notified of high WBC results, staff would have ordered additional labs for following day, possibly order chest x-ray, urine collection, blood cultures and reach out to infectious disease. V25 stated an elevated White blood cell count can led to sepsis if not treated. R16 admitted in the facility on 9/27/22 and was discharged on 11/1/22. Hospital record of R16 reviewed upon initial admission to the facility dated 9/27/22, under past surgical/procedure shows IR CVA Port Insertion on 8/29/22. R16 went for chemotherapy appointment on 11/1/22. Facility documentation dated 11/1/22 reads in part: Call received from nurse at appointment, per nurse stated that R16 would be admitted to hospital thru ER (Emergency Room) due to R16's current status. Nurse was not able to give admitting diagnosis. Per nurse R16 was noted with low blood	S9999		

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S9999	Continued From page 15 pressure, R16 noted with complications to port a cath site upon removal of dressing. Hospital record dated 11/1/22, R16 presented in the hospital with tachypnea, hypoxic and dehiscence implanted port. R16 was found unresponsive while still in the ER and then admitted in MICU (Intensive Care Unit). On 11/16/22 at 1pm, V5 (Unit Manager) stated "I believed R16 was in his appointment and the clinic informed me that R16 will be admitted to the hospital from his appointment due to blood pressure being low and complication with the porta cath. " If I don't put it on my notes, I do not recall what was the venous port complications. I was not present when R16 left for R16's appointment and I just received a call when the nurse from the clinic had called to inform us that R16 is going to the hospital". On 11/17/22 at 11am, V28 (Oncologist Personnel) stated "R16 was in our office on 10/7/22 and the porta cath site was fine, and on 11/1/22 appointment, we saw a band aid covering the port cath site. Removed it and noted the skin around the port has deteriorated. Skin surrounding the port is open and you can see the port. The site is clean and no bleeding, so I assumed someone from the facility is aware about the site and had cleaned it and put a band aid over it. R16 was sent to the hospital because of this skin opening surrounding the port. They are high risk of infection, for anyone with port implanted on them". On 11/17/22 at 10am, V2 (DON) "V5 did not report to me or if V5 did, I dent remember if V5 reported to me R16's conditions when the oncologist office called that day. For any new skin	S9999		

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S9999	Continued From page 16	S9999		

alterations. We notify the doctor, family and the wound care team. They have to document new skin alteration and must be assessed to have proper treatment. Wound care team need to evaluate new skin alteration".

On 11/18/22 at 10:30am, V7 (Wound Nurse) stated that R16 was admitted with skin breakdown to his sacral, unstageable. Sacral skin alteration healed before R16 left the facility, healed on 10/28/22. I did not know any other skin issues with R16 besides the sacral site that healed in October. I am not aware of any skin opening on his chest implanted port site. My expectation is for the staff to notify the doctor, family and the wound care team. It would be a concern to me if the port site is open, implanted port site is expected to be under the skin, with the skin intact. With skin opening around the port site, it should have a treatment order to prevent further complications".

R16's facility physician order sheet reviewed and there is no noted order for any treatment for implanted venous port skin alterations.

R16's progress notes reviewed from admission 9/27/22 to 11/1/22, and there is no noted wound/skin alteration related to the implanted venous port site/area.

R16's TAR (Treatment Administration Record) did not show any treatments for skin alteration related to implanted venous port site/area.

Facility policy titled Pressure injury and skin condition assessment revised 1-17-18 documents: Each resident will be observed for skin breakdown daily during care and on assigned bath day by the CNA. Changes shall be

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S9999	Continued From page 17 promptly reported to the charge nurse who will perform the detailed assessment. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. Braden score dated 8/6/22 documents: R9's score as 12 which indicates high risk for acquiring pressure wounds(range 10-12) due to sensory (slightly limited), moisture (very moist), activity (chairfast), mobility(very limited) nutrition (probably inadequate) and friction/shear (problem). Preventive recommendation: Moisture-none. On 11/3/22 at 9:58am, V82 (R9's family) stated, R9 would call me on his mobile phone, ask me to call the nursing station so R9 could be cleaned after a bowel movement. R9 had to wait two hours to be cleaned. On 11/22/22 at 3:56pm, V58 (wound doctor) stated, R9's moisture associated dermatitis (MASD) was related to R9 being incontinence. R9 was left in feces and urine every two hours. When R9 was repositioned every two hours he was soiled. On 11/22/22 at 4:17pm, V58 said, an adult brief can worsen an area with MASD. The adult brief can dig into the impaired skin. On 11/22/22 at 4:27pm, V7 (wound nurse) stated incontinence can cause MASD. On 11/23/22 at 10:30am, V59 (wound nurse practitioner) stated, R9's skin etiology started off as moisture associated dermatitis. With constant moisture of the skin and exposed/impaired skin being traumatized by the adult brief can lead to	S9999		

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S9999	Continued From page 18 subcutaneous tissue being loss. R9's wound picture dated 8/17/22 was observed with slough. R9's wound should have not been classified a MASD but as full thickness loss (Full thickness tissue 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 and tunneling.) I would have debrided R9's wound and packed it depending on the depth after the debridement. Wound assessment dated 8/17/22 documents: R9 had bilateral thighs moisture associated dermatitis which was facility-acquired. Clinical stage: Partial Thickness (Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed without slough.) Wound doctor assessment dated 8/17/22 documents: Wound #4 Right thigh is a MASD, measurements are 10cm length x 0.5cm width x 0.1cm depth (LxWxD), with an area of 5 sq cm and a volume of 0.5 cubic cm. Wound doctor assessment dated 8/17/22 documents: Wound #5 Left thigh is a MASD, measurements are 10cm length x 0.5cm width x 0.1cm depth (LxWxD), with an area of 5 sq cm and a volume of 0.5 cubic cm. Care plan revised on 8/17/22 documents: Bilateral Thigh- MASD- incontinence care as needed, and skin barrier applied and turn and reposition. (A)	S9999		