



Select Medical Corporation
Denise Brown, LSW, DCM
Lead Case Manager
SSH-Danville, KY
Email: denisbrown@selectmedical.com
Tele: 859.239.4297 Fax: 859.712.7044

Fax

To: McGrath Medical From: Denise Brown, LSW, DCM
Fax: 859-399-6697 Date: 9/25/25
Re: Records Page: 88
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progress notes.

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9/25/25, 2:37 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:37 PM

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 7/29/2025 4:20 PM

Wound Progress Note

Reason for wound Consult: admission assessment

Patient is lethargic

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Diagnosis

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Past Surgical History:

Past Surgical History:

Procedure

- | | Laterality | Date |
|---------------------------|------------|------------|
| • BRONCHOSCOPY | | 07/14/2025 |
| • CARDIAC CATHETERIZATION | | |
| x2 stents | | 2020 |
| • CERVICAL LAMINECTOMY | | 04/2025 |
| • COLOSTOMY | | 07/24/2025 |
| • PEG TUBE PLACEMENT | | 07/24/2025 |
| • TRACHEOSTOMY | | 07/11/2025 |
| • WOUND DEBRIDEMENT | | |

Allergies: Patient has no known allergies.

9/25/25, 2:37 PM

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Braden Score: Braden Scale Score: 10

Wound/Ulcer Assessment:

Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 7/29/2025 4:01 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	15 cm
Wound Width (cm)	17 cm
Wound Depth (cm)	7
Calculated Wound Size (cm^2)	255 cm^2
Calculated Wound Size (cm^3)	1785 cm^3
Change in Wound Size %	-32.22
Extent of Tissue Loss	Full thickness tissue loss
Undermining	Undermining >4 cm or tunneling in any area
Undermining -	10-3=5.0cm
Location and Depth	
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	25% to 50% of wound covered
Amount	
Other Wound	Bone
Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	Induration < 2 cm around wound
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	Other (comment)
Wound Management	Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Moist to moist
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

9/25/25, 2:37 PM

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Support Surface	Routine, Until discontinued, Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx	-	Hillary L Sowder, APRN
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Medical grade honey (nickel thickness) (medihoney and pack with vash...	Type of Support Surface: FDS Size of Support Surface: Standard Routine, 2 times daily, First occurrence on Tue 7/29/25 at 1615, Until Specified Wound Pressure Injury Coccyx Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Medical grade honey (nickel thickness) / medihoney and pack with vashe moistened gauze. Please ensure to pack track between coccyx and right gluteus., Other Cover: ABD Secure with: Tape Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)
 Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;Lateral

Assessments
Wound Image



7/29/2025 4:01 PM

Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 15 cm
 (cm)

9/25/25, 2:37 PM

Wound Width 5 cm
 (cm)
 Wound Depth 0.1
 (cm)
 Calculated Wound Size 75 cm²
 (cm²)
 Calculated Wound Size 7.5 cm³
 (cm³)
 Extent of Tissue Obscured by necrosis
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
 Necrotic Tissue Eschar: Firmly adherent, hard, black eschar
 Type
 Necrotic Tissue 75% to 100% of wound covered
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Cleansed;Barrier Film;Abdominal dressing;Roll gauze;Topical anti-microbial
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no lo...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg Distal;Lower;Right;Lateral Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting,	-	Hillary L Sowder, APRN

9/25/25, 2:37 PM

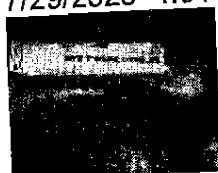
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leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Leg Left;Lower;Posterior (Active) **Pre-Existing Wound:** Yes **Anatomical Site:** Leg
Date First Assessed/Time First Assessed: 07/28/25 2000 **Wound Location Orientation:** Left;Lower;Posterior

Assessments 7/29/2025 4:01 PM

Wound Image



Wound Length (cm)	5.4 cm
Wound Width (cm)	2.5 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm ²)	13.5 cm ²
Calculated Wound Size (cm ³)	4.05 cm ³
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	<25% wound bed covered
Amount	
Other Wound Bed	Tendon
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Abdominal dressing;Barrier Film;Alginate;Cleansed;Medical grade honey;Roll gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

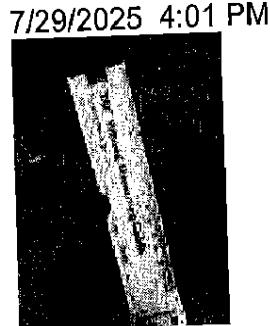
Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified	-	Hillary L Sowder, APRN

9/25/25, 2:37 PM

Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated
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Wound Pressure Injury Elbow Left (Active)**Date First Assessed/Time First Assessed:** 07/28/25 2000 **Wound Type - REQUIRED: Pressure Injury****Pre-Existing Wound:** Yes **Anatomical Site:** Elbow **Wound Location Orientation:** Left**Assessments**

Wound Image



7/29/2025 4:01 PM

Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	1 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered

9/25/25, 2:37 PM

Necrotic Tissue Eschar: Adherent, soft, black eschar
 Type
 Necrotic Tissue 75% to 100% of wound covered
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Barrier Film;Cleansed;Foam;Alginate;Medical grade honey
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting...)	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Surgical Wound Quadrant: abdomen Upper;Medial (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Surgical Wound
 Pre-Existing Wound: Yes Anatomical Site: Quadrant, abdomen Wound Location Orientation: Upper;Medial

Assessments 7/29/2025 4:01 PM

9/25/25, 2:37 PM

Wound Image



Wound Length (cm)	0.5 cm
Wound Width (cm)	0.6 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm ²)	0.3 cm ²
Calculated Wound Size (cm ³)	0.03 cm ³
Extent of Tissue Loss	Partial thickness tissue loss
Undermining	None present
Granulation	No granulation tissue present
Tissue Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type Necrotic Tissue	None visible
Amount Other Wound	Dermis/Pink Tissue
Bed Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch
Color Periwound Skin	No swelling or edema
Edema Periwound Skin	None present
Induration Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor Wound	None Alginate;Barrier Film;Cleansed;Split gauze
Management Dressing	Changed
Changed Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/28/25 2328	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order;	Routine, Daily, First occurrence on Mon 7/28/25 at 2329, Until Specified Wound Surgical Wound Quadrant, abdomen Upper;Medial Wound Location: Use	-	Waddah Yaacoubagha, MD

9/25/25, 2:37 PM

Wet; Normal	Associated Wounds location
Saline; Prep	Wound Management:
with skin prep	Wound care per specified
and allow to dry;	algorithm/order
Alginate; Other	Type: Wet
(split gauze);	Cleanse: Normal Saline
Dressing no	Prep: Prep with skin prep
longer intact (i.e.	and allow to dry
lifting, leaking,	Fill/Apply: Alginate
damaged),	Cover: Other / split gauze
Dressi...	Change/PRN: Dressing no
	longer intact (i.e. lifting,
	leaking, damaged),
	Dressing damp, moist or
	saturated

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral

Assessments 7/29/2025 4:01 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	12 cm
Wound Width (cm)	3.5 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm^2)	42 cm^2
Calculated Wound Size (cm^3)	12.6 cm^3
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	<25% wound bed covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Barrier Film;Cleansed;Alginate;Abdominal dressing;Medical grade honey;Roll gauze

9/25/25, 2:37 PM

Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse; Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Ilium Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2031 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Ilium Wound Location Orientation: Left

Assessments 7/29/2025 4:01 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1.8 cm
Wound Width (cm)	11.1 cm
Wound Depth (cm)	0.3
Calculated Wound Size	19.98 cm^2

9/25/25, 2:37 PM

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(cm ²)	
Calculated Wound Size	5.99 cm ³
(cm ³)	
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	>50% to <75% of wound covered
Amount	
Other Wound Bed	Dermis/Pink Tissue
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Abdominal dressing;Alginate;Barrier Film;Cleansed;Medical grade honey;Tape change
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting...)	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

9/25/25, 2:37 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:37 PM

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3

Assessments 7/29/2025 4:01 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	6 cm
Wound Width (cm)	1.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	9 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation	No granulation tissue present
Tissue Type	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Epithelialization	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue	
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Cleansed;Topical anti-microbial
Dressing	OTA (open to air)
Changed	
Dressing Status	OTA (open to air)

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Toe	Betadine paint to area	Hillary L Sowder, APRN

9/25/25, 2:37 PM

location; Wound # Anterior;Right;1;3

care per
algorithm Betadine paint to area
 Wound Location: Use
 Associated Wounds location
 Wound Management:
 Wound care per algorithm

Wound Pressure Injury Foot Left;Lateral (Active)
Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 7/29/2025 4:01 PM
Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1.5 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm ²)	1.5 cm ²
Calculated Wound Size (cm ³)	0.45 cm ³
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation	No granulation tissue present
Tissue Type	0 to <25% wound covered
Epithelialization	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue	75% to 100% of wound covered
Amount	Distinct, outline clearly visible, attached and even with wound base
Wound Edges	Bright red and/or blanches to touch
Periwound Skin Color	No swelling or edema
Periwound Skin Edema	None present
Induration	Serosanguineous: thin watery, pale re/pink
Exudate Type	Small
Exudate Amount	None
Odor	Barrier Film;Cleansed;Alginate;Abdominal dressing;Medical grade honey;Roll gauze
Wound Management	Changed
Dressing Changed	Clean;Dry;Intact
Dressing Status	

9/25/25, 2:37 PM

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Foot Anterior;Right;Medial (Active)
 Wound Type - REQUIRED: Pressure Injury
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Location Orientation: Anterior;Right;Medial
 Pre-Existing Wound: Yes Anatomical Site: Foot

Assessments 7/29/2025 4:01 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	1 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining Granulation	None present No granulation tissue present

9/25/25, 2:37 PM

Tissue

Epithelialization 0 to <25% wound covered
 Necrotic Tissue Eschar: Firmly adherent, hard, black eschar

Type

Necrotic Tissue 75% to 100% of wound covered

Amount

Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group

Color

Periwound Skin No swelling or edema

Edema

Periwound Skin None present

Induration

Exudate Type None

Exudate Amount None, dry wound

Odor None

Wound Open to air

Management

Dressing OTA (open to air)

Changed

Dressing Status OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments

Wound Image

7/29/2025 4:01 PM

**Stage**

Wound Length (cm)

3.5 cm

Wound Width (cm)

2 cm

Wound Depth (cm)

0.2

Calculated Wound Size (cm^2)

7 cm^2

Calculated Wound Size (cm^3)

1.4 cm^3

Extent of Tissue Loss

Undermining None present

Granulation No granulation tissue present

Tissue

Epithelialization 50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
 Necrotic Tissue Slough: white/gray non-viable and/or non-adherent yellow

Type

Necrotic Tissue 75% to 100% of wound covered

Amount

Other Wound Dermis/Pink Tissue

Bed

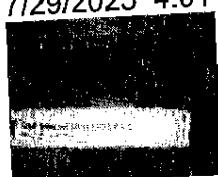
9/25/25, 2:37 PM

Characteristics	Distinct, outline clearly visible, attached and even with wound base
Wound Edges	Bright red and/or blanches to touch
Periwound Skin	
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Barrier Film;Abdominal dressing;Alginate;Cleansed;Medical grade honey;Roll gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...)	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Perineum (Active)
 Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 7/29/2025 4:01 PM
 Wound Image



9/25/25, 2:37 PM

Stage	Stage 3
Wound Length (cm)	6.2 cm
Wound Width (cm)	4.5 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm ²)	27.9 cm ²
Calculated Wound Size (cm ³)	8.37 cm ³
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type	
Necrotic Tissue	None visible
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Bloody; Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Barrier Film; Alginate; Cleansed; Abdominal dressing
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

No associated orders.

Recommendations: patient has multiple extensive wounds. Sacral wound communicates with right gluteus wound. Recommend packing with medi honey and vashe moistened gauze. Patient may benefit from a wound debridement. Right heel and left leg/foot and let elbow wounds recommend medi honey alginate dressing. Right lateral leg recommend betadine soaked gauze. Heel lift boots in place. Ordered FDS mattress for optimal offloading. Unable to do Side to side turns only as patient does not tolerate right side laying due to respiratory issues.

Signature: LONG, MAHALEY G., RN

Date: 7/29/2025

Time: 4:20 PM EDT

9/25/25, 2:37 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:37 PM

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note
Signed

Date of Service: 7/29/2025 4:30 PM

Wound Progress Note

7/29/2025, 1452, I met with Son Stevie to discuss the wound plan of care including:

- Introduced the patient and family to the wound team members, wound team availability and how to contact the wound care team
- Wound care expectations:
 - How often wound team sees Robert D King
 - Which provider is managing wounds; provider rounding schedule (if applicable)
- Wound Plan of Care including:
 - List of current, active wounds, etiology and treatment plan
 - Projected healing process and advanced care needs
 - Offered to review the wound photos with them
- Reviewed Prevention Plan of Care
- Addressed questions or concerns

Signature: LONG, MAHALEY G., RN

Date: 7/29/2025

Time: 4:30 PM EDT

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 8/4/2025 5:31 PM

Wound Progress Note

Reason for wound Consult: weekly skin assessment

Patient is awake, alert, and oriented

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Date

Diagnosis

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Past Surgical History:

Past Surgical History:

Laterality

Date

Procedure

- | | | |
|---------------------------|--|------------|
| • BRONCHOSCOPY | | 2020 |
| • CARDIAC CATHETERIZATION | | 04/2025 |
| x2 stents | | 07/24/2025 |
| • CERVICAL LAMINECTOMY | | 07/24/2025 |
| • COLOSTOMY | | 07/11/2025 |
| • PEG TUBE PLACEMENT | | |
| • TRACHEOSTOMY | | |
| • WOUND DEBRIDEMENT | | |

Allergies: Patient has no known allergies.

9/25/25, 2:38 PM

Braden Score: Braden Scale Score: 12

Wound/Ulcer Assessment:

Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 8/4/2025 5:17 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	6.5 cm
Wound Width (cm)	16 cm
Wound Depth (cm)	7
Calculated Wound Size (cm^2)	104 cm^2
Calculated Wound Size (cm^3)	728 cm^3
Change in Wound Size %	46.07
Extent of Tissue Loss	Full thickness tissue loss
Undermining	Undermining >4 cm or tunneling in any area
Undermining - Location and Depth	11-3=5.7cm
Tunneling - Location and Depth	5=6.3cm
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	<25% wound bed covered
Necrotic Tissue Amount	
Other Wound Bed Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Barrier Film;Cleansed;Alginate;NPWT
Dressing	Changed

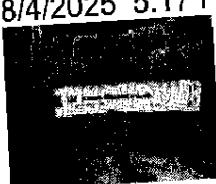
9/25/25, 2:38 PM

Changed
Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/01/25 1457	Wound Management: Use Associated Wounds location; NPWT; No; Alginate, Contact Layer; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated; Continuous; -125; Per manufacturer recommendation	Routine, Every Mon, Wed, Fri, First occurrence on Fri 8/1/25 at 1458, Until Specified Wound Pressure Injury Coccyx Wound Location: Use Associated Wounds location Wound Management: NPWT NPWT + Instillation? No NPWT Wound Management: Alginate, Contact Layer Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated Pressure Type: Continuous Pressure Setting (mmHg): -125 Change Canister: Per manufacturer recommendations Routine, Until discontinued, - Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx	-	Hillary L Sowder, APRN
07/29/25 1618	Support Surface	Type of Support Surface: FDS Size of Support Surface: Standard		Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;Lateral

Assessments 8/4/2025 5:17 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	15 cm
Wound Width (cm)	3 cm
Wound Depth (cm)	0
Calculated	45 cm^2

9/25/25, 2:38 PM

Wound Size (cm^2)	0 cm^3
Calculated	
Wound Size (cm^3)	
Extent of Tissue	Obscured by necrosis
Loss	
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	75% to 100% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Cleansed; Barrier Film; Abdominal dressing; Roll gauze; Topical anti-microbial
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no lo...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg Distal; Lower; Right; Lateral Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged). Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

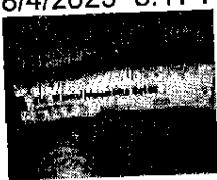
Wound Leg Left; Lower; Posterior (Active)

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Date First Assessed/Time First Assessed: 07/28/25 2000 Pre-Existing Wound: Yes Anatomical Site: Leg
 Wound Location Orientation: Left;Lower;Posterior

Assessments 8/4/2025 5:17 PM
Wound Image



Wound Length (cm)	5 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm ²)	5 cm ²
Calculated Wound Size (cm ³)	1.5 cm ³
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. <75% and >25% of wound filled
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Adherent, soft, black eschar
Necrotic Tissue Amount	<25% wound bed covered
Other Wound Bed	Tendon
Characteristics Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Barrier Film;Cleansed;Alginate;Abdominal dressing;Medical grade honey;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order;	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury	-	Hillary L Sowder, APRN

