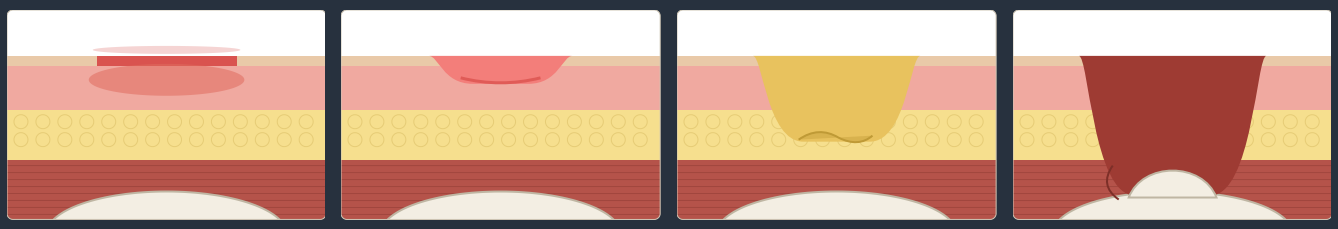


NEW YORK NURSING HOME RESOURCE CENTER

The Family Guide to Bedsores

Pressure injuries in New York nursing homes: what they look like, how they are treated, what the facility must document and report, and what your family can do



- The stages, illustrated, with what each one looks like at the bedside
- Treatment options, from repositioning to surgery
- The care, documentation and reporting the law requires
- Warning signs, questions to ask, and where to report

Free. Please read it, print it, and share it with anyone whose loved one lives in a nursing home or rehab facility.

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BEFORE YOU START

How to use this guide

A bedsore, also called a pressure ulcer or pressure injury, is one of the most common and most preventable harms in a nursing home. It is also one of the most painful. Families are often the first to notice one, and they are often told less than they should be about how it happened and how it is being treated.

This guide is written for families, not for doctors or lawyers. It explains what bedsores are, how they are staged and treated, what New York and federal law require a nursing home to do to prevent them, what the facility must write down, and whom it must tell. Wherever a rule comes from a statute or regulation, the citation is given so that you, or your lawyer, can check it.

Three things worth knowing now

1. **Most bedsores are preventable.** Federal law says a resident must not develop one unless the resident's clinical condition shows it was unavoidable, and the facility has to prove that it did everything required. A new bedsore is a reason to ask questions, not a normal part of aging.
2. **They get worse quickly.** Damage can begin within hours of unrelieved pressure. A wound that looks small on the surface can be much deeper underneath. Do not wait for the next care plan meeting to raise a concern.
3. **The records tell the story.** Turning schedules, skin checks, wound measurements and notices to the doctor and family are all supposed to be written down. You have a right to see them, and gaps in them matter.

> A NOTE ON WHAT THIS IS
>
> This guide is general information about New York and federal law and about standard wound care. It is not medical advice and not legal advice, and it does not create an attorney-client relationship. Every resident is different: questions about a particular wound belong with the resident's physician or a wound care specialist, and questions about a particular case belong with a lawyer.

IF YOU SEE A WOUND TODAY

Ask the nurse to look at it with you, ask what stage it is and when the doctor was told, and write down the date, the time and the name of the person you spoke to. Take a photograph if the resident agrees and facility policy permits. If the resident has a fever, confusion, a foul-smelling wound or spreading redness, ask that the doctor be called now.

PART 1

Understanding bedsores

What a pressure injury is, why nursing home residents are at such high risk, where the injuries form, and how clinicians describe how deep the damage goes.

1 What a bedsore is, and how fast one forms

2 Where bedsores form

3 The stages, illustrated

4 What they look like: photographs

5 Who is at risk: the Braden Scale

CHAPTER 1 · THE BASICS

What a bedsore is, and how fast one forms

A pressure injury is damage to the skin and the tissue beneath it, usually over a bone, caused by pressure that is not relieved, or by pressure combined with shear. The wound can be intact skin that has changed color, or an open sore that reaches muscle and bone.

The terms are used interchangeably. Families usually say **bedsore**. Older records say **decubitus ulcer** or **pressure ulcer**. Current clinical guidelines say **pressure injury**, because damage can exist before the skin opens. This guide uses all of them.

How the damage happens

PRESSURE

Blood cannot get through

When a resident lies or sits in one position, body weight squeezes the tissue between the bone and the mattress or chair. The small blood vessels close, and the tissue is starved of oxygen. Muscle and fat near the bone are damaged first, which is why a wound can be deep before it is visible.

SHEAR

Layers pulled apart

When the head of the bed is raised, the body slides down while the skin stays against the sheet. The deeper layers stretch and tear. Sliding a resident up in bed instead of lifting them does the same thing. Shear is a major cause of wounds over the tailbone.

MOISTURE

Weakened skin

Urine, stool and sweat soften the skin and make it break down faster. A resident left in a wet brief is at much greater risk. Incontinence-associated skin damage is not itself a pressure injury, but it often sits right next to one.

POOR NUTRITION

No material to repair with

Skin needs protein, calories and fluid to stay strong and to heal. Weight loss, poor appetite, dehydration and low protein all raise the risk and slow healing. That is why a dietitian is part of the care team.

How fast

Tissue damage can begin within hours of unrelieved pressure in a frail resident. A resident who cannot move without help depends entirely on staff to change position. That is why repositioning, skin checks and pressure-relieving surfaces are basic nursing care, not extras.

> WHY NURSING HOME RESIDENTS ARE AT SUCH HIGH RISK
>
> Many residents cannot move on their own, cannot feel discomfort or cannot say they are in pain, because of stroke, dementia, Parkinson’s disease, a hip fracture, diabetes or sedating medication. Many are incontinent, underweight or both. These are exactly the residents the law requires a facility to identify on admission and protect.

CHAPTER 2 · LOCATION

Where bedsores form

Bedsores form where bone is close to the skin and the body's weight rests. Where a wound appears tells you a lot about which position the resident was left in.

LYING ON THE BACK

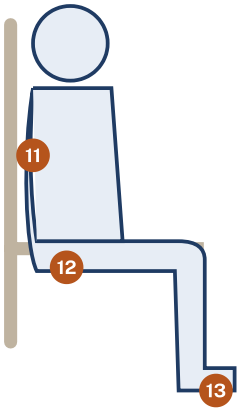


LYING ON THE SIDE



Plus anywhere a device presses: oxygen tubing behind the ears, masks, catheters, splints, braces and tight stockings.