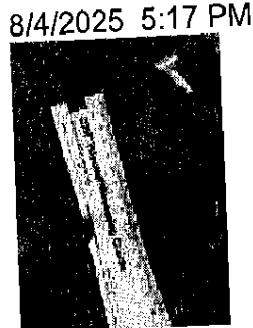
9/25/25, 2:38 PM

Dry, necrotic; Foot Left;Lateral
 Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep Wound Location: Use
 with skin prep Associated Wounds location
 and allow to dry; Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Elbow Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Elbow Wound Location Orientation: Left

Assessments
 Wound Image



8/4/2025 5:17 PM

Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0.8 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	0.8 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Adherent, soft, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Barrier Film;Cleansed;Alginate;Foam;Medical grade honey
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting...)	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Surgical Wound Quadrant, abdomen Upper;Medial (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Surgical Wound
 Pre-Existing Wound: Yes Anatomical Site: Quadrant, abdomen Wound Location Orientation:
 Upper;Medial

Assessments
 Wound Image 8/4/2025 5:17 PM


Wound Length (cm) 0.5 cm

9/25/25, 2:38 PM

Wound Width (cm)	1 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	0.5 cm^2
Calculated Wound Size (cm^3)	0.1 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: loosely adherent, yellow slough
Necrotic Tissue Amount	>50% to <75% of wound covered
Other Wound Bed	Dermis/Pink Tissue
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serous: thin, water, clear
Exudate Amount	Small
Odor	None
Wound Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Intact;Dry

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/28/25 2328	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Normal Saline; Prep with skin prep and allow to dry; Alginate; Other (split gauze); Dressing no longer intact (i.e. lifting, leaking, damaged), Dressi...	Routine, Daily, First occurrence on Mon 7/28/25 at 2329, Until Specified Wound Surgical Wound Quadrant, abdomen Upper;Medial Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Alginate Cover: Other / split gauze Change/PRN: Dressing no	-	Waddah Yaacoubagha, MD

9/25/25, 2:38 PM

longer intact (i.e. lifting,
leaking, damaged),
Dressing damp, moist or
saturated

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)
Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral

Assessments 8/4/2025 5:17 PM
Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	11 cm
Wound Width (cm)	2 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	22 cm^2
Calculated Wound Size (cm^3)	4.4 cm^3
Undermining	None present
Granulation	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Tissue Type	0 to <25% wound covered
Epithelialization	Eschar: Adherent, soft, black eschar
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	No swelling or edema
Periwound Skin	No swelling or edema
Edema	None present
Periwound Skin	None present
Induration	Serosanguineous: thin watery, pale re/pink
Exudate Type	Small
Exudate Amount	None
Odor	Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Moist to moist;Roll
Wound Management	gauze
Dressing	Changed
Changed	Clean;Dry;Intact
Dressing Status	

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

specified algorithm/order; Dry, necrotic; Other (Comment Required)	Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right
(vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. if...)	Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated

Wound Pressure Injury Ilium Left (Active)
Date First Assessed/Time First Assessed: 07/28/25 2031 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Ilium **Wound Location Orientation:** Left

Assessments

Wound Image



8/4/2025 5:17 PM

Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	11.5 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	11.5 cm^2
Calculated Wound Size (cm^3)	2.3 cm^3
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation	No granulation tissue present
Tissue Epithelialization	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Necrotic Tissue Type	Slough: loosely adherent, yellow slough
Necrotic Tissue	25% to 50% of wound covered

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Amount	
Other Wound	Dermis/Pink Tissue
Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Alginate;Barrier Film;Cleansed;Medical grade honey;Foam
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifti...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3Assessments
Wound ImageStage
Wound Length

Unstageable, necrotic tissue (slough/eschar)

5 cm

9/25/25, 2:38 PM

(cm)	
Wound Width	1.5 cm
(cm)	
Wound Depth	0
(cm)	
Calculated Wound Size	7.5 cm^2
(cm^2)	
Calculated Wound Size	0 cm^3
(cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation	No granulation tissue present
Tissue Type	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Epithelialization	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue	
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Topical anti-microbial
Dressing	OTA (open to air)
Changed Dressing Status	OTA (open to air)

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Toe #Anterior;Right;1;3 Betadine paint to area Wound Location: Use Associated Wounds location Wound Management: Wound care per algorithm	Betadine paint to area	Hillary L Sowder, APRN

Wound Pressure Injury Foot Left;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 8/4/2025 5:17 PM

9/25/25, 2:38 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm ²)	1 cm ²
Calculated Wound Size (cm ³)	0.1 cm ³
Undermining	None present
Granulation	No granulation tissue present
Tissue Type	0 to <25% wound covered
Epithelialization	Eschar: Adherent, soft, black eschar
Necrotic Tissue	Adherent, soft, black eschar
Type	>50% to <75% of wound covered
Amount	Distinct, outline clearly visible, attached and even with wound base
Wound Edges	Pink or normal for ethnic group
Periwound Skin	No swelling or edema
Color	No swelling or edema
Edema	None present
Periwound Skin	None present
Induration	Serous: thin, water, clear
Exudate Type	Scant, wound moist but no observable exudate
Exudate Amount	None
Odor	Barrier Film;Cleansed;Abdominal dressing;Alginate;Medical grade honey;Roll gauze
Wound Management	Changed
Dressing	Changed
Changed	Clean;Dry;Intact
Dressing Status	

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

with skin prep Wound Location: Use
 and allow to dry; Associated Wounds location
 Honey alginate; Wound Management:
 ABD; Roll
 gauze; Dressing
 no longer intact Wound care per specified
 (i.e. lif...) algorithm/order
 Type: Dry, necrotic
 Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Foot Anterior;Right;Medial (Active)
Date First Assessed/Time First Assessed: 07/28/25 2000 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Foot **Wound Location Orientation:** Anterior;Right;Medial

Assessments 8/4/2025 5:17 PM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	0.6 cm
Wound Depth (cm)	0
Calculated Wound Size (cm ²)	0.6 cm ²
Calculated Wound Size (cm ³)	0 cm ³
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	75% to 100% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	

9/25/25, 2:38 PM

Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Open to air
 Management
 Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right/Active
 Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments 8/4/2025 5:17 PM
 Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 3.5 cm
 (cm)
 Wound Width 2 cm
 (cm)
 Wound Depth 0.2
 (cm)
 Calculated 7 cm²
 Wound Size
 (cm²)
 Calculated 1.4 cm³
 Wound Size
 (cm³)
 Change in 0
 Wound Size %
 Extent of Tissue Full thickness tissue loss
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 25% to <50% wound covered
 Necrotic Tissue Slough: white/gray non-viable and/or non-adherent yellow
 Type
 Necrotic Tissue >50% to <75% of wound covered
 Amount
 Other Wound Dermis/Pink Tissue
 Bed
 Characteristics
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serosanguineous: thin watery, pale re/pink
 Exudate Amount Small
 Odor None

9/25/25, 2:38 PM

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Wound Management
Dressing Changed
Dressing Status Clean;Dry;Intact

Barrier Film;Cleansed;Abdominal dressing;Alginate;Medical grade honey;Roll gauze
Changed

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Perineum (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 8/4/2025 5:17 PM

Wound Image



Stage Stage 3
Wound Length 5 cm
(cm)
Wound Width 1 cm
(cm)
Wound Depth 1
(cm)
Calculated Wound Size 5 cm^2
(cm^2)
Calculated 5 cm^3

9/25/25, 2:38 PM

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Wound Size (cm ³)	
Change in Wound Size %	40.26
Undermining	None present
Granulation	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Necrotic Tissue Amount	None visible
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Barrier Film;Cleansed;Alginate
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/04/25 1731	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Alginate silver; ABD; Tape; Dressing no longer intact (i.e. lifting, leaking, ...)	Routine, Every Mon, Wed, Fri, First occurrence on Wed 8/6/25 at 1000, Until Specified Wound Pressure Injury Perineum Wound care nurse to change with vac dressing Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Other (Comment Required) / vashe Fill/Apply: Alginate silver Cover: ABD Secure with: Tape Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged) / wound care nurse to change MWF, Dressing damp, moist or saturated, Other	Wound care nurse to change with vac dressing	Hillary L Sowder, APRN

Negative Pressure Wound Therapy (Active)

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Placement Date/Time: 07/31/25 (c) 1900

Assessments 8/4/2025 5:17 PM

Pressure Setting -125 mmHg

Pressure Type Continuous

Wound Foam;Drape;Cavilon

Management

Number of sponges 2

Sponges

NPWT Status Dry;Intact;Clean

NPWT Exudate Serosanguineous: thin watery, pale re/pink

Type

Output (mL) 250 mL

Canister yes

Change

No associated orders.

Wound Wound/Other Skin tear Elbow Right (Active)

Date First Assessed/Time First Assessed: 08/04/25 1728 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: Skin tear Anatomical Site: Elbow Wound Location Orientation: Right

Assessments 8/4/2025 5:17 PM

Wound Image



Wound Length 2 cm

(cm)

Wound Width 1 cm

(cm)

Wound Depth 0.1

(cm)

Calculated 2 cm^2

Wound Size

(cm^2)

Calculated 0.2 cm^3

Wound Size

(cm^3)

Extent of Tissue Partial thickness tissue loss

Loss

Undermining None present

Granulation No granulation tissue present

Tissue

Epithelialization 0 to <25% wound covered

Necrotic Tissue None visible

Type

Necrotic Tissue None visible

Amount

Other Wound Dermis/Pink Tissue

Bed

Characteristics

Wound Edges Distinct, outline clearly visible, attached and even with wound base

Periwound Skin Pink or normal for ethnic group

Color

Periwound Skin No swelling or edema

9/25/25, 2:38 PM

Edema

Periwound Skin None present

Induration

Exudate Type Serosanguineous: thin watery, pale re/pink

Exudate Amount Scant, wound moist but no observable exudate

Odor None

Wound Cleansed; Absorbent clear

Management

Dressing Changed

Changed

Dressing Status Clean; Dry; Intact

No associated orders.

Recommendations: perineum wound was sewn shut during debridement on Thursday, now is starting to dehisce. Applied silver alginate and drape, will change with vac dressing change on MWF. Bilateral lower leg wounds are stable, recommend to continue current wound care orders.

Signature: LONG, MAHALEY G., RN

Date: 8/4/2025

Time: 5:31 PM EDT

9/25/25, 2:38 PM

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 8/11/2025 11:34 AM

Wound Progress Note

Reason for wound Consult: weekly skin assessment

Patient is awake, alert, and oriented

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Diagnosis

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Date

Past Surgical History:

Past Surgical History:

Procedure

- | | Laterality | Date |
|---------------------------|------------|------------|
| • BRONCHOSCOPY | | 07/14/2025 |
| • CARDIAC CATHETERIZATION | | 07/14/2025 |
| x2 stents | | 07/14/2025 |
| • CERVICAL LAMINECTOMY | | 07/14/2025 |
| • COLOSTOMY | | 07/14/2025 |
| • PEG TUBE PLACEMENT | | 07/14/2025 |
| • TRACHEOSTOMY | | 07/11/2025 |
| • WOUND DEBRIDEMENT | | 07/11/2025 |

Allergies: Patient has no known allergies.

9/25/25, 2:38 PM

Braden Score: Braden Scale Score: 12

Wound/Ulcer Assessment:

Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 8/11/2025 10:54 AM

Wound Image



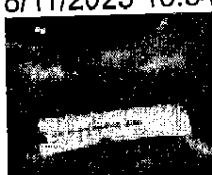
Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	7 cm
Wound Width (cm)	17 cm
Wound Depth (cm)	5.3
Calculated Wound Size (cm^2)	119 cm^2
Calculated Wound Size (cm^3)	630.7 cm^3
Change in Wound Size %	53.28
Extent of Tissue Loss	Full thickness tissue loss
Undermining	Undermining >4 cm or tunneling in any area
Undermining - Location and Depth	9-3=7cm
Tunneling - Location and Depth	5=5.8cm
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Other Wound Bed Characteristics	Bone
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate

9/25/25, 2:38 PM

Odor	None
Wound Management	Barrier Film;Cleansed;Contact layer;Medical grade honey;NPWT
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/01/25 1457	Wound Management: Use Associated Wounds location; NPWT; No; Alginate, Contact Layer; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated; Continuous; -125; Per manufacturer recommendation	Routine, Every Mon, Wed, Fri, First occurrence on Fri 8/1/25 at 1458, Until Specified Wound Pressure Injury Coccyx Wound Location: Use Associated Wounds location Wound Management: NPWT NPWT + Instillation? No NPWT Wound Management: Alginate, Contact Layer Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated Pressure Type: Continuous Pressure Setting (mmHg): -125 Change Canister: Per manufacturer recommendations	-	Hillary L Sowder, APRN
07/29/25 1618	Support Surface	Routine, Until discontinued, Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx Type of Support Surface: FDS Size of Support Surface: Standard	-	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;LateralAssessments 8/11/2025 10:54 AM
Wound Image

Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	15 cm
Wound Width	2.5 cm

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

(cm)
Wound Depth 0
(cm)
Calculated 37.5 cm²
Wound Size
(cm²)
Calculated 0 cm³
Wound Size
(cm³)
Extent of Tissue Obscured by necrosis
Loss
Undermining None present
Granulation No granulation tissue present
Tissue
Epithelialization 0 to <25% wound covered
Necrotic Tissue Eschar: Firmly adherent, hard, black eschar
Type
Necrotic Tissue 75% to 100% of wound covered
Amount
Wound Edges Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Pink or normal for ethnic group
Color
Periwound Skin No swelling or edema
Edema
Periwound Skin None present
Induration
Exudate Type None
Exudate Amount None, dry wound
Odor None
Wound Barrier Film;Cleansed;Abdominal dressing;Roll gauze;Topical anti-microbial
Management
Dressing Changed
Changed
Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no lo...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg Distal;Lower;Right;Lateral Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged),	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Dressing damp, moist or
saturated

Wound Leg Left;Lower;Posterior (Active)
Date First Assessed/Time First Assessed: 07/28/25 2000 **Pre-Existing Wound:** Yes **Anatomical Site:** Leg
Wound Location Orientation: Left;Lower;Posterior

Assessments 8/11/2025 10:54 AM

Wound Image



Wound Length (cm) 4.5 cm

Wound Width (cm) 1 cm

Wound Depth (cm) 0.3

Calculated Wound Size (cm²) 4.5 cm²

Calculated Wound Size (cm³) 1.35 cm³

Wound Size (cm³)

Extent of Tissue Loss Full thickness tissue loss

Undermining None present

Granulation Tissue Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth

Epithelialization 0 to <25% wound covered

Necrotic Tissue None visible

Type

Necrotic Tissue None visible

Amount

Other Wound Bed Tendon

Characteristics

Wound Edges Distinct, outline clearly visible, attached and even with wound base

Periwound Skin Pink or normal for ethnic group

Color

Periwound Skin No swelling or edema

Edema

Periwound Skin None present

Induration

Exudate Type Serosanguineous: thin watery, pale red/pink

Exudate Amount Small

Odor None

Wound Management Alginic;Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Roll gauze

Dressing Changed

Changed

Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg	-	Hillary L Sowder, APRN

location; Wound Left;Lower;Posterior
 care per Wound Pressure Injury Leg
 specified Distal;Left;Lower;Lateral
 algorithm/order; Wound Pressure Injury
 Dry, necrotic; Foot Left;Lateral
 Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep
 with skin prep Wound Location: Use
 and allow to dry; Associated Wounds location
 Honey alginate; Wound Management:
 ABD; Roll
 gauze; Dressing Wound care per specified
 no longer intact algorithm/order
 (i.e. lif... Type: Dry, necrotic
 Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Elbow Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Elbow **Wound Location Orientation:** Left

Assessments 8/11/2025 10:54 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0.8 cm
Wound Width (cm)	0.9 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm^2)	0.72 cm^2
Calculated Wound Size (cm^3)	0.07 cm^3
Extent of Tissue Loss	Obscured by necrosis
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Adherent, soft, black eschar
Necrotic Tissue Amount	>50% to <75% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serous: thin, water, clear
 Exudate Amount Scant, wound moist but no observable exudate
 Odor None
 Wound Barrier Film;Alginate;Cleansed;Foam;Medical grade honey
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Surgical Wound Quadrant, abdomen Upper;Medial (Active)
 Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Surgical Wound
 Pre-Existing Wound: Yes Anatomical Site: Quadrant, abdomen Wound Location Orientation:
 Upper;Medial