SITTING IN A CHAIR



1. Back of the head
2. Shoulder blades
3. Elbows
4. Tailbone and sacrum
5. Heels
6. Ear
7. Shoulder
8. Hip bone
9. Knee (inner and outer)
10. Ankle
11. Spine and back
12. Sitting bones (buttocks)
13. Feet and heels

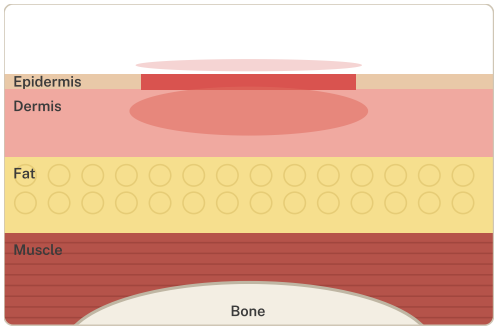
What the location can tell you

Location	What it often points to
Tailbone, sacrum, buttocks	Long periods on the back, the head of the bed kept raised (shear), or incontinence care that was not done promptly. The most common site.
Heels	Heels resting directly on the mattress. Heels have little padding and a poor blood supply; they should be "floated" off the bed with a pillow under the calves or a heel boot.
Hips	Long periods on one side without being turned, or turning only between the back and the same side.
Sitting bones (ischium)	Long periods in a wheelchair or recliner without a pressure-relieving cushion or without being shifted.
Ears, nose, behind the head	Oxygen tubing, masks and other devices that were not padded or checked under the device.

A resident can develop more than one wound at a time. Each wound should be separately located, staged, measured and documented.

The stages, illustrated

Clinicians stage a pressure injury by how deep the damage goes. Each drawing below shows the layers of the skin from the surface down to the bone.

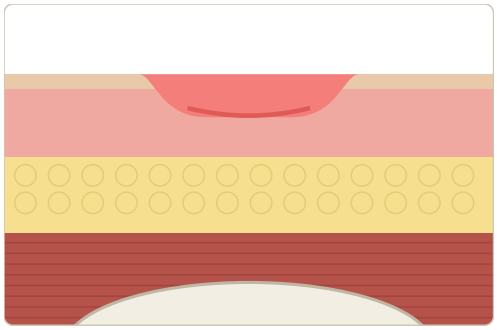


STAGE 1

Red skin that does not fade

Intact skin with a patch of redness that does not turn white (“blanch”) when pressed lightly with a finger. The skin is not broken. The area may feel warmer or cooler, firmer or softer than the skin around it, and it may hurt or itch. In darker skin, redness may be hard to see; the area may look darker, purple-tinged or shiny instead.

What you may see: A red or dark patch over a bone that is still there 30 minutes after pressure is taken off. This is a warning: with pressure removed and good care, a Stage 1 can resolve.

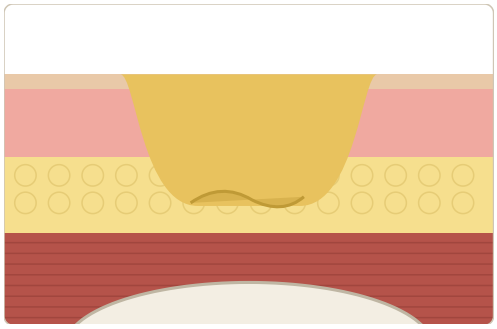


STAGE 2

A shallow open sore or blister

Partial-thickness loss of skin. The wound is shallow, with a pink or red, moist bed and no fat showing. It can also look like an intact or broken blister filled with clear fluid. There is no yellow or black dead tissue.

What you may see: A shallow scrape-like sore or blister over the tailbone, hip or heel. Moisture damage, skin tears and tape injuries are not Stage 2 pressure injuries and should not be charted as one, but they need treatment too.

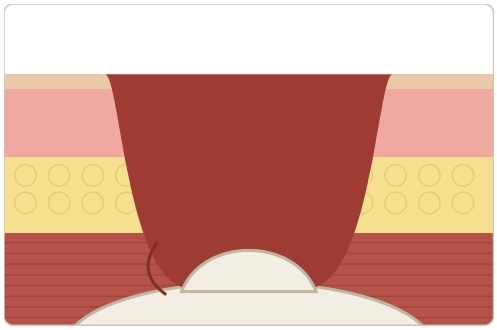


STAGE 3

A deep crater into the fat

Full-thickness skin loss. The wound goes through the skin into the fat beneath it. Yellow or tan dead tissue (slough) may be present, and the edges may be rolled. The wound can tunnel or extend under the surrounding skin (undermining). Muscle, tendon and bone are not visible.

What you may see: A crater. Depth depends on the location: over the bridge of the nose or ear a Stage 3 can be shallow; over the buttocks it can be deep.

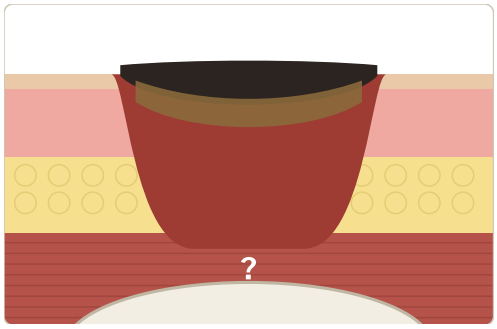


STAGE 4

Muscle, tendon or bone exposed

Full-thickness loss of skin and tissue, with muscle, tendon, ligament, cartilage or bone exposed or directly felt in the wound. Slough or black dead tissue (eschar) is often present, as are tunneling and undermining. Infection of the bone (osteomyelitis) is a serious risk.

What you may see: A deep wound in which bone or muscle can be seen or felt. A Stage 4 wound can take many months to heal, and some never heal.

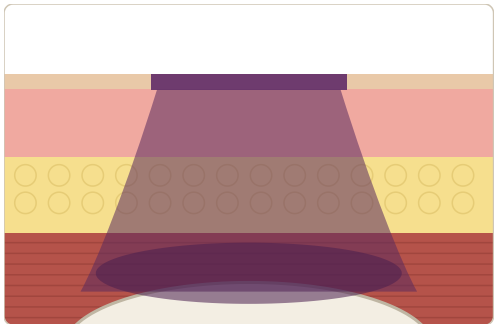


UNSTAGEABLE

The bottom cannot be seen

Full-thickness damage hidden under slough or eschar, so its true depth cannot be judged. Once the dead tissue is removed, it will be revealed as a Stage 3 or Stage 4. Dry, stable black eschar on the heel is usually left in place as a natural cover and watched closely.

What you may see: A wound covered by a black, brown or yellow crust or film. “Unstageable” does not mean minor. It means at least Stage 3.



DEEP TISSUE INJURY

A bruise that starts at the bone

Intact or broken skin with a persistent deep red, maroon or purple area, or a blood-filled blister. The damage starts deep, near the bone, and works outward. Pain and a change in temperature often come first. It may resolve, or it may open quickly into a Stage 3 or 4.

What you may see: What looks like a deep bruise over the tailbone or heel. Ask how long the resident was left in one position.

CHECKING DARKER SKIN

Redness can be hard or impossible to see on brown and Black skin, and early pressure injuries in residents of color are too often missed. Look in good light and compare with the same spot on the other side of the body. Watch for skin that is darker than the surrounding area or has a purple, blue or gray tint, and feel for warmth or coolness, firmness, swelling or tenderness. Ask staff how they check skin tone changes in your loved one.

Three more things about staging

Wounds are not “reverse staged”

A wound is staged at its deepest point and keeps that stage as it heals. A Stage 4 that is filling in is a “healing Stage 4,” not a Stage 3, 2 or 1. If the records show a wound’s stage going down week by week, ask how it was measured.

Injuries from medical devices

Oxygen tubing, masks, feeding tubes, catheters, splints, braces, compression stockings and even a bed rail can cause a pressure injury in the shape of the device. These are staged the same way, and the facility must check the skin under and around every device. An injury inside the nose, mouth or other moist membrane is not staged but must still be treated.

“Kennedy” ulcers and end-of-life skin changes

Some dying residents develop a sudden, pear- or butterfly-shaped wound over the tailbone, often called a Kennedy terminal ulcer, as the body’s circulation fails. Federal survey guidance recognizes that some wounds at the end of life may be unavoidable, but it also requires the facility to assess and classify the wound accurately and to show that preventive care was actually in place.

Families should be cautious when a wound is labeled “terminal” or “unavoidable” for the first time after it has already become severe. The label should come from a physician’s documented assessment, not appear in the chart after the fact.

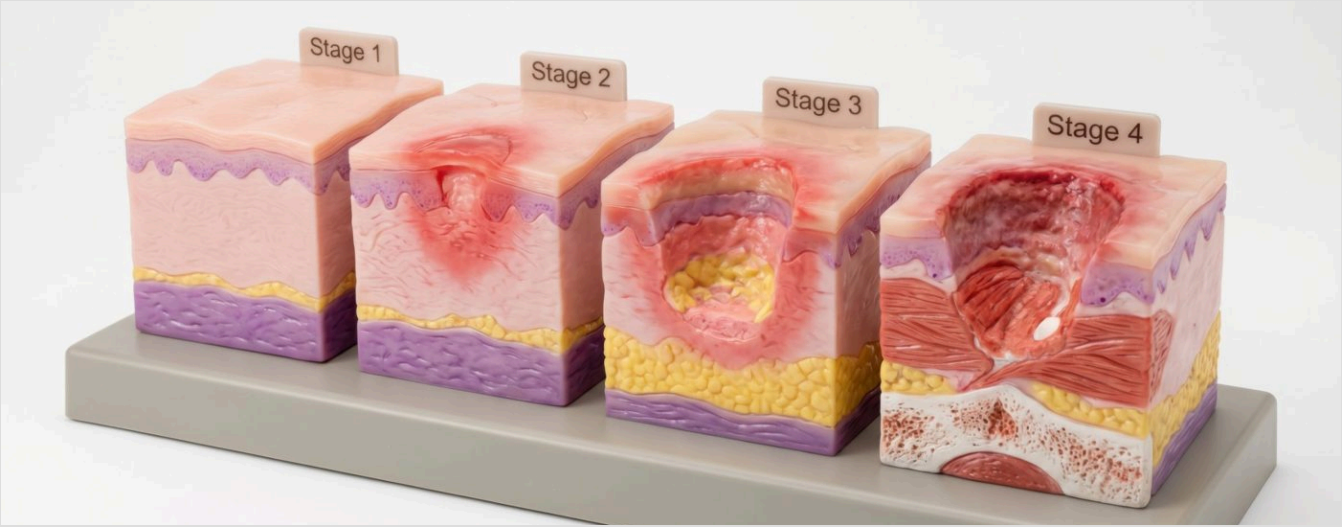
THE WORDS IN THE CHART

Term	Meaning
Slough	Yellow, tan, gray or green dead tissue, soft and stringy
Eschar	Black or brown dead tissue, hard or leathery
Granulation	Healthy, beefy red, bumpy new tissue: a sign of healing
Undermining / tunneling	The wound extends under the skin edge, or in a channel, beyond what can be seen
Exudate	Drainage. Its amount, color and odor are recorded
Maceration	White, soggy skin around a wound from too much moisture

What they look like

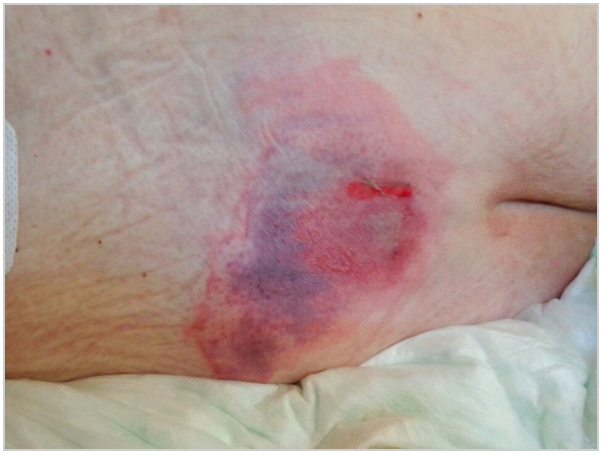
PLEASE NOTE

The photographs in this chapter show real wounds and may be upsetting. They are included because families are often the first to see a wound, and knowing what to look for can lead to earlier treatment.



Used with permission.

A teaching model of the four stages. Stage 1: the skin is intact but damaged. Stage 2: a shallow wound through the outer skin. Stage 3: a crater into the yellow fat layer. Stage 4: a wound through the fat into muscle, reaching the bone at the bottom. The photographs that follow show what these stages look like on real residents.



"Decubitus 01" by AfroBrazilian, Wikimedia Commons, licensed CC BY-SA 3.0 (creativecommons.org/licenses/by-sa/3.0). Unmodified.

EARLY OPEN WOUND OVER THE SACRUM

Discoloration around a small open area

The photographer describes this as a Stage 2 pressure injury on the sacrum, the flat bone above the tailbone. Notice the purple and red discoloration spreading well beyond the small open area at the center.

Discoloration like this can mean that the deeper tissue is damaged, as in a deep tissue injury, even where the surface looks less serious. A wound like this must be measured, staged, reported to the physician and given a written treatment plan, and pressure must be kept off the area.



Used with permission.

FULL-THICKNESS WOUND OVER THE SACRUM

Measured with a ruler

A full-thickness pressure injury over the sacrum, at least Stage 3. The ruler shows a wound roughly 9 to 10 centimeters, about 4 inches, across.