Assessments
 Wound Image



Wound Length 0.8 cm
 (cm)
 Wound Width 1 cm

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

(cm)	
Wound Depth	0.1
(cm)	
Calculated	0.8 cm^2
Wound Size	
(cm^2)	
Calculated	0.08 cm^3
Wound Size	
(cm^3)	
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	>50% to <75% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Alginate;Cleansed;Split gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/28/25 2328	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Normal Saline; Prep with skin prep and allow to dry; Alginate; Other (split gauze); Dressing no longer intact (i.e. lifting, leaking, damaged), Dressi...	Routine, Daily, First occurrence on Mon 7/28/25 at 2329, Until Specified Wound Surgical Wound Quadrant, abdomen Upper;Medial Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Alginate Cover: Other / split gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Waddah Yaacoubagha, MD

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral

Assessments 8/11/2025 10:54 AM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	11.3 cm
Wound Width (cm)	2.5 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm ²)	28.25 cm ²
Calculated Wound Size (cm ³)	5.65 cm ³
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: loosely adherent, yellow slough
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale red/pink
Exudate Amount	Small
Odor	None
Wound Management	Alginate;Barrier Film;Collagen dressing;Abdominal dressing;Medical grade honey;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

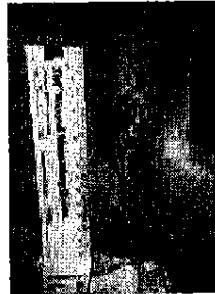
specified Distal;Left;Lower;Lateral
 algorithm/order; Wound Pressure Injury
 Dry, necrotic; Foot Left;Lateral
 Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep
 with skin prep Wound Location: Use
 and allow to dry; Associated Wounds location
 Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Ilium Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2031 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Ilium Wound Location Orientation: Left

Assessments 8/11/2025 10:54 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0.6 cm
Wound Width (cm)	1.5 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	0.9 cm^2
Calculated Wound Size (cm^3)	0.18 cm^3
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. <75% and >25% of wound filled
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue	<25% wound bed covered

9/25/25, 2:38 PM

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Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink; Bloody
Exudate Amount	Small
Odor	None
Wound	Alginate; Barrier Film; Cleansed; Foam; Medical grade honey
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting...)	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Elbow Left Wound Pressure Injury Ilium Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3

Assessments 8/11/2025 10:54 AM
Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)

9/25/25, 2:38 PM

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Wound Length (cm)	5.5 cm
Wound Width (cm)	1.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm ²)	8.25 cm ²
Calculated Wound Size (cm ³)	0 cm ³
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	50% to <75% wound covered and/or epithelial tissue extends <0.5 cm into wound bed
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	25% to 50% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Topical anti-microbial;Cleansed
Management	
Dressing	OTA (open to air)
Changed	
Dressing Status	OTA (open to air)

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Toe # Anterior;Right;1;3 Betadine paint to area Wound Location: Use Associated Wounds location Wound Management: Wound care per algorithm	Betadine paint to area	Hillary L Sowder, APRN

Wound Pressure Injury Foot Left;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 8/11/2025 10:54 AM

9/25/25, 2:38 PM

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Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	1 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Wound Size (cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	
Dressing Changed	Topical anti-microbial
Dressing Status	OTA (open to air)

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Other (Comment	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Dry, necrotic; Foot Left;Lateral Other (Comment Wound Pressure Injury	-	Hillary L Sowder, APRN

Required) Heel/Calcaneus Right
 (vashe); Prep Wound Location: Use
 with skin prep Associated Wounds location
 and allow to dry; Honey alginate;
 Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Foot Anterior;Right;Medial (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Anterior;Right;Medial

Assessments 8/11/2025 10:54 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	0.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	0.5 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group

9/25/25, 2:38 PM

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Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Cleansed;Topical anti-microbial
 Management
 Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments 8/11/2025 10:54 AM
 Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 3.6 cm
 (cm)
 Wound Width 0.6 cm
 (cm)
 Wound Depth 0.4
 (cm)
 Calculated 2.16 cm²
 Wound Size (cm²)
 Calculated 0.86 cm³
 Wound Size (cm³)
 Change in 38.57
 Wound Size %
 Extent of Tissue Full thickness tissue loss
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 75% to <100% wound covered and/or epithelial tissue extends >0.5 cm into wound bed
 Necrotic Tissue Eschar: Adherent, soft, black eschar
 Type
 Necrotic Tissue <25% wound bed covered
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serous: thin, water, clear
 Exudate Amount Scant, wound moist but no observable exudate

9/25/25, 2:38 PM

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Odor	None
Wound Management	Alginate;Abdominal dressing;Barrier Film;Cleansed;Medical grade honey;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Perineum (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 8/11/2025 10:54 AM
Wound Image

Stage	Stage 3
Wound Length (cm)	6.5 cm
Wound Width (cm)	2.8 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	18.2 cm^2

9/25/25, 2:38 PM

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Calculated Wound Size (cm^3)	3.64 cm^3
Change in Wound Size %	56.51
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type	
Necrotic Tissue Amount	None visible
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Alginate;Abdominal dressing
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/06/25 1655	Wound Management: Other - enter in comments (perineum and right gluteus); Wound care per specified algorithm/order; Wet; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Alginate silver; ABD; Tape; Dressing no longer intact ...	Routine, Daily, First occurrence on Thu 8/7/25 at 1000, Until Specified Wound Pressure Injury Perineum Wound Location: Other - enter in comments / perineum and right gluteus Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Alginate silver Cover: ABD Secure with: Tape Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Negative Pressure Wound Therapy (Active)

9/25/25, 2:38 PM

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Placement Date/Time: 07/31/25 (c) 1900

Assessments 8/11/2025 10:54 AM
Pressure Setting -125 mmHg
Pressure Type Continuous
Wound Management Foam;Contact Layer;Medical honey;Specialized Foam
Number of Sponges 6 sponges
NPWT Status Clean;Dry;Intact
NPWT Exudate Type Serosanguineous: thin watery, pale re/pink
Canister Change no

No associated orders.

Wound Wound/Other Skin tear Elbow Right (Active)

Date First Assessed/Time First Assessed: 08/04/25 1728 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: Skin tear Anatomical Site: Elbow Wound Location Orientation: Right

Assessments 8/11/2025 10:54 AM
Wound Image



Wound Length (cm) 0 cm
Wound Width (cm) 0 cm
Wound Depth (cm) 0
Calculated Wound Size (cm^2) 0 cm²
Calculated Wound Size (cm^3) 0 cm³
Change in Wound Size % 100
Undermining None present
Granulation Tissue No granulation tissue present
Epithelialization 100% wound covered, surface intact
Necrotic Tissue Type None visible
Necrotic Tissue Amount None visible
Wound Edges Indistinct, diffuse, none clearly visible
Periwound Skin None present
Induration
Exudate Type None
Exudate Amount None, dry wound
Odor None
Wound Management Open to air

9/25/25, 2:38 PM

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Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

No associated orders.

Wound Wound/Other Skin tear Arm Left;Lower (Active)

Date First Assessed/Time First Assessed: 08/07/25 1815 Wound Type - REQUIRED: Wound/Other

Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Left;Lower

Assessments 8/11/2025 10:54 AM

Wound Image



Wound Length 4.5 cm

(cm)

Wound Width 3 cm

(cm)

Wound Depth 0.1

(cm)

Calculated 13.5 cm^2

Wound Size

(cm^2)

Calculated 1.35 cm^3

Wound Size

(cm^3)

Extent of Tissue Loss

Undermining

None present

Epithelialization

0 to <25% wound covered

Necrotic Tissue

None visible

Type

Necrotic Tissue

None visible

Amount

Other Wound

Dermis/Pink Tissue

Bed

Characteristics

Wound Edges Distinct, outline clearly visible, attached and even with wound base

Periwound Skin Pink or normal for ethnic group

Color

Periwound Skin

No swelling or edema

Edema

Periwound Skin

None present

Induration

Exudate Type Serosanguineous: thin watery, pale red/pink

Exudate Amount

Small

Odor

None

Wound

Absorbent clear; Barrier Film; Cleansed

Management

Dressing

Changed

Changed

Dressing Status

Clean; Dry; Intact

Active Orders**Date****Order****Order Summary****Order Comments****Authorizing**

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Provider
 Hillary L
 Sowder, APRN

08/11/25 1133 Wound Routine, Every 21 days, -
 Management: First occurrence on Fri
 Use Associated 8/29/25 at 1000, Until
 Wounds Specified
 location; Wound Wound Wound/Other Skin
 care per tear Arm Left;Lower
 specified Wound Wound/Other Skin
 algorithm/order; tear Arm
 Skin tear; Anterior;Lower;Proximal;Rig
 Normal Saline; ht
 Absorbent clear
 acrylic dressing Wound Location: Use
 (21 days); Associated Wounds location
 Dressing no Wound Management:
 longer intact (i.e. Wound care per specified
 lifting, leaking, algorithm/order
 damaged), Type: Skin tear
 Dressing damp, Cleanse: Normal Saline
 moist or s... Fill/Cover: Absorbent clear
 acrylic dressing (21 days)
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Wound/Other Skin tear Arm Anterior;Lower;Proximal;Right (Active)

Date First Assessed/Time First Assessed: 08/11/25 1131 Wound Type - REQUIRED: Wound/Other Pre-

Existing Wound: No Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation:

Anterior;Lower;Proximal;Right

Assessments 8/11/2025 10:54 AM
 Wound Image



Wound Length 2 cm
 (cm)
 Wound Width 1.5 cm
 (cm)
 Wound Depth 0.1
 (cm)
 Calculated 3 cm²
 Wound Size
 (cm²)
 Calculated 0.3 cm³
 Wound Size
 (cm³)
 Extent of Tissue Partial thickness tissue loss
 Loss
 Undermining None present
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue None visible
 Type
 Necrotic Tissue None visible

9/25/25, 2:38 PM

Amount	
Other Wound	Dermis/Pink Tissue
Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Barrier Film;Cleansed;Absorbent clear
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/11/25 1133	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Skin tear; Normal Saline; Absorbent clear acrylic dressing (21 days); Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or s...	Routine, Every 21 days, First occurrence on Fri 8/29/25 at 1000, Until Specified Wound Wound/Other Skin tear Arm Left;Lower Wound Wound/Other Skin tear Arm Anterior;Lower;Proximal;Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Skin tear Cleanse: Normal Saline Fill/Cover: Absorbent clear acrylic dressing (21 days) Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Recommendations: coccyx wound is stable, less slough noted in wound bed, recommend to continue NPWT. Perineum has completely dehisced, recommend silver alginate dressings daily. Recommend to continue current wound care orders

Signature: LONG, MAHALEY G., RN

Date: 8/11/2025

Time: 11:34 AM EDT

King, Robert D

MRN: 8580

Mahaley G. Long, RN Wound Progress Note  Date of Service: 8/13/2025 3:50 PM
Registered Nurse Signed

Wound Progress Note

Right gluteal wound that was stitched during debridement of sacral wound has completely dehisced. Wound still communicates with sacral wound. Applied white foam in tract. And bridged right gluteal wound. Seal at -125mmhg

Signature: LONG, MAHALEY G., RN

Date: 8/13/2025

Time: 3:50 PM EDT

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 8/18/2025 4:00 PM

Wound Progress Note

Reason for wound Consult: weekly skin assessment

Patient is awake, alert, and oriented

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Diagnosis

Date

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Past Surgical History:

Past Surgical History:

Procedure

Laterality

Date

- BRONCHOSCOPY 07/14/2025
- CARDIAC CATHETERIZATION
- x2 stents
- CERVICAL LAMINECTOMY 2020
- COLOSTOMY 04/2025
- PEG TUBE PLACEMENT 07/24/2025
- TRACHEOSTOMY 07/24/2025
- WOUND DEBRIDEMENT 07/11/2025

Allergies: Patient has no known allergies.

Braden Score: Braden Scale Score: 10

Wound/Ulcer Assessment:

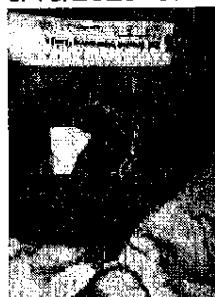
Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 8/18/2025 3:43 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	7 cm
Wound Width (cm)	10 cm
Wound Depth (cm)	6.6
Calculated Wound Size (cm^2)	70 cm^2
Calculated Wound Size (cm^3)	462 cm^3
Change in Wound Size %	65.78
Extent of Tissue Loss	Full thickness tissue loss
Undermining	Undermining >4 cm or tunneling in any area
Undermining - Location and Depth	9-3=7.1
Tunneling - Location and Depth	7=6.0cm
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Other Wound Bed	Bone
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Large

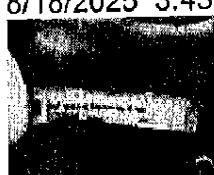
9/25/25, 2:38 PM

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Odor	None
Wound Management	Barrier Film;Cleansed;Medical grade honey;NPWT
Dressing Changed	Changed
Dressing Status	Clean;Intact;Dry

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; NPWT; No; Alginate, Contact Layer; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated; Continuous; -125; Per manufacturer recommendation	Routine, Every Mon, Wed, Fri, First occurrence on Wed 8/20/25 at 1000, Until Specified Wound Pressure Injury Coccyx Wound Pressure Injury Gluteal/Gluteus Right Wound Location: Use Associated Wounds location Wound Management: NPWT NPWT + Instillation? No NPWT Wound Management: Alginate, Contact Layer Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated Pressure Type: Continuous Pressure Setting (mmHg): -125 Change Canister: Per manufacturer recommendations	-	Hillary L Sowder, APRN
07/29/25 1618	Support Surface	Routine, Until discontinued, Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx	Type of Support Surface: FDS Size of Support Surface: Standard	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;LateralAssessments 8/18/2025 3:43 PM
Wound ImageStage Unstageable, necrotic tissue (slough/eschar)
Wound Length 15 cm

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

(cm)	
Wound Width	4 cm
(cm)	
Wound Depth	0
(cm)	
Calculated	60 cm^2
Wound Size	
(cm^2)	
Calculated	0 cm^3
Wound Size	
(cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	75% to 100% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Barrier Film;Cleansed;Abdominal dressing;Roll gauze;Topical anti-microbial
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no lo...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg Distal;Lower;Right;Lateral Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no	-	Hillary L Sowder, APRN

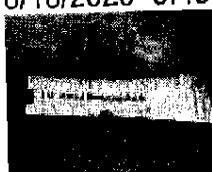
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longer intact (i.e. lifting,
leaking, damaged),
Dressing damp, moist or
saturated

Wound Leg Left;Lower;Posterior (Active)
Date First Assessed/Time First Assessed: 07/28/25 2000 **Pre-Existing Wound:** Yes **Anatomical Site:** Leg
Wound Location Orientation: Left;Lower;Posterior

Assessments 8/18/2025 3:43 PM
Wound Image



Wound Length 3.8 cm
 (cm)
 Wound Width 0.8 cm
 (cm)
 Wound Depth 0.3
 (cm)
 Calculated Wound Size 3.04 cm²
 (cm²)
 Calculated Wound Size 0.91 cm³
 (cm³)
 Extent of Tissue Loss Full thickness tissue loss
 Undermining None present
 Granulation Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue Eschar: Adherent, soft, black eschar
 Type
 Necrotic Tissue <25% wound bed covered
 Amount
 Other Wound Tendon
 Bed
 Characteristics
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serosanguineous: thin watery, pale re/pink
 Exudate Amount Small
 Odor None
 Wound Cleansed;Barrier Film;Abdominal dressing;Alginate;Medical grade honey;Roll gauze
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

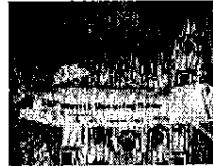
Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management:	Routine, Daily, First occurrence on Tue 7/29/25	-	Hillary L Sowder, APRN

Use Associated at 1619, Until Specified
 Wounds Wound Leg
 location; Wound Left;Lower;Posterior
 care per Wound Pressure Injury Leg
 specified Distal;Left;Lower;Lateral
 algorithm/order; Wound Pressure Injury
 Dry, necrotic; Foot Left;Lateral
 Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep
 with skin prep Wound Location: Use
 and allow to dry; Associated Wounds location
 Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Elbow Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Elbow Wound Location Orientation: Left

Assessments 8/18/2025 3:43 PM
 Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 0.5 cm
 (cm)
 Wound Width 0.5 cm
 (cm)
 Wound Depth 0
 (cm)
 Calculated 0.25 cm^2
 Wound Size
 (cm^2)
 Calculated 0 cm^3
 Wound Size
 (cm^3)
 Extent of Tissue Obscured by necrosis
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue Eschar: Firmly adherent, hard, black eschar
 Type
 Necrotic Tissue 75% to 100% of wound covered

Amount
 Wound Edges Indistinct, diffuse, none clearly visible
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Cleansed;Topical anti-microbial
 Management
 Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