The red, bumpy tissue is granulation, a sign of healing. The white and yellow strands are slough or deeper tissue. The edges are rolled. A ruler in the photograph is the way wound size should be documented, and the measurements in the chart should match what a photograph like this shows.



Used with permission.

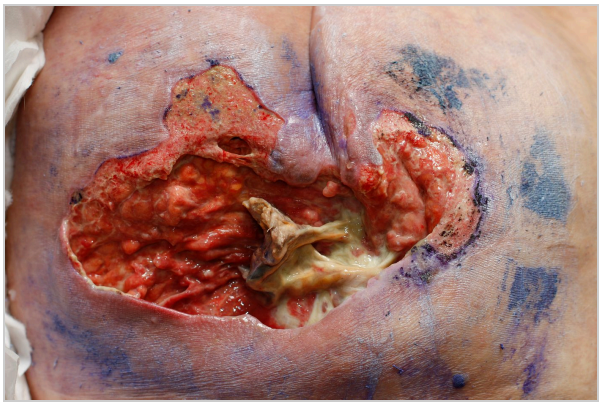
BEDBOUND RESIDENT

A large wound over the buttock and hip

A large, deep pressure injury over the buttock and hip of a bedbound resident with a urinary catheter, photographed while staff turned the resident onto one side.

The open wound is surrounded by a wide area of deep purple and red discoloration: damaged tissue that extends well beyond the open area and may still break down. Wounds in this location often reflect long periods lying on the back or on one side without being turned.

A wound like this needs a physician, a wound care specialist, a specialized air mattress, a strict turning schedule, a nutrition plan and close watching for infection.



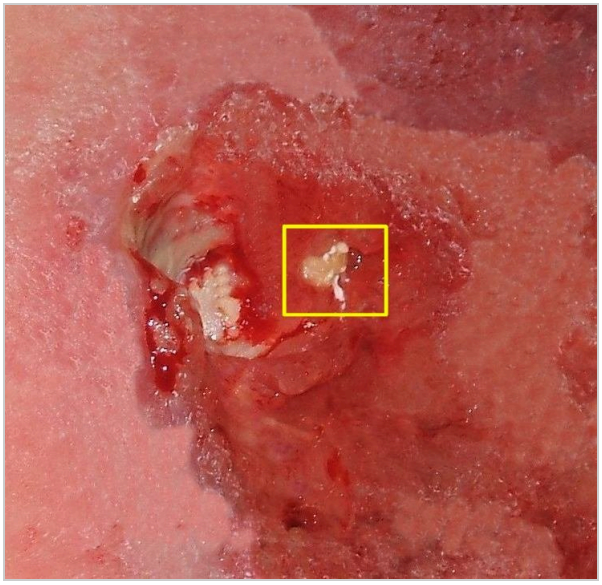
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STAGE 4

An advanced wound over the sacrum

An advanced Stage 4 pressure injury spanning the sacrum and both buttocks. The center contains gray-tan dead tissue and yellow slough; the edges show red granulation tissue and a tunnel running under the skin at the upper border.

The skin around the wound is purple and fragile. The dark blue patches on the surrounding skin appear to be marking ink, not part of the wound. Wounds like this carry a high risk of sepsis and bone infection.



"Decubitus ulcer stage 4" by Noles1984, Wikimedia Commons, released into the public domain by the author.

STAGE 4

Bone exposed in the wound

A Stage 4 pressure injury over the ischium, the "sitting bone" of the pelvis. The area inside the yellow box, marked by the photographer, is exposed bone.

Wounds like this often follow long periods of sitting without a pressure-relieving cushion or repositioning. A Stage 4 wound carries a high risk of bone infection and sepsis and frequently needs a surgeon, a specialized bed and months of care.



Used with permission.

DEEP TISSUE INJURY BREAKING DOWN

Dark discoloration over the hip and buttock

A resident turned onto one side, showing a band of dark purple-to-black discoloration running from the hip toward the buttock, with an open, blackened wound below it.

This is what a deep tissue injury can look like as it breaks down: the purple and maroon area marks tissue that was damaged from the bone outward, and where the skin has opened, dead tissue is visible. The brown staining on the pad beneath the resident shows heavy drainage.

Once a wound like this opens, it is usually found to be Stage 3 or Stage 4 or is classified as unstageable until the dead tissue is removed. Look closely at the hips and tailbone of any resident who cannot turn without help: discoloration like this is often visible days before the skin opens.

WHAT THESE PHOTOGRAPHS HAVE IN COMMON

Each wound sits over a bony area where body weight rests: the sacrum, the buttocks, the hip or the sitting bone. Each could have been found earlier through the weekly skin checks, and its risk reduced through the turning, support surfaces and nutrition that the law requires. Chapters 9 through 11 explain those requirements.

Taking your own photographs. Photographs are often the clearest record of how a wound looked on a given day. Ask the resident's permission, or the permission of the health care agent if the resident cannot decide; respect the privacy of other residents; and follow facility policy. Put a dated note or a ruler beside the wound if you can, and keep the photographs with your notes. Ask whether the facility photographs wounds and how you can get copies.

CHAPTER 5 · RISK

Who is at risk: the Braden Scale

Every nursing home must assess each resident's risk of developing a pressure injury. Most New York facilities use a tool called the Braden Scale. Ask for your loved one's scores.

The Braden Scale rates six things. The lower the score, the higher the risk. The total runs from 6 to 23.

Category	What is rated	Points
Sensory perception	Can the resident feel and respond to discomfort?	1–4
Moisture	How often is the skin wet from sweat, urine or stool?	1–4
Activity	Bedfast, chairfast, walks occasionally, or walks frequently?	1–4
Mobility	Can the resident change position without help?	1–4
Nutrition	How much of each meal is eaten? Protein, fluids, tube feeding?	1–4
Friction and shear	Does the resident slide down in bed or chair, or need to be lifted?	1–3

15–18	13–14	10–12	9 OR LESS
At risk	Moderate risk	High risk	Very high risk

How often the risk should be checked

Federal survey guidance describes the common practice of assessing risk on admission, weekly for the first four weeks, then at least quarterly and whenever the resident's condition changes, such as after a hospital stay, a fall, a new illness or weight loss. The skin itself should be checked at least weekly, and more often for a resident at high risk.

CMS STATE OPERATIONS MANUAL, APP. PP, F686 (SURVEY GUIDANCE)

Other risk factors the score may miss

- A recent hospital stay, surgery or hip fracture, or long hours on a stretcher or in a wheelchair
- Diabetes, peripheral artery disease, kidney disease, heart failure or a stroke
- Dementia, sedating medication, or an inability to speak or ask for help
- Weight loss, a poor appetite, dehydration or low protein in blood tests
- A previous pressure injury, including one that has healed: the scar is weaker than normal skin

> **A SCORE IS NOT A CARE PLAN**
>
> A low Braden score is supposed to lead to action: a turning schedule, a pressure-redistributing mattress, heel protection, incontinence care and a dietitian review. Ask what was done after each score.

PART 2

Treatment

How pressure injuries are treated at each stage, what the common treatments are, and the warning signs that a wound is getting worse and needs a doctor now.

6 Treatment at a glance, by stage

7 Treatment options explained

8 When a wound is getting worse

Treatment at a glance, by stage

Every treatment plan starts with the same step: take the pressure off the wound. No dressing or medication can heal a wound that is still being pressed on.

Stage	Goals	Common treatments
Stage 1	Restore blood flow; stop it from opening	Keep all pressure off the area; reposition on a schedule; pressure-redistributing mattress or cushion; protect the skin with a barrier or protective film; manage moisture; review nutrition and fluids
Stage 2	Keep the wound clean and moist so it can close	Everything for Stage 1, plus gentle cleansing with saline or wound cleanser and a moist dressing such as a hydrocolloid, foam, hydrogel or transparent film; watch for infection
Stage 3	Remove dead tissue; fill the wound from the bottom up; control drainage and infection	Debridement of slough; absorbent dressings such as foams, alginates or hydrofibers; packing for tunnels; antimicrobial dressings when needed; advanced support surface; dietitian plan with added protein; wound care specialist
Stage 4	Same as Stage 3, plus protect the bone and treat infection	Debridement, often surgical; negative pressure wound therapy; evaluation for bone infection; antibiotics when infection is present; specialized air bed; surgical consult, sometimes for a flap repair
Unstageable	Find out how deep it is, or protect it if stable	Debridement to reveal the wound bed; but dry, stable eschar on the heel is often left in place, padded and checked daily for redness, softening or drainage
Deep tissue injury	Stop it from opening	Complete off-loading of the area, especially heels and tailbone; protect intact skin; frequent reassessment, because it can open into a Stage 3 or 4 within days

WHAT EVERY TREATMENT PLAN SHOULD INCLUDE

- ☐ A physician's or nurse practitioner's order for the specific treatment and how often it is done
- ☐ A turning and repositioning schedule written into the care plan
- ☐ A named support surface: the type of mattress, overlay or cushion
- ☐ Pain control before dressing changes
- ☐ A dietitian assessment and a nutrition plan
- ☐ A date to reassess, and what happens if the wound is not improving

Treatment choices belong to the resident's clinicians and depend on the resident's overall health. This table describes common approaches drawn from published wound care guidelines; it is not a substitute for the physician's orders.

Treatment options explained

Taking the pressure off

Repositioning. Federal survey guidance describes the common practice of repositioning a dependent resident in bed at least every two hours, or more often depending on the resident's condition, and shifting a dependent resident who is sitting up about every hour. The resident should never be positioned on an existing wound. A slight shift of a pillow (a "microshift") is generally not enough.

Heels. Heels should be lifted completely off the mattress, with a pillow lengthwise under the calves or a heel off-loading boot, so the heel floats.

The head of the bed. Keeping the head of the bed at 30 degrees or lower, unless there is a medical reason not to, reduces shear on the tailbone. A resident who must sit up for meals or breathing needs closer watching.

Lifting, not sliding. Staff should use a draw sheet or lift to move a resident up in bed rather than dragging the resident across the sheet.

Mattresses, overlays and cushions

A standard foam mattress is not enough for a high-risk resident. Options include high-specification foam mattresses, gel or air overlays, alternating-pressure air mattresses, and low-air-loss and air-fluidized beds for residents with large or multiple wounds. A wheelchair or recliner needs its own pressure-redistributing cushion. A special mattress does not replace repositioning.

Keeping the skin clean and dry

Prompt incontinence care, gentle cleansing, moisture-barrier creams and breathable pads protect the skin. Plastic-backed pads and multiple layers of linen under the resident trap heat and moisture and should be avoided.

Dressings

Dressing	What it does
Transparent film	Protects intact skin or a shallow wound; lets staff see the wound
Hydrocolloid	Keeps a shallow, low-drainage wound moist; stays on several days
Foam	Absorbs moderate drainage and cushions; often used to protect the sacrum and heels
Hydrogel	Adds moisture to a dry wound; helps soften dead tissue
Alginate / hydrofiber	Absorbs heavy drainage; can be used to fill deeper wounds and tunnels
Antimicrobial	Silver, iodine, honey and similar dressings reduce bacteria in infected or high-risk wounds

Removing dead tissue (debridement)

Dead tissue feeds bacteria and keeps a wound from healing. It can be removed in several ways: **sharp or surgical** debridement with a scalpel or scissors by a trained clinician or surgeon; **enzymatic** debridement with a prescription ointment that dissolves dead tissue; **autolytic** debridement, in which a moist dressing lets the body's own enzymes do the work; and **mechanical** methods such as irrigation. The choice depends on the wound and the resident's health.

Infection

Every open wound carries bacteria, but an infected wound needs treatment. Signs include new or spreading redness, warmth, swelling, increasing pain, pus, a foul odor, a wound that suddenly gets larger, and fever or new confusion. Treatment can include antimicrobial dressings, cleansing and debridement, and antibiotics by mouth or by vein. A deep wound that will not heal, or one where bone can be felt, should be evaluated for **osteomyelitis**, an infection of the bone, which often requires imaging such as an MRI, a bone biopsy and weeks of antibiotics.

Negative pressure wound therapy

Sometimes called a "wound vac," this is a sealed foam dressing attached to a small pump that applies gentle suction. It removes drainage and can help a deep Stage 3 or Stage 4 wound fill in. It must be checked regularly for leaks and alarms.

Surgery

Some Stage 4 wounds need a plastic or general surgeon for surgical debridement or for a flap, in which nearby healthy tissue is moved to close the wound. Surgery is usually considered only once infection is controlled, nutrition is adequate and the pressure that caused the wound can be prevented afterward.

Nutrition and fluids

A resident with a pressure injury needs a dietitian's assessment and a plan that addresses calories, protein, fluids and, where appropriate, vitamins and minerals. International guidelines suggest higher protein and calorie intake for adults with pressure injuries who are malnourished or at risk. Weights should be tracked; a resident who is not eating needs a plan, not just a note that meals were refused.

Pain

Pressure injuries hurt, and dressing changes can hurt more. A resident who cannot speak may show pain by grimacing, moaning, guarding, restlessness or refusing care. Pain should be assessed and treated, including before dressing changes.

> **OTHER TREATMENTS YOU MAY HEAR ABOUT**
>
> Electrical stimulation, hyperbaric oxygen and skin substitutes are used in some cases. Ask the wound care clinician whether they fit the resident's wound, and why or why not.