Active Orders		Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600		Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Pressure Injury Toe # Anterior;Right;1;3 Wound Pressure Injury Elbow Left	Betadine paint to area	Hillary L Sowder, APRN

Betadine paint to area
 Wound Location: Use
 Associated Wounds location
 Wound Management:
 Wound care per algorithm

Wound Surgical Wound Quadrant, abdomen Upper;Medial (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Surgical Wound

Pre-Existing Wound: Yes Anatomical Site: Quadrant, abdomen Wound Location Orientation:
Upper;Medial

Assessments 8/18/2025 3:43 PM
 Wound Image



Wound Length (cm) 0 cm
 Wound Width (cm) 0 cm
 Wound Depth (cm) 0
 Calculated Wound Size (cm^2) 0 cm^2
 Calculated Wound Size (cm^3) 0 cm^3

Undermining None present
Epithelialization 100% wound covered, surface intact
Necrotic Tissue None visible
Type
Necrotic Tissue None visible
Amount
Other Wound Intact Skin
Bed
Characteristics
Exudate Type None
Exudate Amount None, dry wound
Odor None
Wound Open to air
Management
Dressing OTA (open to air)
Changed
Dressing Status OTA (open to air)

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral

Assessments 8/18/2025 3:43 PM

Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
Wound Length 11.2 cm
(cm)
Wound Width 4 cm
(cm)
Wound Depth 0.2
(cm)
Calculated 44.8 cm²
Wound Size
(cm²)
Calculated 8.96 cm³
Wound Size
(cm³)
Extent of Tissue Full thickness tissue loss
Loss
Undermining None present
Granulation Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Tissue
Epithelialization 25% to <50% wound covered
Necrotic Tissue None visible
Type
Necrotic Tissue None visible
Amount
Wound Edges Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Pink or normal for ethnic group
Color
Periwound Skin No swelling or edema
Edema
Periwound Skin None present
Induration
Exudate Type Serosanguineous: thin watery, pale re/pink
Exudate Amount Small
Odor None

9/25/25, 2:38 PM

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Wound Management Dressing Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Ilium Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2031 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Ilium Wound Location Orientation: Left

Assessments 8/18/2025 3:43 PM
 Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length (cm) 0.6 cm
 Wound Width (cm) 1.3 cm
 Wound Depth (cm) 0.3

9/25/25, 2:38 PM

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Calculated Wound Size (cm^2)	0.78 cm^2
Calculated Wound Size (cm^3)	0.23 cm^3
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound Management	Barrier Film;Cleansed;Alginate;Foam;Medical grade honey
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifti...	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Pressure Injury Ilium Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

9/25/25, 2:38 PM

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Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3

Assessments 8/18/2025 3:43 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	5 cm
Wound Width (cm)	1.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	7.5 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Wound Size (cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Topical anti-microbial;Cleansed
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Pressure Injury Toe # Anterior;Right;1;3 Wound Pressure Injury Elbow Left	Betadine paint to area	Hillary L Sowder, APRN

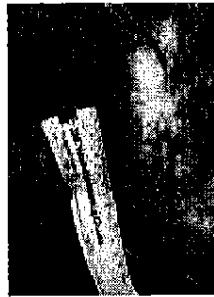
Betadine paint to area
Wound Location: Use
Associated Wounds location
Wound Management:
Wound care per algorithm

Wound Pressure Injury Foot Left;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 8/18/2025 3:43 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1.2 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	1.2 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Open to air
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Active Orders

9/25/25, 2:38 PM

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Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	<p>Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...</p>	<p>Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified</p> <p>Wound Leg Left;Lower;Posterior</p> <p>Wound Pressure Injury Leg Distal;Left;Lower;Lateral</p> <p>Wound Pressure Injury Foot Left;Lateral</p> <p>Wound Pressure Injury Heel/Calcaneus Right</p> <p>Wound Location: Use Associated Wounds location</p> <p>Wound Management: Wound care per specified algorithm/order</p> <p>Type: Dry, necrotic</p> <p>Cleanse: Other (Comment Required) / vashe</p> <p>Prep: Prep with skin prep and allow to dry</p> <p>Fill/Apply: Honey alginate</p> <p>Cover: ABD</p> <p>Secure with: Roll gauze</p> <p>Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated</p>	-	Hillary L Sowder, APRN

Wound Pressure Injury Foot Anterior;Right;Medial (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Foot **Wound Location Orientation:** Anterior;Right;Medial

Assessments 8/18/2025 3:43 PM
Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	1 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue	Obscured by necrosis

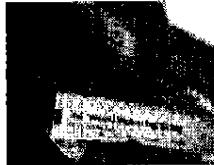
Loss	
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	>25% wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Open to air
Management	
Dressing	OTA (open to air)
Changed	
Dressing Status	OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments 8/18/2025 3:43 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	0.6 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm^2)	0.6 cm^2
Calculated Wound Size (cm^3)	0.18 cm^3
Change in Wound Size %	87.14
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Adherent, soft, black eschar
Type	
Necrotic Tissue	<25% wound bed covered
Amount	
Other Wound	Dermis/Pink Tissue

9/25/25, 2:38 PM

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Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Abdominal dressing;Alginate;Barrier Film;Cleansed;Medical grade honey;Roll gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Intact;Dry

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...)	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Perineum (Active)

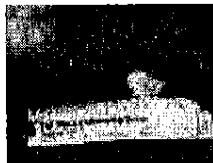
Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 8/18/2025 3:43 PM

9/25/25, 2:38 PM

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Wound Image



Stage	Stage 3
Wound Length (cm)	6 cm
Wound Width (cm)	2.6 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm ²)	15.6 cm ²
Calculated Wound Size (cm ³)	3.12 cm ³
Change in Wound Size %	62.72
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type	
Necrotic Tissue	None visible
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound Management	Barrier Film;Alginate;Abdominal dressing;Cleansed
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/13/25 1553	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Other (Comment Required) (vashe); Prep	Routine, Daily, First occurrence on Thu 8/14/25 at 1000, Until Specified Wound Pressure Injury location; Wound care per specified algorithm/order Type: Wet	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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with skin prep Cleanse: Other (Comment
 and allow to dry; Required) / vashe
 Alginate silver; Prep: Prep with skin prep
 ABD; Tape;
 Dressing no and allow to dry
 longer intact (i.e. Cover: ABD
 lifting, leaking, ... Secure with: Tape
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Negative Pressure Wound Therapy (Active)

Placement Date/Time: 07/31/25 (c) 1900

Assessments 8/18/2025 3:43 PM

Pressure Setting -125 mmHg

Pressure Type Continuous

Wound Foam;Specialized Foam;Medical honey

Management

Number of sponges

Sponges

NPWT Status Dry;Clean;Intact

NPWT Exudate Serosanguineous: thin watery, pale re/pink

Type

Canister no

Change

No associated orders.**Wound Wound/Other Skin tear Arm Left;Lower (Active)**

Date First Assessed/Time First Assessed: 08/07/25 1815 Wound Type - REQUIRED: Wound/Other

Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Left;Lower

Assessments 8/18/2025 3:43 PM

Wound Image



Wound Length (cm) 4.2 cm

Wound Width (cm) 3 cm

Wound Depth (cm) 0.1

Calculated Wound Size (cm^2) 12.6 cm^2

Calculated Wound Size (cm^3) 1.26 cm^3

Extent of Tissue Loss Partial thickness tissue loss

Undermining None present

Granulation No granulation tissue present

9/25/25, 2:38 PM

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Tissue
Epithelialization 0 to <25% wound covered
Necrotic Tissue None visible
Type
Necrotic Tissue None visible
Amount
Other Wound Dermis/Pink Tissue
Bed
Characteristics
Wound Edges Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Pink or normal for ethnic group
Color
Periwound Skin No swelling or edema
Edema
Periwound Skin None present
Induration
Exudate Type Serous: thin, watery, pale re/pink
Exudate Amount Small
Odor None
Wound Absorbent clear; Barrier Film; Cleansed
Management
Dressing Changed
Changed
Dressing Status Clean; Dry; Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry; Normal Saline; Prep with skin prep and allow to dry; Other (N/A); Tegaderm absorbent clear; Other (N/A); Dressing no longer intact (i.e. lifting, leak...)	Routine, Every 21 days, First occurrence on Fri 9/5/25 at 1000, Until Specified Wound Wound/Other Skin tear Arm Lower; Right; Posterior Wound Wound/Other Skin tear Arm Left; Lower Wound Wound/Other Skin tear Arm Anterior; Lower; Proximal; Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / N/A Cover: Tegaderm absorbent clear Secure with: Other / N/A Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Wound Wound/Other Skin tear Arm Anterior;Lower;Proximal;Right (Active)
Date First Assessed/Time First Assessed: 08/11/25 1131 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Anterior;Lower;Proximal;Right

Assessments 8/18/2025 3:43 PM
Wound Image



Wound Length (cm)	0 cm
Wound Width (cm)	0 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	0 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Change in Wound Size %	100
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	100% wound covered, surface intact
Necrotic Tissue	None visible
Type	
Necrotic Tissue Amount	None visible
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Open to air
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry; Normal Saline; Prep	Routine, Every 21 days, First occurrence on Fri 9/5/25 at 1000, Until Specified Wound Wound/Other Skin tear Arm Lower;Right;Posterior Wound Wound/Other Skin tear Arm Left;Lower Wound Wound/Other Skin	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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with skin prep tear Arm
and allow to dry; Anterior;Lower;Proximal;Rig
Other (N/A); ht
Tegaderm
absorbent clear; Wound Location: Use
Other (N/A); Associated Wounds location
Dressing no Wound Management:
longer intact (i.e. Wound care per specified
lifting, leak... algorithm/order
Type: Dry
Cleanse: Normal Saline
Prep: Prep with skin prep
and allow to dry
Fill/Apply: Other / N/A
Cover: Tegaderm absorbent
clear
Secure with: Other / N/A
Change/PRN: Dressing no
longer intact (i.e. lifting,
leaking, damaged),
Dressing damp, moist or
saturated

Wound Wound/Other Skin tear Arm Lower;Right;Posterior (Active)

Date First Assessed/Time First Assessed: 08/14/25 1806 **Wound Type - REQUIRED:** Wound/Other **Pre-Existing Wound:** No **Wound Type:** Skin tear **Anatomical Site:** Arm **Wound Location Orientation:** Lower;Right;Posterior

Assessments 8/18/2025 3:43 PM

Wound Image



Wound Length (cm) 1.5 cm

Wound Width (cm) 1 cm

Wound Depth (cm) 0.1

Calculated 1.5 cm²

Wound Size (cm²)

Calculated 0.15 cm³

Wound Size (cm³)

Extent of Tissue Loss Partial thickness tissue loss

Undermining

None present

Granulation Tissue

No granulation tissue present

Tissue

Epithelialization 0 to <25% wound covered

Necrotic Tissue None visible

Type

Necrotic Tissue None visible

Amount

Other Wound Dermis/Pink Tissue

9/25/25, 2:38 PM

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Bed**Characteristics**

Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Absorbent clear; Barrier Film; Cleansed
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry; Normal Saline; Prep with skin prep and allow to dry; Other (N/A); Tegaderm absorbent clear; Dressing no longer intact (i.e. lifting, leak...)	Routine, Every 21 days, First occurrence on Fri 9/5/25 at 1000, Until Specified location; Wound tear Arm Lower; Right; Posterior Wound tear Arm Left; Lower Wound tear Arm Anterior; Lower; Proximal; Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / N/A Cover: Tegaderm absorbent clear Secure with: Other / N/A Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Wound/Other MASD Groin/Inguinal All/Entire (Active)

Date First Assessed/Time First Assessed: 08/18/25 1555 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: MASD Anatomical Site: Groin/Inguinal Wound Location Orientation: All/Entire

Assessments 8/18/2025 3:43 PM

9/25/25, 2:38 PM

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Wound Image



Wound Length (cm)	14 cm
Wound Width (cm)	13 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm ²)	182 cm ²
Calculated Wound Size (cm ³)	18.2 cm ³
Extent of Tissue Loss	Partial thickness tissue loss
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	None visible
Necrotic Tissue Amount	None visible
Other Wound Bed Characteristics	Dermis/Pink Tissue
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serous: thin, water, clear
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound Management	Barrier Film;Cleansed;Other (Comment) (antifungal powder)
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Apply Miconazole 2% powder to the skin/skin folds BID and PRN soiling/saturatio n	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Wound/Other MASD Groin/Inguinal All/Entire Wound Location: groin and folds	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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Wound Pressure Injury Gluteal/Gluteus Right (Active)

Date First Assessed/Time First Assessed: 07/28/25 2123 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Gluteal/Gluteus **Wound Location Orientation:** Right **Wound Description (Comments):** No longer communicates with co...

Assessments 8/18/2025 3:43 PM
Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	5 cm
Wound Width (cm)	1.8 cm
Wound Depth (cm)	1.9
Calculated Wound Size (cm²)	9 cm ²
Calculated Wound Size (cm³)	17.1 cm ³
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	Bright, beefy red. <75% and >25% of wound filled
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Adherent, soft, black eschar
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Cleansed; Barrier Film; Medical grade honey; NPWT
Dressing Changed	Changed
Dressing Status	Clean; Dry; Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated	Routine, Every Mon, Wed, Fri, First occurrence on Wed 8/20/25 at 1000, Until	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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Wounds Specified
location; NPWT; Wound Pressure Injury
No; Alginate, Coccyx
Contact Layer; Wound Pressure Injury
Dressing no Gluteal/Gluteus Right
longer intact (i.e.
lifting, leaking, Wound Location: Use
damaged), Associated Wounds location
Dressing damp, Wound Management:
moist or NPWT
saturated; NPWT + Instillation? No
Continuous; NPWT Wound
-125; Per Management: Alginate,
manufacturer Contact Layer
recommendation Change/PRN: Dressing no
s longer intact (i.e. lifting,
leaking, damaged),
Dressing damp, moist or
saturated
Pressure Type: Continuous
Pressure Setting (mmHg):
-125
Change Canister: Per
manufacturer
recommendations

Recommendations: right glut wound and coccyx no longer communicated. Vac placed on r glut and bridged to r glut wound, pressure at -125mmhg. Will order spry pillow to aid in offloading pressure of lower legs and heels.

Signature: LONG, MAHALEY G., RN

Date: 8/18/2025

Time: 4:00 PM EDT

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 8/25/2025 10:26 AM

Wound Progress Note

Reason for wound Consult: weekly skin assessment

Patient is awake, alert, and oriented

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Diagnosis

Date

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Past Surgical History:

Past Surgical History:

Procedure

Laterality

Date

- BRONCHOSCOPY 07/14/2025
- CARDIAC CATHETERIZATION
- x2 stents
- CERVICAL LAMINECTOMY 2020
- COLOSTOMY 04/2025
- PEG TUBE PLACEMENT 07/24/2025
- TRACHEOSTOMY 07/24/2025
- WOUND DEBRIDEMENT 07/11/2025

Allergies: Patient has no known allergies.