CHAPTER 8 · WARNING SIGNS

When a wound is getting worse

A wound that is being treated properly should show signs of progress within a few weeks: less drainage, healthy red tissue, edges moving in. If it is not, the plan should change.

ASK THAT THE DOCTOR BE CALLED NOW

Signs of serious infection

- Fever or chills
- New confusion, sleepiness or agitation
- Fast heart rate or breathing, or low blood pressure
- Spreading redness, warmth or swelling around the wound
- Pus, a strong odor, or a sudden increase in drainage
- A wound that opens or deepens quickly

These can signal cellulitis, bone infection or sepsis, which is a medical emergency. A resident with these signs may need to go to the hospital.

RAISE IT AT THE CARE PLAN MEETING

Signs the plan is not working

- No measurable improvement after two to four weeks
- The wound is larger at each measurement
- Black or yellow tissue is spreading
- New wounds have appeared elsewhere
- The resident is losing weight or not eating
- The dressing is often dated days ago, soiled, or missing
- The resident is regularly found in the same position

What to ask for when a wound is not improving

1. **A wound care specialist.** Ask whether a certified wound nurse, wound care physician or surgeon has examined the wound, and when.
2. **A review of the support surface.** Ask whether the mattress or cushion should be upgraded.
3. **Tests for infection.** Ask whether blood work, a wound culture, imaging or a bone evaluation is needed.
4. **A nutrition review.** Ask for the dietitian's notes and the resident's weights for the past three months.
5. **A revised care plan.** The plan must be revised when the resident's needs change. Ask to see what was changed, and when.

IF THE RESIDENT GOES TO THE HOSPITAL

Ask the hospital staff to document every wound on arrival: location, stage and size. Hospital admission records are often the most objective record of how the wound looked when the resident left the nursing home. Keep copies of the discharge papers as well.

PART 3

What the nursing home must do

The legal standard for preventing and treating pressure injuries, the records a facility must keep, and whom it must notify when a wound appears or gets worse.

9 The legal standard: avoidable and unavoidable

10 Documentation the facility must keep

11 Notice to the family and reporting to the State

The legal standard: avoidable and unavoidable

Every nursing home in New York that accepts Medicare or Medicaid must meet federal requirements, and every one is also licensed by the State Department of Health under New York's own regulations. Both set the same basic rule.

THE FEDERAL RULE

Based on the comprehensive assessment of a resident, the facility must ensure that 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." A resident who has one must receive necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

42 C.F.R. § 483.25(B)(1); SEE ALSO 10 NYCRR § 415.12(C)

Avoidable or unavoidable

Federal survey guidance used by state inspectors defines both terms. A pressure injury is **avoidable** if the facility did not do one or more of these four things. It is **unavoidable** only if the facility did all four and the resident developed it anyway.

1. **Evaluate** the resident's clinical condition and risk factors.
2. **Define and implement** interventions consistent with the resident's needs, goals and professional standards of practice.
3. **Monitor and evaluate** whether those interventions are working.
4. **Revise** the interventions as appropriate.

CMS STATE OPERATIONS MANUAL, APP. PP, F686

In other words, "unavoidable" is not a label a facility can apply because a resident was frail. It is a conclusion that has to be supported by the record: an assessment, a care plan, proof that the care was given, and proof that the plan was changed when it was not working.

Other requirements that apply

- **Comprehensive assessment** of every resident, including skin condition, within 14 days of admission, then at least quarterly, annually and after any significant change. 42 C.F.R. § 483.20
- **Care plan**: a baseline plan within 48 hours of admission, and a comprehensive care plan within 7 days after the comprehensive assessment, revised as the resident's needs change. 42 C.F.R. § 483.21
- **Nutrition and hydration** to maintain acceptable body weight and protein levels. 42 C.F.R. § 483.25(G)
- **Sufficient, competent staff** to provide the care each resident needs. 42 C.F.R. § 483.35

Documentation the facility must keep

If it was not written down, it is very hard to prove it was done. These records should exist for any resident at risk of, or with, a pressure injury.

Record	What it should show
Admission skin assessment	The skin on arrival, including any existing wounds with location, stage and size: how a facility shows a wound was "present on admission"
Risk assessments (Braden Scale)	Scores on admission and at regular intervals, and after any change in condition
Minimum Data Set (MDS), Section M	The federally required assessment; records the number and stage of pressure injuries and treatments in place, and feeds Medicare's public quality ratings
Care plan	Specific, measurable prevention and treatment interventions: turning schedule, support surface, heel protection, incontinence care, nutrition, and who is responsible
Weekly skin checks	Head-to-toe skin inspections, usually by a nurse, at least weekly
Turning and repositioning records	Proof, usually on aide ADL flow sheets, that the resident was actually turned on schedule
Physician orders and the Treatment Administration Record (TAR)	Each ordered treatment, and initials showing when each dressing change was done
Wound assessments	Detailed measurements at least weekly (see below), often with photographs if facility policy provides for them
Dietitian notes and weights	Nutritional assessment, intake records, weights and supplements
Nursing notes and the 24-hour report	When a wound was first found, who was told, and what was done
Notifications	When the physician and the family were told of a new wound or a decline

What a wound assessment must include

Federal survey guidance expects each pressure injury to be documented with each dressing change or at least weekly, and more often if complications arise, including:

- ☐ Date
- ☐ Location and stage
- ☐ Length and width, measured at right angles
- ☐ Depth
- ☐ Undermining or tunneling
- ☐ Drainage: type, color, odor, amount
- ☐ Pain
- ☐ The wound bed: type of tissue
- ☐ The wound edges and surrounding skin

CMS STATE OPERATIONS MANUAL, APP. PP, F686

Notice to the family and reporting to the State

The facility must tell the doctor and the family

A nursing home must immediately inform the resident, consult with the resident's physician, and notify the resident's representative when there is an accident causing injury that may need a physician, a significant change in the resident's physical, mental or psychosocial status, or a need to alter treatment significantly. A new pressure injury, a wound that becomes infected, or a wound that gets substantially worse will usually meet that standard.

42 C.F.R. § 483.10(G)(14); 10 NYCRR § 415.3

When neglect is suspected, the facility must report it

Requirement	What it says
Federal: alleged neglect	Alleged violations involving abuse, neglect or injuries of unknown source must be reported to the administrator and to the State survey agency (in New York, the Department of Health) immediately, and no later than **2 hours** after the allegation is made if the events involve abuse or result in serious bodily injury, or no later than **24 hours** otherwise. The results of the facility's investigation must be reported within **5 working days**. 42 C.F.R. § 483.12(C)
New York: mandated reporters	Nursing home employees, contractors, administrators, physicians, nurses and other listed professionals who have reasonable cause to believe a resident has been abused, mistreated or neglected must report it to the Department of Health immediately by telephone and in writing within 48 hours. Good-faith reporters are protected from liability and from retaliation. N.Y. PUB. HEALTH LAW § 2803-D
Federal: suspected crimes	Covered individuals at facilities receiving at least $10,000 a year in federal funds must report a reasonable suspicion of a crime against a resident to the State survey agency and to law enforcement, within 2 hours if serious bodily injury results. 42 U.S.C. § 1320B-25

What is reported publicly

MDS pressure injury data feed the public quality measures and star ratings on Medicare's Care Compare website, and State inspection reports, including citations under federal tag F686, are public. Our directory at rightsforvictims.com summarizes ratings and penalties for every New York nursing home.

> **WANT MORE DETAIL ON REPORTING?**
>
> See our free guide, *What a New York Nursing Home Must Report, and How Fast*, at rightsforvictims.com.

PART 4

What your family can do

How to spot trouble early, the questions to ask, how to get the records, where to report a concern, and the legal rights and deadlines that protect a resident and the family.

12 Warning signs and questions to ask

13 Getting the records

14 Where to report a concern

15 Your legal rights and the deadlines

16 Frequently asked questions

17 Visit log and glossary

Warning signs and questions to ask

Warning signs during a visit

- ☐ The resident is in the same position, or the same chair, every time you visit
- ☐ A wet or soiled brief, or wet sheets
- ☐ A strong odor that does not come from the brief
- ☐ Drainage or blood on sheets, clothing or the brief
- ☐ Heels resting directly on the mattress; no heel boots or pillows
- ☐ The head of the bed always raised high, with the resident slumped down
- ☐ Pain or flinching when the resident is moved or touched on the hip, tailbone or heel
- ☐ Untouched meal trays, weight loss, dry mouth or new confusion
- ☐ A dressing dated days ago, soiled, or missing
- ☐ No special mattress or cushion for a resident who cannot move

Questions to ask the nurse or care team

1. What is my loved one's Braden score, and what is being done about it?
2. How often is my loved one turned, and where is that written down?
3. What kind of mattress and cushion is being used?
4. Does my loved one have any wounds now? Where, and what stage?
5. When was the wound first found, and when was the doctor told?
6. Was it present on admission? Where is the admission skin assessment?
7. What are the current measurements, and how have they changed?
8. What treatment was ordered, and who is doing the dressing changes?
9. Has a wound care specialist seen it? When is the next visit?
10. Has the dietitian seen my loved one? What are the recent weights?
11. Has the care plan been updated? May I have a copy?

USE THE CARE PLAN MEETING

The resident and the resident's representative have the right to take part in care planning. You can ask for a care plan meeting at any time, not only at the scheduled quarterly review. Bring this guide, your notes and your questions, and ask that your concerns be written into the plan.

42 C.F.R. §§ 483.10(C), 483.21(B)

KEEP NOTES

Write down every visit, every wound you see, and every conversation: date, time, the name and title of the person you spoke with, and what they said. Use the visit log at the back of this guide.

Getting the records

A resident, and a representative with legal authority, has the right to see and copy the resident's records. Requests can be made orally or in writing; a written, dated request is easier to prove.

Right	Rule
To inspect	Records must be made available for inspection within 24 hours of a request, excluding weekends and holidays
To get copies	Copies must be provided within two working days of a request
Cost	The facility may charge a reasonable, cost-based fee; New York caps copying charges at 75 cents a page, and copies cannot be denied because a person cannot pay

42 C.F.R. § 483.10(G)(2); 10 NYCRR § 415.3; N.Y. PUB. HEALTH LAW § 18

What to ask for

- ☐ Admission records and admission skin assessment
- ☐ All Braden Scale or other risk assessments
- ☐ MDS assessments, including Section M
- ☐ Baseline and comprehensive care plans, with all revisions
- ☐ Physician and nurse practitioner orders
- ☐ Treatment Administration Record (TAR)
- ☐ Medication Administration Record (MAR)
- ☐ Wound assessment flow sheets and wound photographs
- ☐ Wound care consultant notes
- ☐ Weekly skin check sheets
- ☐ Turning and repositioning records, and ADL flow sheets
- ☐ Dietitian notes, weights, intake and fluid records
- ☐ Nursing progress notes
- ☐ Physician progress notes
- ☐ Notifications to the physician and family
- ☐ Hospital transfer forms
- ☐ Incident and accident reports
- ☐ Laboratory results

After a resident has died

The right to the records usually passes to the executor or administrator of the estate, which normally requires an appointment by the Surrogate's Court. In some situations, New York law also allows close family members to obtain records. Our free *Family Guide to Surrogate's Court* explains how to get appointed.

> **SOME RECORDS ARE NOT IN THE CHART**
>
> Staffing schedules, assignment sheets, the 24-hour report, the facility's own investigation and internal emails are often kept separately and may not be produced in response to a records request. A lawyer can seek them, and can ask the facility to preserve them, if a claim is being considered.

Where to report a concern

Start with the facility if you can, but you do not have to. You can go directly to the State at any time, and the law protects residents from retaliation for complaints.

1. **The charge nurse, director of nursing or administrator.** Ask that a concern about a wound be recorded, and ask for a written response. Every facility must have a grievance process and a grievance official. 42 C.F.R. § 483.10(J)
2. **The New York State Department of Health.** The Department investigates complaints about nursing home care.

   > **Nursing Home Complaint Hotline: 1-888-201-4563**
   > Available 24 hours a day for messages; staffed weekdays during business hours. Complaints can also be filed online through the Department of Health's Nursing Home Complaint Form at health.ny.gov.

3. **The Long Term Care Ombudsman Program.** Ombudsmen are independent advocates for residents. They can visit, help resolve problems and explain residents' rights, at no cost.

   > **LTCOP Helpline: 1-855-582-6769 (1-855-LTCOPNY)**
   > ltcombudsman.ny.gov

4. **911 or the hospital.** If the resident is in danger or shows signs of serious infection, call 911 or insist on a transfer to the hospital.
5. **Law enforcement.** If you believe a crime has been committed against a resident, you can report it to the police. The New York Attorney General's Medicaid Fraud Control Unit also investigates abuse and neglect in nursing homes.

What to include in a complaint

- The resident's name, the facility, and the unit or room
- What you saw, when, and where on the body
- Whom you told at the facility, when, and what they said
- Photographs and copies of your notes, if you have them

Contact information was checked in November 2026 but can change. Confirm current numbers on the agency websites.

Your legal rights and the deadlines

When a resident is harmed by a preventable pressure injury, New York law provides several ways to hold the facility accountable.