Braden Score: Braden Scale Score: 11

Wound/Ulcer Assessment:

Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 8/25/2025 10:03 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	8.1 cm
Wound Width (cm)	9 cm
Wound Depth (cm)	5.8
Calculated Wound Size (cm^2)	72.9 cm^2
Calculated Wound Size (cm^3)	422.82 cm^3
Change in Wound Size %	68.68
Extent of Tissue Loss	Full thickness tissue loss
Undermining	Undermining >4 cm or tunneling in any area
Undermining - Location and Depth	10-3=7.3
Tunneling - Location and Depth	4=5.6cm
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	25% to 50% of wound covered
Other Wound Bed Characteristics	Bone
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Cleansed; Barrier Film; Medical grade honey; NPWT
Dressing	Changed

Changed
 Dressing Status Clean;Intact;Dry

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; NPWT; No; Alginate, Contact Layer; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated; Continuous; -125; Per manufacturer recommendation	Routine, Every Mon, Wed, Fri, First occurrence on Wed 8/20/25 at 1000, Until Specified Wound Pressure Injury Coccyx Wound Pressure Injury Gluteal/Gluteus Right Wound Location: Use Associated Wounds location Wound Management: NPWT NPWT + Instillation? No NPWT Wound Management: Alginate, Contact Layer Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated Pressure Type: Continuous Pressure Setting (mmHg): -125 Change Canister: Per manufacturer recommendations	-	Hillary L Sowder, APRN
07/29/25 1618	Support Surface	Routine, Until discontinued, Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx Type of Support Surface: FDS Size of Support Surface: Standard	-	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;Lateral

Assessments 8/25/2025 10:03 AM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	15 cm
Wound Width (cm)	4 cm
Wound Depth	0

9/25/25, 2:38 PM

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(cm)	
Calculated Wound Size	60 cm^2
(cm^2)	
Calculated Wound Size	0 cm^3
(cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Abdominal dressing;Cleansed;Roll gauze;Topical anti-microbial
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine) soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no lo...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg location; Wound care per specified algorithm/order Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

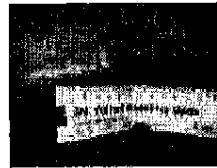
Wound Leg Left;Lower;Posterior (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Pre-Existing Wound: Yes Anatomical Site: Leg

Wound Location Orientation: Left;Lower;Posterior

Assessments 8/25/2025 10:03 AM

Wound Image



Wound Length (cm)	5.5 cm
Wound Width (cm)	0.8 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm ²)	4.4 cm ²
Calculated Wound Size (cm ³)	0.88 cm ³
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound Management	Abdominal dressing;Alginate;Barrier Film;Cleansed;Medical grade honey;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic;	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep
 with skin prep Wound Location: Use
 and allow to dry; Associated Wounds location
 Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Elbow Left (Active)**Date First Assessed/Time First Assessed:** 07/28/25 2000 **Wound Type - REQUIRED:** Pressure Injury**Pre-Existing Wound:** Yes **Anatomical Site:** Elbow **Wound Location Orientation:** Left**Assessments** 8/25/2025 10:03 AM

Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 0.6 cm
 (cm)
 Wound Width 0.6 cm
 (cm)
 Wound Depth 0.2
 (cm)
 Calculated 0.36 cm²
 Wound Size
 (cm²)
 Calculated 0.07 cm³
 Wound Size
 (cm³)
 Extent of Tissue Obscured by necrosis
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue Slough: white/gray non-viable and/or non-adherent yellow
 Type
 Necrotic Tissue 75% to 100% of wound covered
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present

9/25/25, 2:38 PM

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Induration

Exudate Type	Serous: thin, water, clear
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Alginate;Barrier Film;Cleansed;Foam;Medical grade honey
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/25/25 1026	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Normal Saline; Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressi...	Routine, Daily, First occurrence on Mon 8/25/25 at 1027, Until Specified Wound Pressure Injury Elbow Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral

Assessments 8/25/2025 10:03 AM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	13 cm
Wound Width (cm)	2 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	26 cm^2
Calculated Wound Size (cm^3)	5.2 cm^3
Extent of Tissue Loss	Full thickness tissue loss

9/25/25, 2:38 PM

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Undermining	None present
Granulation	Pink, and/or dull, dusky red and/or fills <25% of wound
Tissue	
Epithelialization	25% to <50% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue	<25% wound bed covered
Amount	
Other Wound	Dermis/Pink Tissue
Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Small
Odor	None
Wound	Barrier Film;Alginate;Cleansed;Abdominal dressing;Medical grade honey;Roll gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

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Wound Pressure Injury Ilium Left (Active)**Date First Assessed/Time First Assessed:** 07/28/25 2031 **Wound Type - REQUIRED:** Pressure Injury**Pre-Existing Wound:** Yes **Anatomical Site:** Ilium **Wound Location Orientation:** Left

Assessments 8/25/2025 10:03 AM
Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0.6 cm
Wound Width (cm)	1.3 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	0.78 cm^2
Calculated Wound Size (cm^3)	0.16 cm^3
Wound Size (cm^3)	
Extent of Tissue Loss	Partial thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. <75% and >25% of wound filled
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale red/pink
Exudate Amount	Small
Odor	None
Wound Management	Cleansed;Barrier Film;Alginate;Foam;Medical grade honey
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management: Use Associated Wounds location; Wound	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Pressure Injury Ilium Left	-	Hillary L Sowder, APRN

9/25/25, 2:38 PM

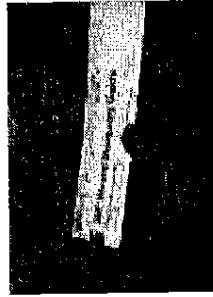
King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

care per
 specified Wound Location: Use
 algorithm/order; Associated Wounds location
 Dry, necrotic; Wound Management:
 Other (Comment Wound care per specified
 Required) algorithm/order
 (vashe); Prep Type: Dry, necrotic
 with skin prep Cleanse: Other (Comment
 and allow to dry; Required) / vashe
 Honey alginate; Prep: Prep with skin prep
 Adhesive foam; and allow to dry
 Dressing no Fill/Apply: Honey alginate
 longer intact (i.e. Cover: Adhesive foam
 lifti... Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3

Assessments 8/25/2025 10:03 AM
 Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	6 cm
Wound Width (cm)	1.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	9 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	Epithelialization: 25% to <50% wound covered
Necrotic Tissue Type	Necrotic Tissue: Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	25% to 50% of wound covered
Wound Edges	Wound Edges: Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Periwound Skin: Pink or normal for ethnic group
Periwound Skin Edema	Periwound Skin: No swelling or edema

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Periwound Skin None present
 Induration
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Cleansed;Topical anti-microbial
 Management
 Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

Active Orders		Order	Order Summary	Order Comments	Authorizing Provider
Date					
08/25/25 1026		Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Tue 8/26/25 at 1000, Until Specified Wound Pressure Injury Toe # Anterior;Right;1;3 Betadine paint to area Wound Location: Use Associated Wounds location Wound Management: Wound care per algorithm	Betadine paint to area	Hillary L Sowder, APRN

Wound Pressure Injury Foot Left;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 8/25/2025 10:03 AM
 Wound Image 

Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length (cm) 1 cm
 Wound Width (cm) 1 cm
 Wound Depth (cm) 0
 Calculated Wound Size (cm^2) 1 cm^2
 Wound Size (cm^2) 0 cm^3
 Calculated Wound Size (cm^3)
 Extent of Tissue Loss Obscured by necrosis
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue Eschar: Firmly adherent, hard, black eschar
 Type
 Necrotic Tissue 75% to 100% of wound covered
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group

9/25/25, 2:38 PM

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Color
 Periwound Skin No swelling or edema
Edema
 Periwound Skin None present
Induration
Exudate Type None
Exudate Amount None, dry wound
Odor None
Wound Cleansed;Topical anti-microbial
Management
Dressing OTA (open to air)
Changed
Dressing Status OTA (open to air)

Active Orders		Order	Order Summary	Order Comments	Authorizing Provider
Date					
07/29/25 1618		Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lif...	Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified Wound Leg Left;Lower;Posterior Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Pressure Injury Foot Left;Lateral Wound Pressure Injury Heel/Calcaneus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Foot Anterior;Right;Medial (Active)

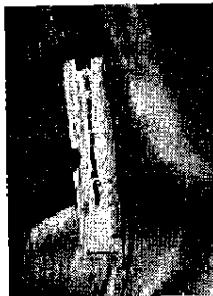
Date First Assessed/Time First Assessed: 07/28/25 2000 **Wound Type - REQUIRED:** Pressure Injury
Pre-Existing Wound: Yes **Anatomical Site:** Foot **Wound Location Orientation:** Anterior;Right;Medial

Assessments 8/25/2025 10:03 AM

9/25/25, 2:38 PM

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Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0.6 cm
Wound Width (cm)	0.6 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	0.36 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation	No granulation tissue present
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	
Necrotic Tissue	75% to 100% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Open to air
Management	
Dressing	OTA (open to air)
Changed	
Dressing Status	OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments 8/25/2025 10:03 AM

9/25/25, 2:38 PM

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Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	0.6 cm
Wound Depth (cm)	0.3
Calculated Wound Size (cm^2)	0.6 cm^2
Calculated Wound Size (cm^3)	0.18 cm^3
Wound Size (cm^3)	
Change in Wound Size %	87.14
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: loosely adherent, yellow slough
Necrotic Tissue Amount	>50% to <75% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale red/pink
Exudate Amount	Small
Odor	None
Wound Management	Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Alginate;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Intact;Dry

Active Orders

Date

Order

Order Summary

Order Comments

Authorizing Provider

Hillary L Sowder, APRN

07/29/25 1618

Wound Management:
Use Associated Wounds
location; Wound care per specified algorithm/order;

Routine, Daily, First occurrence on Tue 7/29/25 at 1619, Until Specified
Wound Leg
Left;Lower;Posterior
Wound Pressure Injury Leg
Distal;Left;Lower;Lateral
Wound Pressure Injury

9/25/25, 2:38 PM

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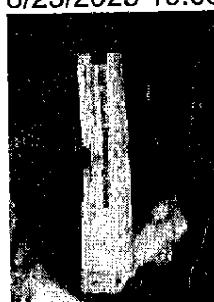
Dry, necrotic; Foot Left;Lateral
 Other (Comment Wound Pressure Injury
 Required) Heel/Calcaneus Right
 (vashe); Prep Wound Location: Use
 with skin prep Associated Wounds location
 and allow to dry; Honey alginate; Wound Management:
 ABD; Roll Wound care per specified
 gauze; Dressing algorithm/order
 no longer intact Type: Dry, necrotic
 (i.e. lif... Cleanse: Other (Comment
 Required) / vashe
 Prep: Prep with skin prep
 and allow to dry
 Fill/Apply: Honey alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Perineum (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 8/25/2025 10:03 AM

Wound Image



Stage	Stage 3
Wound Length (cm)	6.2 cm
Wound Width (cm)	2 cm
Wound Depth (cm)	0.2
Calculated Wound Size (cm^2)	12.4 cm^2
Calculated Wound Size (cm^3)	2.48 cm^3
Change in Wound Size %	70.37
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Tunneling -	12=0.6
Location and Depth	
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered

9/25/25, 2:38 PM

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Necrotic Tissue None visible
 Type
 Necrotic Tissue None visible
 Amount
 Other Wound Dermis/Pink Tissue
 Bed
 Characteristics
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serosanguineous: thin watery, pale re/pink (brown)
 Exudate Amount Small
 Odor None
 Wound Cleansed;Barrier Film;Abdominal dressing;Moist to moist
 Management
 Dressing Changed
 Changed
 Dressing Status Dry;Clean;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/25/25 1026	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Other (Comment Required) / vashe (vashe); Prep with skin prep and allow to dry; Other (vashe moistened gauze); ABD; Tape; Dressing no longer intact ...	Routine, 2 times daily, First occurrence on Mon 8/25/25 at 2200, Until Specified Wound Pressure Injury Perineum Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Other / vashe moistened gauze Cover: ABD Secure with: Tape Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Negative Pressure Wound Therapy (Active)

Placement Date/Time: 07/31/25 (c) 1900

Assessments 8/25/2025 10:03 AM
 Pressure Setting -125 mmHg
 Pressure Type Continuous
 Wound Foam;Specialized Foam;Medical honey
 Management
 Number of 5 sponges (1 white 4 black)

9/25/25, 2:38 PM

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Sponges
NPWT Status Clean;Dry;Intact
NPWT Exudate Serosanguineous: thin watery, pale re/pink
Type
Output (mL) 100 mL
Canister yes
Change

No associated orders.

Wound Wound/Other Skin tear Arm Left;Lower (Active)

Date First Assessed/Time First Assessed: 08/07/25 1815 Wound Type - REQUIRED: Wound/Other
Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Left;Lower**Assessments** 8/25/2025 10:03 AM

Wound Image



Wound Length 3 cm
(cm)
Wound Width 2.5 cm
(cm)
Wound Depth 0.2
(cm)
Calculated 7.5 cm²
Wound Size
(cm²)
Calculated 1.5 cm³
Wound Size
(cm³)
Extent of Tissue Partial thickness tissue loss
Loss
Undermining None present
Granulation No granulation tissue present
Tissue
Epithelialization 0 to <25% wound covered
Necrotic Tissue None visible
Type
Necrotic Tissue None visible
Amount
Other Wound Dermis/Pink Tissue
Bed
Characteristics
Wound Edges Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Pink or normal for ethnic group
Color
Periwound Skin No swelling or edema
Edema
Periwound Skin None present
Induration
Exudate Type Serosanguineous: thin watery, pale re/pink
Exudate Amount Small
Odor None
Wound Barrier Film;Alginate;Cleansed;Foam
Management

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Dressing Changed
Changed
Dressing Status Clean;Dry;Intact

Wound Wound/Other Skin tear Arm Lower;Right;Posterior (Active)
Date First Assessed/Time First Assessed: 08/14/25 1806 Wound Type - REQUIRED: Wound/Other Pre-
Existing Wound: No Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation:
Lower;Right;Posterior

Assessments 8/25/2025 10:03 AM
Wound Image



Wound Length 0 cm
(cm)
Wound Width 0 cm
(cm)
Wound Depth 0
(cm)
Calculated Wound Size 0 cm^2
(cm^2)
Calculated Wound Size 0 cm^3
(cm^3)
Change in Wound Size % 100
Wound Size %
Undermining None present
Granulation No granulation tissue present
Tissue
Epithelialization 100% wound covered, surface intact
Necrotic Tissue None visible
Type
Necrotic Tissue None visible
Amount
Exudate Type None
Exudate Amount None, dry wound
Odor None
Wound Open to air
Management
Dressing OTA (open to air)
Changed
Dressing Status OTA (open to air)

Wound Wound/Other MASD Groin/Inguinal All/Entire (Active)
Date First Assessed/Time First Assessed: 08/18/25 1555 Wound Type - REQUIRED: Wound/Other Pre-
Existing Wound: No Wound Type: MASD Anatomical Site: Groin/Inguinal Wound Location Orientation:
All/Entire

Assessments 8/25/2025 10:03 AM

9/25/25, 2:38 PM

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Wound Image



Wound Length (cm)	0 cm
Wound Width (cm)	0 cm
Wound Depth (cm)	0
Calculated Wound Size (cm ²)	0 cm ²
Calculated Wound Size (cm ³)	0 cm ³
Change in Wound Size %	100
Undermining	None present
Granulation	No granulation tissue present
Tissue	
Epithelialization	100% wound covered, surface intact
Necrotic Tissue	None visible
Type	
Necrotic Tissue	None visible
Amount	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Open to air
Management	
Dressing	OTA (open to air)
Changed	
Dressing Status	OTA (open to air)

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Apply Miconazole 2% powder to the skin/skin folds BID and PRN soiling/saturation	Routine, Daily, First occurrence on Tue 8/19/25 at 1000, Until Specified Wound Wound/Other MASD Groin/Inguinal All/Entire Wound Location: groin and folds	-	Hillary L Sowder, APRN

Wound Pressure Injury Gluteal/Gluteus Right (Active)

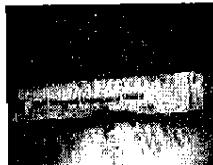
Date First Assessed/Time First Assessed: 07/28/25 2123 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Gluteal/Gluteus Wound Location Orientation: Right Wound Description (Comments): No longer communicates with co...

Assessments 8/25/2025 10:03 AM

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	4.8 cm
Wound Width (cm)	1 cm
Wound Depth (cm)	1.5
Calculated Wound Size (cm^2)	4.8 cm^2
Calculated Wound Size (cm^3)	7.2 cm^3
Change in Wound Size %	57.89
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Slough: white/gray non-viable and/or non-adherent yellow
Type	
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Barrier Film;Cleansed;Medical grade honey;NPWT
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/18/25 1600	Wound Management:	Routine, Every Mon, Wed, Fri, First occurrence on Wed	-	Hillary L Sowder, APRN
	Use Associated Wounds location; NPWT; No; Alginate, Contact Layer; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp,	8/20/25 at 1000, Until Specified Coccyx Wound Pressure Injury Gluteal/Gluteus Right Wound Location: Use Associated Wounds location Wound Management:	-	

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

moist or saturated;	NPWT
Continuous; -125; Per manufacturer recommendation s	NPWT + Instillation? No NPWT Wound Management: Alginate, Contact Layer Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated Pressure Type: Continuous Pressure Setting (mmHg): -125 Change Canister: Per manufacturer recommendations

Recommendations: Perineum wound now has a tunnel at 12:00, noticed forcefully brown effluent from tunneled area twice during wound assessment. Notified Np Hillary of findings. For now, pack with vaseline moistened gauze BID.

Signature: LONG, MAHALEY G., RN

Date: 8/25/2025

Time: 10:26 AM EDT

9/25/25, 2:38 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:38 PM

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note  
Signed

Date of Service: 8/27/2025 4:42 PM

Wound Progress Note

Son at bedside. Large amount of brown drainage that smelled of stool noted from perineum wound today. Drainage had gotten underneath vac drape caused maceration. NP Hillary notified. Removed vac, wet to dry TID ordered.

Signature: LONG, MAHALEY G., RN

Date: 8/27/2025

Time: 4:43 PM EDT

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 9/1/2025 11:36 AM

Wound Progress Note

Reason for wound Consult: weekly skin assessment

Patient is awake, alert, and oriented

Robert D King is a 73 y.o. male with the following Problems.

Problem List

Patient Active Problem List

Diagnosis

- Acute urinary tract infection
- Coronary arteriosclerosis
- Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Essential (primary) hypertension
- Hyperlipidemia
- Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site
- Pressure injury of left ankle stage III
- Pressure injury of left heel stage III
- Pressure injury of sacral region of back stage IV
- Severe protein-calorie malnutrition
- Osteomyelitis
- Necrotizing fasciitis
- Cardiac arrest
- Acute respiratory failure

Past Medical History:

Past Medical History:

Diagnosis

- Congestive heart failure
- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum
- Paraplegia

Date

Past Surgical History:

Past Surgical History:

Procedure

- | Procedure | Laterality | Date |
|---------------------------|------------|------------|
| • BRONCHOSCOPY | | 07/14/2025 |
| • CARDIAC CATHETERIZATION | | |
| x2 stents | | |
| • CERVICAL LAMINECTOMY | | 2020 |
| • COLOSTOMY | | 04/2025 |
| • PEG TUBE PLACEMENT | | 07/24/2025 |
| • TRACHEOSTOMY | | 07/24/2025 |
| • WOUND DEBRIDEMENT | | 07/11/2025 |

Allergies: Patient has no known allergies.

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Braden Score: Braden Scale Score: 13

Wound/Ulcer Assessment:

Wound Pressure Injury Coccyx (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Coccyx

Assessments 9/1/2025 11:16 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	8.5 cm
Wound Width (cm)	9 cm
Wound Depth (cm)	6.7
Calculated Wound Size (cm ²)	76.5 cm ²
Calculated Wound Size (cm ³)	512.55 cm ³
Change in Wound Size %	62.03
Extent of Tissue Loss	Obscured by necrosis
Undermining	Undermining >4 cm or tunneling in any area
Undermining - Location and Depth	11-3=6.5
Tunneling - Location and Depth	4=4.4
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Other Wound Bed	Bone
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Moist to moist
Dressing	Changed

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Changed
Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/27/25 1642	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Medical grade honey (nickel thickness) (vashe moistened gauze), Othe...	Routine, 3 times daily, First occurrence on Wed 8/27/25 at 1800, Until Specified Wound Pressure Injury Coccyx Wound Pressure Injury Gluteal/Gluteus Right Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Medical grade honey (nickel thickness) / vashe moistened gauze, Other Cover: ABD Secure with: Tape Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN
07/29/25 1618	Support Surface	Routine, Until discontinued, Starting on Tue 7/29/25 at 1614, Until Specified Wound Pressure Injury Coccyx	Type of Support Surface: FDS Size of Support Surface: Standard	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Lower;Right;Lateral (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Lower;Right;Lateral

Assessments
Wound Image



Stage
Wound Length (cm)
Wound Width (cm)

Unstageable, necrotic tissue (slough/eschar)
14 cm
7 cm

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Wound Depth (cm)	0
Calculated Wound Size (cm^2)	98 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Tissue Type	25% to <50% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	>50% to <75% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Cleansed;Barrier Film;Abdominal dressing;Roll gauze;Topical anti-microbial
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
07/29/25 1618	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Type: Wet, necrotic; Normal Saline; Prep with skin prep and allow to dry; Other (betadine soaked gauze to necrotic area); ABD (gauze); Roll gauze; Dressing no...	Routine, Daily, First occurrence on Wed 7/30/25 at 1000, Until Specified Wound Pressure Injury Leg Distal;Lower;Right;Lateral Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Other / betadine soaked gauze to necrotic area Cover: ABD / gauze Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or	-	Hillary L Sowder, APRN

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

saturated

Wound Leg Left;Lower;Posterior (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Pre-Existing Wound: Yes Anatomical Site: Leg

Wound Location Orientation: Left;Lower;Posterior

Assessments 9/1/2025 11:16 AM

Wound Image

Wound Length
(cm) 5 cmWound Width
(cm) 0.5 cmWound Depth
(cm) 0.1Calculated
Wound Size
(cm^2) 2.5 cm^2Wound Size
(cm^2)Calculated
Wound Size
(cm^3) 0.25 cm^3Extent of Tissue
LossUndermining
Granulation
TissueNone present
Bright, beefy red. <75% and >25% of wound filled

Epithelialization

25% to <50% wound covered
Necrotic Tissue Slough: white/gray non-viable and/or non-adherent yellow

Type

Necrotic Tissue <25% wound bed covered

Amount

Other Wound Dermis/Pink Tissue

Bed

Characteristics

Wound Edges Distinct, outline clearly visible, attached and even with wound base

Periwound Skin Pink or normal for ethnic group

Color

Periwound Skin No swelling or edema

Edema

Periwound Skin None present

Induration

Exudate Type Serosanguineous: thin watery, pale re/pink

Exudate Amount Small

Odor None

Wound Barrier Film;Abdominal dressing;Alginate;Cleansed;Collagen dressing;Roll gauze

Management

Dressing Changed

Changed

Dressing Status Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
09/01/25 1134	Wound Management:	Routine, Every Mon, Wed, Fri, First occurrence on Mon	-	Hillary L Sowder, APRN
	Use Associated Wounds location;	9/1/25 at 1135, Until Specified Wound Pressure Injury Leg		

9/25/25, 2:39 PM

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care per Distal;Left;Lower;Lateral
 specified Wound Leg
 algorithm/order; Left;Lower;Posterior
 Wet; Other
 (Comment Wound Location: Use
 Required) Associated Wounds location
 (vashe); Prep Wound Management:
 with skin prep Wound care per specified
 and allow to dry; algorithm/order
 Other (apply Type: Wet
 endofrom to Cleanse: Other (Comment
 wound bed Required) / vashe
 cover with silver Prep: Prep with skin prep
 alginate); ABD; and allow to dry
 Roll gauz... Fill/Apply: Other / apply
 endofrom to wound bed
 cover with silver alginate
 Cover: ABD
 Secure with: Roll gauze
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Pressure Injury Elbow Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Elbow Wound Location Orientation: Left

Assessments 9/1/2025 11:16 AM

Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 0.6 cm
 (cm)
 Wound Width 0.6 cm
 (cm)
 Wound Depth 0.2
 (cm)
 Calculated 0.36 cm²
 Wound Size
 (cm²)
 Calculated 0.07 cm³
 Wound Size
 (cm³)
 Extent of Tissue Obscured by necrosis
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue Slough: white/gray non-viable and/or non-adherent yellow
 Type
 Necrotic Tissue 75% to 100% of wound covered

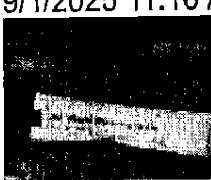
9/25/25, 2:39 PM

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Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Bright red and/or blanches to touch
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serous: thin, water, clear
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Cleansed; Barrier Film; Foam; Alginate; Medical grade honey
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/25/25 1026	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Normal Saline; Prep with skin prep and allow to dry; Honey alginate; Adhesive foam; Dressing no longer intact (i.e. lifting, leaking, damaged), Dressi...	Routine, Daily, First occurrence on Mon 8/25/25 at 1027, Until Specified Wound Pressure Injury Elbow Left Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: Adhesive foam Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Leg Distal;Left;Lower;Lateral (Active)Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Leg Wound Location Orientation: Distal;Left;Lower;Lateral**Assessments** 9/1/2025 11:16 AM
Wound Image 

Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	12 cm
Wound Width (cm)	3 cm
Wound Depth (cm)	0.1
Calculated	36 cm^2

9/25/25, 2:39 PM

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Wound Size (cm ²)	3.6 cm ³
Calculated	3.6 cm ³
Wound Size (cm ³)	
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Pink, and/or dull, dusky red and/or fills <25% of wound
Epithelialization	25% to <50% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound Management	Barrier Film;Alginate;Cleansed;Abdominal dressing;Collagen dressing;Roll gauze
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
09/01/25 1134	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Wet; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Other (apply endofrom to wound bed cover with silver alginate); ABD; Roll gauz...	Routine, Every Mon, Wed, Fri, First occurrence on Mon 9/1/25 at 1135, Until Specified Wound Pressure Injury Leg Distal;Left;Lower;Lateral Wound Leg Left;Lower;Posterior Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Other / apply endofrom to wound bed cover with silver alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged),	-	Hillary L Sowder, APRN

9/25/25, 2:39 PM

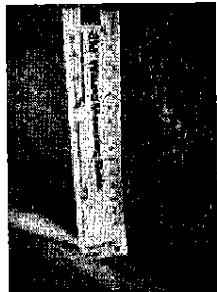
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Dressing damp, moist or
saturated

Wound Pressure Injury Ilium Left (Active)

Date First Assessed/Time First Assessed: 07/28/25 2031 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Ilium Wound Location Orientation: Left**Assessments** 9/1/2025 11:16 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0 cm
Wound Width (cm)	0 cm
Wound Depth (cm)	0
Calculated Wound Size (cm ²)	0 cm ²
Calculated Wound Size (cm ³)	0 cm ³
Undermining Tissue	None present
Granulation Tissue	No granulation tissue present
Epithelialization	100% wound covered, surface intact
Necrotic Tissue Type	None visible
Necrotic Tissue Amount	None visible
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Open to air
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Wound Pressure Injury Toe # Anterior;Right;1;3 (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Toe # Wound Location Orientation: Anterior;Right;1;3**Assessments** 9/1/2025 11:16 AM

Wound Image



9/25/25, 2:39 PM

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Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	5.5 cm
Wound Width (cm)	2 cm
Wound Depth (cm)	0
Calculated Wound Size (cm ²)	11 cm ²
Calculated Wound Size (cm ³)	0 cm ³
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Firmly adherent, hard, black eschar
Type	Necrotic Tissue
Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound	Cleansed;Topical anti-microbial
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/25/25 1026	Wound Management: Use Associated Wounds location; Wound care per algorithm	Routine, Daily, First occurrence on Tue 8/26/25 at 1000, Until Specified Wound Pressure Injury Toe # Anterior;Right;1;3 Betadine paint to area Wound Location: Use Associated Wounds location Wound Management: Wound care per algorithm	Betadine paint to area	Hillary L Sowder, APRN

Wound Pressure Injury Foot Left;Lateral (Active)

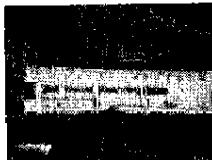
Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Left;Lateral

Assessments 9/1/2025 11:16 AM

9/25/25, 2:39 PM

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Wound Image



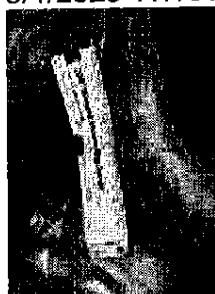
Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	1 cm
Wound Width (cm)	0.5 cm
Wound Depth (cm)	0
Calculated Wound Size (cm^2)	0.5 cm^2
Calculated Wound Size (cm^3)	0 cm^3
Wound Size (cm^3)	
Extent of Tissue Loss	Obscured by necrosis
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Eschar: Firmly adherent, hard, black eschar
Necrotic Tissue Amount	75% to 100% of wound covered
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Periwound Skin Induration	None present
Exudate Type	None
Exudate Amount	None, dry wound
Odor	None
Wound Management	Cleansed;Topical anti-microbial
Dressing Changed	OTA (open to air)
Dressing Status	OTA (open to air)

Wound Pressure Injury Foot Anterior;Right;Medial (Active)

Date First Assessed/Time First Assessed: 07/28/25 2000 Wound Type - REQUIRED: Pressure Injury
Pre-Existing Wound: Yes Anatomical Site: Foot Wound Location Orientation: Anterior;Right;Medial

Assessments 9/1/2025 11:16 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	0 cm

9/25/25, 2:39 PM

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Wound Width 0 cm
 (cm)
 Wound Depth 0
 (cm)
 Calculated 0 cm²
 Wound Size (cm²)
 Calculated 0 cm³
 Wound Size (cm³)
 Undermining None present
 Granulation No granulation tissue present
 Tissue
 Epithelialization 100% wound covered, surface intact
 Necrotic Tissue None visible
 Type
 Necrotic Tissue None visible
 Amount
 Exudate Type None
 Exudate Amount None, dry wound
 Odor None
 Wound Open to air
 Management
 Dressing OTA (open to air)
 Changed
 Dressing Status OTA (open to air)

Wound Pressure Injury Heel/Calcaneus Right (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Heel/Calcaneus Wound Location Orientation: Right

Assessments 9/1/2025 11:16 AM
 Wound Image



Stage Unstageable, necrotic tissue (slough/eschar)
 Wound Length 1 cm
 (cm)
 Wound Width 0.6 cm
 (cm)
 Wound Depth 0.7
 (cm)
 Calculated 0.6 cm²
 Wound Size (cm²)
 Calculated 0.42 cm³
 Wound Size (cm³)
 Change in 70
 Wound Size %
 Extent of Tissue Obscured by necrosis
 Loss
 Undermining None present
 Granulation No granulation tissue present
 Tissue

9/25/25, 2:39 PM

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Epithelialization	0 to <25% wound covered
Necrotic Tissue	Eschar: Adherent, soft, black eschar
Type	
Necrotic Tissue	75% to 100% of wound covered
Amount	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale red/pink
Exudate Amount	Small
Odor	None
Wound	Cleansed; Barrier Film; Abdominal dressing; Alginate; Medical grade honey; Roll gauze
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
09/01/25 1134	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Dry, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Honey alginate; ABD; Roll gauze; Dressing no longer intact (i.e. lift...)	Routine, Daily, First occurrence on Tue 9/2/25 at 1000, Until Specified Wound Pressure Injury location; Wound care per specified algorithm/order Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Dry, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry Fill/Apply: Honey alginate Cover: ABD Secure with: Roll gauze Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Perineum (Active)

Date First Assessed/Time First Assessed: 07/29/25 1611 Wound Type - REQUIRED: Pressure Injury

Pre-Existing Wound: Yes Anatomical Site: Perineum

Assessments 9/1/2025 11:16 AM
 Wound Image



Stage Stage 3
 Wound Length 3.5 cm

9/25/25, 2:39 PM

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(cm)
 Wound Width 6 cm
 (cm)
 Wound Depth 0.2
 (cm)
 Calculated Wound Size 21 cm²
 (cm²)
 Calculated Wound Size 4.2 cm³
 (cm³)
 Change in Wound Size % 49.82
 Wound Size %
 Extent of Tissue Loss Full thickness tissue loss
 Undermining None present
 Tunneling - 12=0.7
 Location and Depth
 Granulation Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
 Tissue
 Epithelialization 0 to <25% wound covered
 Necrotic Tissue None visible
 Type
 Necrotic Tissue None visible
 Amount
 Wound Edges Distinct, outline clearly visible, attached and even with wound base
 Periwound Skin Pink or normal for ethnic group
 Color
 Periwound Skin No swelling or edema
 Edema
 Periwound Skin None present
 Induration
 Exudate Type Serosanguineous: thin watery, pale re/pink
 Exudate Amount Moderate
 Odor None
 Wound Cleansed;Abdominal dressing;Moist to moist
 Management
 Dressing Changed
 Changed
 Dressing Status Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
08/28/25 0807	Wound Management: Use Associated Wounds location; care per specified algorithm/order; Wet, necrotic; Other (Comment Required) (vashe); Prep with skin prep and allow to dry; Other (vashe moistened	Routine, 3 times daily, First occurrence on Thu 8/28/25 at 0807, Until Specified Wound Pressure Injury location; Wound Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Wet, necrotic Cleanse: Other (Comment Required) / vashe Prep: Prep with skin prep and allow to dry	-	Hillary L Sowder, APRN

9/25/25, 2:39 PM

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gauze); ABD; Fill/Apply: Other / vashe
 Tape; Dressing moistened gauze
 no longer intact Cover: ABD
 ... Secure with: Tape
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Ostomy LUQ (Active)

Date First Assessed/Time First Assessed: 07/28/25 1820 Location: LUQ

Assessments 9/1/2025 11:16 AM

Ostomy Color Pink
 Ostomy Viability Moist
 Ostomy Tone Firm
 Ostomy Profile Moderately protruding 1-3cm
 Ostomy Shape Oval
 Mucocutaneous Intact
 Junction
 Peristomal Skin Intact
 Treatment Bag change
 Stomal 1 piece
 Appliance
 Stool Output 100 mL
 (mL)

No associated orders.**Wound Wound/Other Skin tear Arm Left;Lower (Active)**Date First Assessed/Time First Assessed: 08/07/25 1815 Wound Type - REQUIRED: Wound/Other
Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Left;Lower**Assessments** 9/1/2025 11:16 AM

Wound Image



Wound Length (cm) 2 cm

Wound Width (cm) 1 cm

Wound Depth (cm) 0.1

Calculated Wound Size (cm^2) 2 cm^2

Calculated Wound Size (cm^3) 0.2 cm^3

Extent of Tissue Loss Partial thickness tissue loss

Undermining None present

Granulation Tissue No granulation tissue present

9/25/25, 2:39 PM

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Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type	
Necrotic Tissue	None visible
Amount	
Other Wound	Dermis/Pink Tissue
Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Barrier Film;Cleansed;Absorbent clear
Management	
Dressing	Changed
Changed	
Dressing Status	Clean;Dry;Intact

Active Orders Date	Order	Order Summary	Order Comments	Authorizing Provider
09/01/25 1136	Wound Management: Use Associated Wounds location; Wound care per specified algorithm/order; Skin tear; Normal Saline; Prep with skin prep and allow to dry; Absorbent clear acrylic dressing (21 days); Dressing no longer intact (i.e. lifting, leaking, ...)	Routine, Every 21 days, First occurrence on Tue 9/2/25 at 1000, Until Specified Wound Wound/Other Skin tear Hand/dorsal Left Wound Wound/Other Skin tear Arm Anterior;Lower;Proximal;Right Wound Wound/Other Skin tear Arm Left;Lower Wound Location: Use Associated Wounds location Wound Management: Wound care per specified algorithm/order Type: Skin tear Cleanse: Normal Saline Prep: Prep with skin prep and allow to dry Fill/Cover: Absorbent clear acrylic dressing (21 days) Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated	-	Hillary L Sowder, APRN

Wound Pressure Injury Gluteal/Gluteus Right (Active)

Date First Assessed/Time First Assessed: 07/28/25 2123 Wound Type - REQUIRED: Pressure Injury
 Pre-Existing Wound: Yes Anatomical Site: Gluteal/Gluteus Wound Location Orientation: Right Wound Description (Comments): No longer communicates with co...