Public Health Law § 2801-d

New York gives nursing home residents a specific right to sue a facility that deprives them of any right or benefit created for their well-being by contract or by state or federal law or regulation, including the pressure injury rules described in this guide. The facility can avoid liability only by proving it exercised all care reasonably necessary to prevent and limit the deprivation and the injury. The statute sets minimum damages, allows punitive damages where the deprivation was willful or in reckless disregard of the resident's rights, and allows the court to award attorneys' fees.

N.Y. PUB. HEALTH LAW § 2801-D

Negligence and medical malpractice

A claim may also be brought for negligence in basic nursing care, such as failing to turn or reposition a resident, and in some cases for medical malpractice in the medical treatment of a wound.

Wrongful death and the estate's claim

If a resident has died, the claim belongs to the estate and must be brought by the executor or administrator. The estate can seek damages for the resident's conscious pain and suffering before death and, in a wrongful death claim, for the family's financial losses caused by the death.

N.Y. EST. POWERS & TRUSTS LAW §§ 5-4.1, 11-3.2

The deadlines

Claim	General deadline
Negligence and Public Health Law § 2801-d claims	Generally three years from the injury CPLR 214
Medical malpractice	Generally two and a half years CPLR 214-A
Wrongful death	Two years from the date of death EPTL 5-4.1
A county, city or other public nursing home	A notice of claim is generally due within **90 days** GEN. MUN. LAW § 50-E
A State-operated or federal (VA) facility	Special notice and filing rules apply; act promptly

> **DO NOT RELY ON THIS TABLE ALONE**
>
> Which deadline applies, when it starts to run, and whether it can be extended depend on the facts. Some are much shorter than families expect. Speak with a lawyer as soon as possible; a lawyer can also send a letter requiring the facility to preserve its records.

CHAPTER 16 · QUESTIONS

Frequently asked questions

Can a nursing home say a bedsore was unavoidable?
Yes, but only if the record shows it assessed the resident's risk, put the right interventions in place, monitored them and revised them as needed. The facility has the burden of showing that.

The wound was there when my mother arrived from the hospital. Is the nursing home responsible?
The nursing home is not responsible for a wound that began elsewhere, but it is responsible for treating it and keeping it from getting worse, and for preventing new ones. Ask for the admission skin assessment and the hospital discharge papers.

How long does a bedsore take to heal?
It varies with the stage and the resident's health. A Stage 2 may heal in weeks. A Stage 3 or 4 can take months, and some never fully heal.

Can a bedsore cause death?
Yes. Infected pressure injuries can lead to bone infection and sepsis, which can be fatal, particularly for frail residents. A death certificate may list sepsis or another condition without mentioning the wound.

Does a special mattress mean the resident does not need to be turned?
No. Support surfaces reduce pressure but do not replace repositioning, unless the resident's physician orders a different plan for a documented reason.

My father refuses to be turned. What then?
A resident has the right to refuse care. The facility must explain the risks, try alternatives, document the refusals and the discussions, and update the care plan. One note of a refusal does not end the facility's duty.

Will reporting the facility cause problems for my loved one?
Retaliation against a resident or family member for complaining is prohibited. If you see signs of it, report that too.

Do I need a lawyer?
Not to ask questions, get records or file a complaint. If a resident has suffered a serious wound, infection, hospitalization or death, a lawyer experienced with nursing home cases can explain your options and the deadlines.

Does it cost anything to talk to a lawyer?
Many nursing home lawyers, including Leitner Warywoda PLLC, offer a free consultation and handle these cases on a contingency fee, paid only from a recovery.

CHAPTER 17 · TEAR-OUT PAGE

Visit log

Print as many copies as you need. Write down what you see and whom you speak to on every visit.

Resident: _____ Facility and unit: _____ Room: _____

Date / time	Position found in; brief dry?	Wounds or redness seen (where, size, odor)	Spoke with (name, title) and what they said	Follow-up

Glossary

ADL flow sheet
Aide documentation of daily care: bathing, toileting, eating, turning

Blanching
Skin turning white when pressed, then returning to its color. Skin that does not blanch is a warning sign

Braden Scale
The tool most often used to score pressure injury risk, from 6 (highest risk) to 23

Care plan
The written plan of care for a resident, which must be followed and revised

Debridement
Removing dead tissue from a wound

Deep tissue pressure injury
Purple or maroon discoloration from damage that begins deep, near the bone

Eschar
Black or brown, hard dead tissue

F686
The federal inspection tag for failing to prevent or properly treat pressure injuries

Granulation tissue
Healthy red, bumpy new tissue in a healing wound

Ischium
The “sitting bone” at the bottom of the pelvis

Kennedy terminal ulcer
A sudden wound over the tailbone that some dying patients develop

MDS
Minimum Data Set: the federally required resident assessment

Negative pressure wound therapy
A sealed dressing attached to a suction pump (“wound vac”)

Off-loading
Removing pressure from an area, such as floating the heels

Osteomyelitis
Infection of the bone

Representative
A person with legal authority to act for a resident, such as a health care agent or guardian

Sacrum
The triangular bone at the base of the spine, above the tailbone

Sepsis
A life-threatening reaction to infection

Shear
Force that pulls skin and deeper tissue in opposite directions, as when sliding down in bed

Slough
Yellow, tan or gray soft dead tissue

Support surface
A mattress, overlay or cushion designed to redistribute pressure

TAR
Treatment Administration Record: where nurses document wound treatments

Trochanter
The bony point of the hip

Undermining
Wound damage extending under intact skin at the edge

ABOUT THIS GUIDE

The New York Nursing Home Resource Center

rightsforvictims.com is a free resource for New York families: ratings, inspection results and federal penalties for every nursing home in the State, regional guides to choosing a facility, and family guides like this one.

This guide is sponsored by **Leitner Warywoda PLLC**, New York trial lawyers who represent nursing home residents and families in cases of neglect, abuse, pressure injuries, falls and wrongful death.

QUESTIONS ABOUT A PRESSURE INJURY?

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(631) 240-4390 · nylawinjury.com
Free consultation. No fee unless there is a recovery.

ATTORNEY ADVERTISING. Prior results do not guarantee a similar outcome. This guide provides general information about New York and federal law and common wound care practices. It is not medical or legal advice and does not create an attorney-client relationship. Laws, regulations, agency guidance and contact information change; verify current requirements before relying on them.

Sources. 42 C.F.R. Part 483 (§§ 483.10, 483.12, 483.20, 483.21, 483.25, 483.35); CMS State Operations Manual, Appendix PP, F686; 10 NYCRR Part 415; N.Y. Public Health Law §§ 18, 2801-d, 2803-d; 42 U.S.C. § 1320b-25; CPLR 214, 214-a; EPTL 5-4.1, 11-3.2; General Municipal Law § 50-e; National Pressure Injury Advisory Panel staging definitions; New York State Department of Health; New York State Long Term Care Ombudsman Program.

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