9/25/25, 2:39 PM

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Assessments 9/1/2025 11:16 AM

Wound Image



Stage	Unstageable, necrotic tissue (slough/eschar)
Wound Length (cm)	4 cm
Wound Width (cm)	1.8 cm
Wound Depth (cm)	1.1
Calculated Wound Size (cm ²)	7.2 cm ²
Calculated Wound Size (cm ³)	7.92 cm ³
Change in Wound Size %	53.68
Extent of Tissue Loss	Full thickness tissue loss
Undermining	None present
Granulation Tissue	Bright, beefy red. 75 to 100 % of wound filled and/or tissue overgrowth
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	Slough: white/gray non-viable and/or non-adherent yellow
Necrotic Tissue Amount	<25% wound bed covered
Other Wound Bed Characteristics	Dermis/Pink Tissue
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin Color	Pink or normal for ethnic group
Periwound Skin Edema	No swelling or edema
Induration	None present
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Moderate
Odor	None
Wound Management	Barrier Film;Cleansed;Abdominal dressing;Medical grade honey;Moist to moist
Dressing Changed	Changed
Dressing Status	Clean;Dry;Intact

Active Orders

Date	Order	Order Summary	Order Comments	Authorizing Provider
08/27/25 1642	Wound Management: Use Associated Wounds location; Wound care per specified	Routine, 3 times daily, First occurrence on Wed 8/27/25 at 1800, Until Specified Wound Pressure Injury Coccyx Wound Pressure Injury Gluteal/Gluteus Right	-	Hillary L Sowder, APRN

9/25/25, 2:39 PM

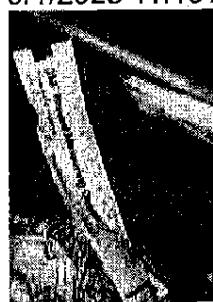
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algorithm/order;
 Wet, necrotic; Wound Location: Use
 Other (Comment Associated Wounds location
 Required) Wound Management:
 (vashe); Prep Wound care per specified
 with skin prep algorithm/order
 and allow to dry; Type: Wet, necrotic
 Medical grade Cleanse: Other (Comment
 honey (nickel Required) / vashe
 thickness) Prep: Prep with skin prep
 (vashe) and allow to dry
 moistened Fill/Apply: Medical grade
 gauze), Othe... honey (nickel thickness) /
 vashe moistened gauze,
 Other
 Cover: ABD
 Secure with: Tape
 Change/PRN: Dressing no
 longer intact (i.e. lifting,
 leaking, damaged),
 Dressing damp, moist or
 saturated

Wound Wound/Other Skin tear Arm Anterior;Lower;Proximal;Right (Active)

Date First Assessed/Time First Assessed: 09/01/25 11:30 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: Skin tear Anatomical Site: Arm Wound Location Orientation: Anterior;Lower;Proximal;Right

Assessments 9/1/2025 11:16 AM
Wound Image



Wound Length (cm)	1 cm
Wound Width (cm)	0.5 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm^2)	0.5 cm^2
Calculated Wound Size (cm^3)	0.05 cm^3
Extent of Tissue Loss	Partial thickness tissue loss
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue Type	None visible
Necrotic Tissue Amount	None visible
Other Wound	Dermis/Pink Tissue

9/25/25, 2:39 PM

King, Robert D (MRN 8680) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Bed	
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Cleansed; Barrier Film; Absorbent clear
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders**Date****Order****Order Summary****Order Comments****Authorizing Provider**Hillary L
Sowder, APRN

09/01/25 1136 Wound Management: Routine, Every 21 days, First occurrence on Tue 9/25 at 1000, Until Specified
 Use Associated Wounds location; Wound care per specified algorithm/order; Skin tear; Normal Saline; Prep with skin prep and allow to dry; Absorbent clear acrylic dressing (21 days); Dressing no longer intact (i.e. lifting, leaking, ...)

Wound Location: Use Associated Wounds location
 Wound Management: Wound care per specified algorithm/order
 Type: Skin tear
 Cleanse: Normal Saline
 Prep: Prep with skin prep and allow to dry
 Fill/Cover: Absorbent clear acrylic dressing (21 days)
 Change/PRN: Dressing no longer intact (i.e. lifting, leaking, damaged), Dressing damp, moist or saturated

Wound Wound/Other Skin tear Hand/dorsal Left (Active)

Date First Assessed/Time First Assessed: 09/01/25 1130 Wound Type - REQUIRED: Wound/Other Pre-Existing Wound: No Wound Type: Skin tear Anatomical Site: Hand/dorsal Wound Location Orientation: Left

Assessments 9/1/2025 11:16 AM

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Wound Image



Wound Length (cm)	5.5 cm
Wound Width (cm)	7 cm
Wound Depth (cm)	0.1
Calculated Wound Size (cm ²)	38.5 cm ²
Calculated Wound Size (cm ³)	3.85 cm ³
Extent of Tissue Loss	Partial thickness tissue loss
Undermining	None present
Granulation Tissue	No granulation tissue present
Epithelialization	0 to <25% wound covered
Necrotic Tissue	None visible
Type	
Necrotic Tissue	None visible
Amount	
Other Wound Bed	Dermis/Pink Tissue
Characteristics	
Wound Edges	Distinct, outline clearly visible, attached and even with wound base
Periwound Skin	Pink or normal for ethnic group
Color	
Periwound Skin	No swelling or edema
Edema	
Periwound Skin	None present
Induration	
Exudate Type	Serosanguineous: thin watery, pale re/pink
Exudate Amount	Scant, wound moist but no observable exudate
Odor	None
Wound	Absorbent clear; Barrier Film; Cleansed
Management	
Dressing	Changed
Changed	
Dressing Status	Clean; Dry; Intact

Active Orders

Date

Order

Order Summary

Order Comments

Authorizing
Provider

09/01/25 1136

Wound

Routine, Every 21 days,

-

Hillary L
Sowder, APRN

Management:

First occurrence on Tue

Use Associated

9/2/25 at 1000, Until

Wounds

Specified

location; Wound

Wound Wound/Other Skin

care per

tear Hand/dorsal Left

specified

Wound Wound/Other Skin

algorithm/order;

tear Arm

9/25/25, 2:39 PM

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Skin tear; Anterior;Lower;Proximal;Rig
Normal Saline; ht
Prep with skin Wound Wound/Other Skin
prep and allow tear Arm Left;Lower
to dry;
Absorbent clear Wound Location: Use
acrylic dressing Associated Wounds location
(21 days); Wound Management:
Dressing no Wound care per specified
longer intact (i.e. algorithm/order
lifting, leakin... Type: Skin tear
Cleanse: Normal Saline
Prep: Prep with skin prep
and allow to dry
Fill/Cover: Absorbent clear
acrylic dressing (21 days)
Change/PRN: Dressing no
longer intact (i.e. lifting,
leaking, damaged),
Dressing damp, moist or
saturated

Recommendations: Perineum wound is still draining thick brown purulent drainage. Recommend to continue wet to dry dressing T1D for drainage control. Recommend endoform to left lateral and posterior leg.

Signature: LONG, MAHALEY G., RN

Date: 9/1/2025

Time: 11:36 AM EDT

MRN: 8580

King, Robert D

Mahaley G. Long, RN
Registered Nurse

Wound Progress Note 
Signed

Date of Service: 9/2/2025 1:47 PM

Wound Progress Note

Dr Tran at bedside to assess wound with drainage. Dr Tran states the it is mucous and that is it fine to continue with wound care. Son at bedside as well.

Signature: LONG, MAHALEY G., RN

Date: 9/2/2025

Time: 1:47 PM EDT

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

MRN: 8580

King, Robert D

Waddah Yaacoubagha, MD
Physician
Internal Medicine

H&P Signed

Date of Service: 7/28/2025 6:03 PM

Patient Name: Robert D King

MRN: 8580

DOB: 6/14/1952

DOS: 7/28/2025

Attending: Waddah Yaacoubagha, MD

Primary Care Provider: No primary care provider on file.

Chief complaint: Osteomyelitis, Acute respiratory failure. Status post tracheostomy/PEG

History of present illness patient is a 73-year-old male with history of paraplegia, congestive heart failure, coronary artery disease with 2 stents his trach, obstructive sleep apnea.

Paraplegic since December last year. At that time he had group B strep cervical abscess, had cervical laminectomy and evacuation of abscess. Has been living at a nursing home. In April he had debridement and diverting loop colostomy by Dr. Shane due to sacral ulcer and osteomyelitis.

He was admitted with sacral pressure ulcer with necrotizing soft tissue infection. And was transferred to University of Louisville H for surgical expertise.

CT scan showed subcutaneous emphysema. He has an indwelling Foley catheter and was thought to have a UTI at that time.

He underwent sacral wound debridement, in the OR (with subsequent bedside debridement) he was noted to have suspected mucus plugging on chest x-ray and went for elective bronchoscopy but had recurrent plugging resulting in Respiratory code requiring CPR and intubation. Due to difficulty weaning he underwent tracheostomy and PEG tube placement and was started on some weaning. He has been tolerating tube feeds via his bag. Having bowel function via his stoma.

He was followed by Infectious Disease team due to sacral osteomyelitis and is recommended for 6 weeks of total therapy to finish on 08/21/2025, currently on vancomycin cefepime and metronidazole.

Allergies:

No Known Allergies

Meds:

Mucomyst, aspirin, Lipitor, cefepime, Lovenox, Robitussin, hydralazine, regular insulin sliding scale, DuoNebs, Flagyl, Protonix, MiraLax, vancomycin PRNs including hypoglycemia protocol, Tylenol, Atarax, midodrine, Zofran, and oxycodone.

Past Medical History:

Diagnosis

- Diabetes mellitus
- Epidural abscess
- Gastroesophageal reflux disease
- Hypertension
- Osteomyelitis of sacrum

Date

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

- Anemia
- Anxiety
- Arthritis
- Charcot's joint of foot, left
- CHF (congestive heart failure)
- Coronary artery disease
- Depression
- Diabetes
- GI bleed
- History of stomach ulcers
- Hyperlipidemia
- Measles
- MRSA (methicillin)

Past Surgical History:

Procedure	Laterality	Date
• BRONCHOSCOPY		07/14/2025
• CERVICAL LAMINECTOMY		2020
• COLOSTOMY		04/2025
• PEG TUBE PLACEMENT		07/24/2025
• TRACHEOSTOMY		07/24/2025
• WOUND DEBRIDEMENT		07/11/2025
Procedure	Laterality	Date
• CARDIAC CATHETERIZATION	N/A	07/29/2022 4
<i>Procedure: Left Heart Cath; Surgeon: Richmond, Henry Charles T IV, MD; Location: BH LEX CATH INVASIVE LOCATION; Service: Cardiovascular; Laterality: N/A;</i>		
• CARDIAC CATHETERIZATION	N/A	08/22/2022 4
<i>Procedure: Stent DES coronary; Surgeon: Richmond, Henry Charles T IV, MD; Location: BH LEX CATH INVASIVE LOCATION; Service: Cardiovascular; Laterality: N/A;</i>		
• CARDIAC CATHETERIZATION	N/A	08/22/2022 4
<i>Procedure: Optical Coherence Tomography; Surgeon: Richmond, Henry Charles T IV, MD; Location: BH LEX CATH INVASIVE LOCATION; Service: Cardiovascular; Laterality: N/A;</i>		
• CERVICAL LAMINECTOMY	N/A	12/29/2022 4
<i>Procedure: POSTERIOR CERVICAL DECOMPRESSION LAMINECTOMY FOR ABSCESS; Surgeon: Villelli, Nicolas, MD; Location: BH LEX OR; Service: Neurosurgery; Laterality: N/A;</i>		
• COLONOSCOPY <i>with polyps removed</i>	N/A	1/23/2025
• COLONOSCOPY		Procedure: COLONOSCOPY; Surgeon: Brown, John A, MD; Location: BH LEX ENDOSCOPY; Service: Gastroenterology; Laterality: N/A;
• CRANIOTOMY		2020
• GALLBLADDER SURGERY		
• INTERVENTIONAL RADIOLOGY PROCEDURE	N/A	1/20/2025
<i>Procedure: Coil Embolization - GI; Surgeon: Given, Curtis A, MD; Location: BH LEX CATH INVASIVE LOCATION; Service: Interventional Radiology; Laterality: N/A;</i>		
• INTERVENTIONAL RADIOLOGY PROCEDURE	N/A	1/22/2025
<i>Procedure: Interventional Radiology Procedure; Surgeon: Given, Curtis</i>		

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

- A, MD; Location: BH LEX CATH INVASIVE LOCATION; Service: Interventional Radiology; Laterality: N/A;
- OTHER SURGICAL HISTORY Right
Arm due to MRSA Infection
 - TEETH EXTRACTION 1982
 - TOE AMPUTATION Left
Great Toe
 - TRANS METATARSAL AMPUTATION Left 1/10/2025
Procedure: FIRST RAY AMPUTATION LEFT; Surgeon: Hamilton, David A Jr., MD; Location: BH LEX OR; Service: Orthopedics; Laterality: Left;
 - WISDOM TOOTH EXTRACTION

Review of Systems

Limited by patient's condition and mechanical ventilation via trach.

Vital Signs

Ht 6' 3" (1.905 m) | Wt 270 lb 9.1 oz (122.7 kg) | BMI 33.82 kg/m²

Physical Exam

Constitutional:

General: He is not in acute distress.

Appearance: He is obese. He is ill-appearing. He is not toxic-appearing.

HENT:

Head: Normocephalic.

Nose: Nose normal.

Mouth/Throat:

Mouth: Mucous membranes are moist.

Eyes:

Conjunctiva/sclera: Conjunctivae normal.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Heart sounds: Normal heart sounds.

Pulmonary:

Effort: No respiratory distress.

Breath sounds: No stridor. Rhonchi present.

Abdominal:

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness. There is no rebound.

Comments: Peg site with no bleeding or drainage. Stoma present.

Musculoskeletal:

Right lower leg: Edema present.

Left lower leg: Edema present.

Neurological:

Mental Status: He is alert.

Motor: Weakness present.

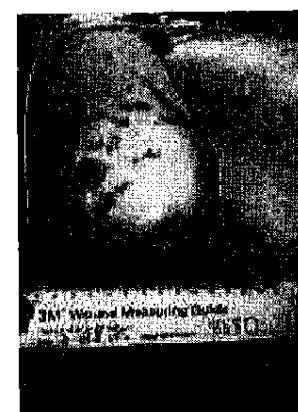
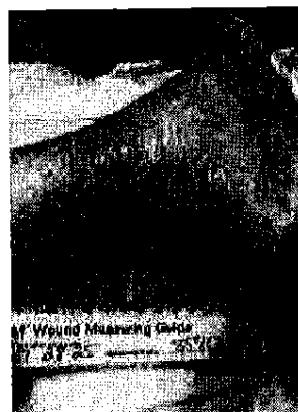
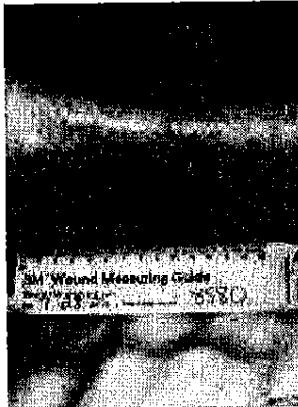
Comments: Quadriplegia

Psychiatric:

Mood and Affect: Mood normal.

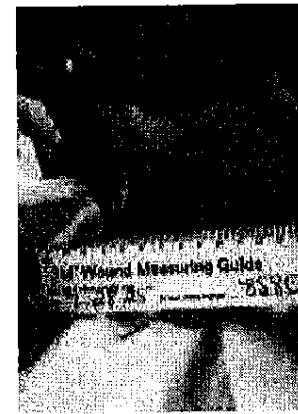
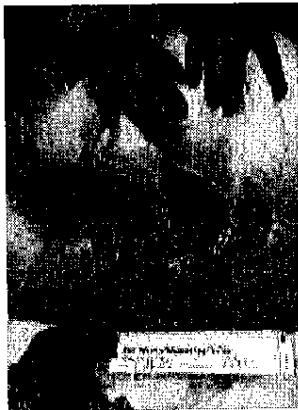
9/25/25, 2:39 PM

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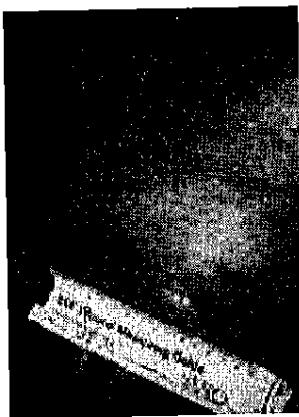
9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM



9/25/25, 2:39 PM

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Skin: Multiple ulcers as noted in admit pictures above.

I reviewed the patient's new clinical results.

Invalid input(s): "LABALBU"

No results found for: "HGBA1C"

Sodium 142 potassium 3.4 chloride 108 bicarb of 28 creatinine 0.29 glucose 204 WBC 7.8 H and H8.1 and 24.6 and platelet count 300k

Assessment and Plan:

Acute respiratory failure, status post tracheostomy

Principal Problem:

Osteomyelitis

Active Problems:

Acute urinary tract infection

Coronary arteriosclerosis

Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

Essential (primary) hypertension

Hyperlipidemia

Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site

Pressure injury of left ankle stage III

Pressure injury of left heel stage III

Pressure injury of sacral region of back stage IV

Severe protein-calorie malnutrition

Necrotizing fasciitis

Cardiac arrest

Plan

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Respiratory failure: Vent support via trach. Pulmonary toilet measures. Weaned from mechanical ventilation as able. Monitor volume status closely. Follow for mucus plugging.

Sacral pressure ulcer, osteomyelitis, multiple ulcers including left heel: Wound care, wound care team consultation. Possibly we will need further debridement enzymatic versus surgical. Antibiotics will be per Infectious Disease team, monitor for adverse drug reactions.

Hypertension: Monitor on current regimen and make adjustments as indicated.

DM 2: Monitor blood glucose on current insulin regimen unchanged as needed for better control.

Nutrition: Tube feeds via PEG. Dietitian will see and follow and give further recommendations.

Coronary artery disease: continue asa/statin/HTN regimen.

1. PT/OT
2. Pain control-prns
3. DVT proph- Mech/lovenox
5. Stoma care.

Guarded to poor long term prognosis.

Dragon disclaimer:

Part of this encounter note is an electronic transcription/translation of spoken language to printed text. The electronic translation of spoken language may permit erroneous, or at times, nonsensical words or phrases to be inadvertently transcribed; Although I have reviewed the note for such errors, some may still exist.

YAACOUBAGHA, WADDAH, MD

07/28/25

6:03 PM EDT

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

MRN: 8580

King, Robert D

Hillary L Sowder, APRN
Nurse Practitioner
Internal Medicine

Progress Notes
Cosign Needed

Date of Service: 9/25/2025 9:29 AM

IM progress note



Robert D King
8580
6/14/1952

LOS: 59 days

Attending: Waddah Yaacoubagha, MD

Subjective

9/1/25: pt rested on trach collar during the day and capped during the dyo on 1 liter. Afebrile. Vital signs stable. Ostomy 500ml, UOP 2400ml

9/2/25: Is seen capped this a.m. on 1 L nasal cannula. Discussed w/ case management about discharge plans, the patient will need cough assist for home per pulmonary's recommendation.

9/3/25: vital signs stable. Po intake yesterday was poor. Son requested to change tube feeds back to continuous and pureed diet as pleasure feeds.

09/04/2025 patient without any event overnight. Denied any new complaint.

9/5/25: the patient is doing well. He continues to tolerate capping during the day, still requiring suctioning. But no new issues.

09/06/2025: Doing well with capped trach during the day, trach collar at night. No new complaints

09/07/2025: Feels okay today with no new issues. Trach is capped when seen.

9/8/25: the patient is doing well. Had no event over night. Trach capped this am. Schedule to speak w/ patient's PCP today around 11:00.

9/9/25: discussed w/ wound RN concerned about the patient' sacral wound has necrotic tissue, not healing. The wound below the rectum continues to have significant drainage. Had to remove wound vac yesterday, change to wet-to-dry. Unfortunately, the patient doesn't have PCP now, CM has reached to PCP in pt's area w/ not successful so far.

9/10/25: had long discussion w/ patient and son yesterday, who was at bedside. Talked about possibly home w/ hospice vs another wound debridement. Explained to patient his sacral wound is worse, and it's unlikely it will ever heal. Patient is deciding between hospice vs another wound debridement.
(Resistant to turning or getting out of bed per rehab services)wy

9/11/25: Case management was able to find a PCP for patient. Was not able to discuss with patient's son yesterday about discharge planning. Will try to talk to him today.

9/12/25: the patient is scheduled for wound debridement today. Was on trach collar last night, and was

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

capped early this am. He is currently NPO for procedure.

09/13/2025 patient had no event overnight. Status post debridement yesterday. No bleeding. Denied increased shortness of air.

09/14/2025 patient without any event overnight. Doing pretty good. No shortness a of air. According to the patient had to be suctioned at 4:00 a.m. this morning but otherwise doing well. Currently tolerating tracheal capping. He is on room air.

9/15/25: febrile yesterday, tmax 100.4. no further fevers noted. This am temp 99.1. HR 88, BP 118/66. No new issues. Continues to tolerate trach capping during the day. Ostomy 750ml.

9/16/25: noted blood glucose has improved since the dietician changed patient back to Glucerna. While on Jevity pt had uncontrolled blood glucose. The patient states his pain has been manageable over the weekend on hydrocodone.

9/17/25: found out yesterday by CM, unfortunately the potentially PCP that was concerning taking the pt, has declined due to pain medications. Cardinal health doesn't prescribe ay narcotics. CM and myself called son (steve) to discuss. Patient seen this am , explained to him that he will be getting unit of blood.

9/18/25: Wound RN discussed with myself yesterday concern of patient's sacral wound worse. He now has a fever, T-max a 100.8° and WBCs have increased. Unfortunately wound VAC is failing. He is at a high risk for requiring another wound debridement. Plan on discussing goals of care with patient and his son today.

9/19/25: had long discussion with patient and his son at bed side, per pt's son he has reached out to baptist health, VNA health about poss palliative care for home. CM and pt's son have exhausted all efforts to secure PCP, but no PCP who can complete telehealth will prescribe narcotics. The patient stated he can go without his pain meds, he takes it at night to help him sleep. Added melatonin and prn trazodone. The patient didn't request PRN oxycodone or trazodone, stated he slept well after RN repositioned him.

09/20/25:

Doing well. No new complaints. Eating some. Trach is capped during the day with no difficulties.

09/21/2025:

Feels okay. Was asleep but awakens easily. Has no new complaints. Trach cap is on.

9/22/25: afebrile. Ostomy output 800ml. Capped trach. He had no event over night.

9/23/25: patient's pain is ok, has not requested for ant PRN oxycodone. Patient rested in trach collar during the night. RT capped trach this am, he's on 1 liter NC. Discussed w/ Wound RN this am, she had to remove wound vac on Friday due to drainage from wound, wound vac not staying inplace

9/24/25: the patient remains on capped trach during the night, and uncapped at night. Still not requiring any pain medications.

Review of Systems

Constitutional: Negative for chills and fever.

Respiratory: Negative. Tolerating TC, capping during the day

Cardiovascular: Positive for leg swelling. - **chronic**

Gastrointestinal: Negative for abdominal distention, abdominal pain and vomiting.

Colostomy

Musculoskeletal:

Paraplegia

Skin: Positive for wound.

Neurological: Negative for tremors and seizures.

Psychiatric/Behavioral: Negative for agitation and confusion.

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Vital Signs**Vitals:**

	09/25/25 0400	09/25/25 0421	09/25/25 0600	09/25/25 0750
BP:	(I) 153/84			
Pulse:	68	81	77	
Resp:		20	20	
Temp:	98.7 °F (37.1 °C)			
TempSrc:	Oral	Oral		
SpO2:	100%	100%	100%	
Weight:				
Height:				
PF:				

Temp (24hrs), Avg:98.2 °F (36.8 °C), Min:97.5 °F (36.4 °C), Max:98.7 °F (37.1 °C)

Intake/Output:

Intake/Output Summary (Last 24 hours) at 9/25/2025 0946

Last data filed at 9/25/2025 0745

Gross per 24 hour

Intake	1324.17 ml
Output	1650 ml
Net	-325.83 ml

Nutrition:**Diet Orders**

(From admission, onward)

Start	Ordered	
09/15/25 1359	Glucerna 1.5; Tube Feeding Continuous rate (mL/hr): 70; Tube Feeding water flush (mL): 10; Water Flush type: Water; Water flush frequency: Every hour; Water Flush Method: Automatic Diet effective now End/Expires: Until Specified	09/15/25 1358
	Question Answer Comment	
	Tube Feeding Glucerna 1.5	
	Formula:	
	Tube Feeding 70	
	Continuous rate	
	(mL/hr):	
	Tube Feeding water 10	
	flush (mL):	
	Water Flush type:	Water
	Water flush	Every hour
	frequency:	
	Water Flush Method:	Automatic
	Place order in third	Done
	party system.	FLOOR STOCK
09/15/25 1110	Adult Diet Therapeutic Diet; Carb Controlled, 2 g Potassium Restriction; 4 Carb/60gm/meal; 4 Pureed (NDD I); 2 Mildly Thick (Nectar) Diet effective now End/Expires: Until Specified	09/15/25 1110

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Question	Answer	Comment
Diet Type:	Therapeutic Diet	
Therapeutic Diet:	Carb Controlled	
Therapeutic Diet:	2 g Potassium Restriction	
Carbohydrate Controlled:	4 Carb/60gm/meal	
Diet Texture:	4 Pureed (NDD I)	
Liquid Consistency:	2 Mildly Thick (Nectar)	
Place order in third party system.	Done	PME

Respiratory:

FiO2 (%): [24 %-28 %] 24 %

Physical Exam:General appearance: alert, appears stated age, cooperative, and no distress. **Morbidly obese**

Head: Normocephalic, without obvious abnormality, atraumatic

Neck: supple, no JVD, no LAP. Trach site is clean, **Tracheostomy is capped**Lungs: **Mild scattered rhonchi**, good respiratory effort

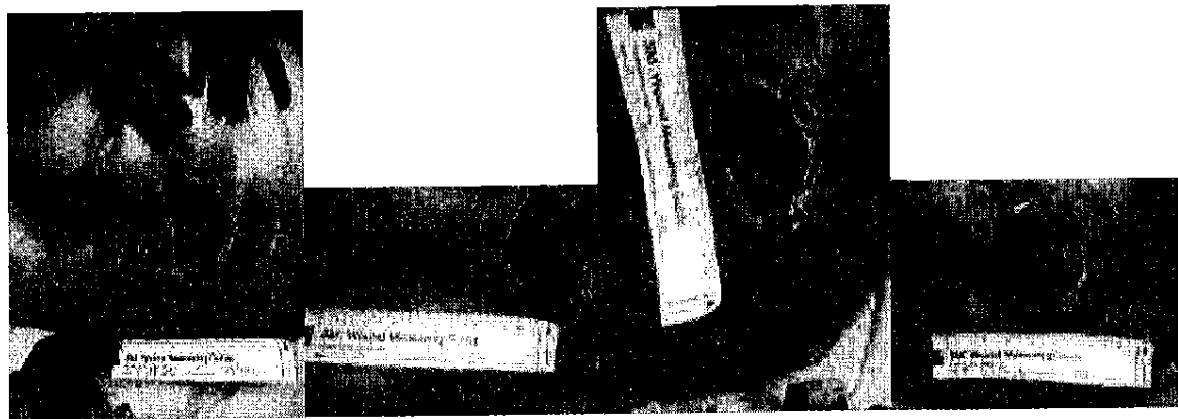
Heart: regular rate and rhythm, S1, S2 normal

Abdomen: soft, non-tender; bowel sounds normal; no masses, no organomegaly. **Peg tube and colostomy**Extremities: extremities normal, atraumatic. **1+ pitting edema- chronic.**

Pulses: 2+ and symmetric

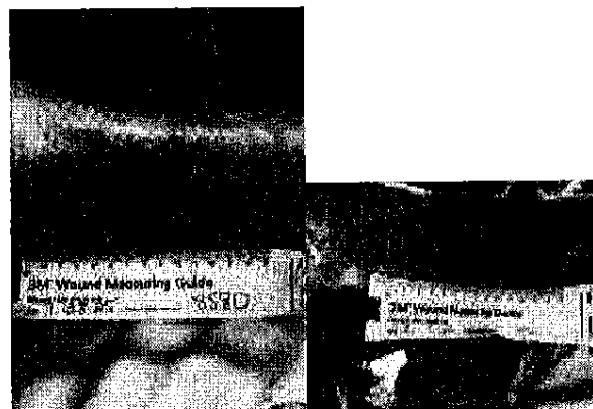
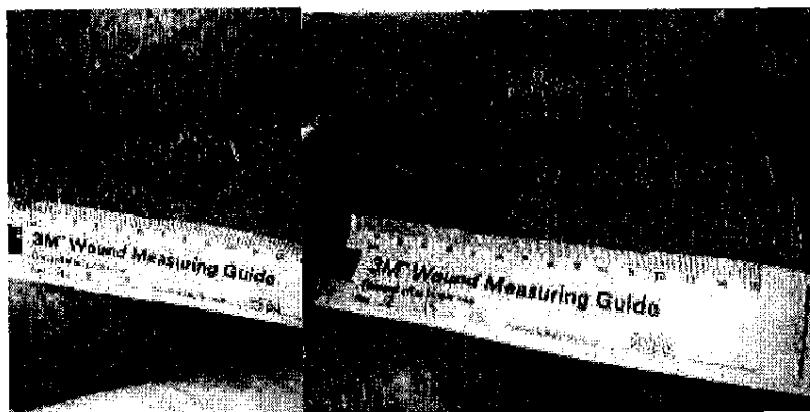
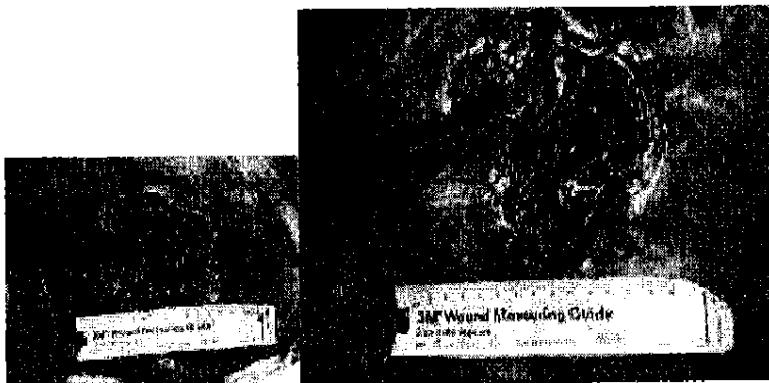
Skin: **Decubitus ulcer w/ necrotic tissue. Tunneled wound just below the rectum w/ drainage**

Neurologic: At baseline, alert and oriented x4.



9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

**Recent Labs**

Lab	Units	09/24/25	09/19/25	09/18/25
		0434	0524	1431
WBC	10 ³ /uL	11.93*	15.35*	16-30*

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

HEMOGLOBIN	g/dL	7.4*	7.7*	--
HEMATOCRIT	%	24.3*	24.6*	--

Recent Labs

Lab	Units	09/24/25 0434	09/21/25 0816	09/19/25 0524
SODIUM	mEq/L	135*	--	136
POTASSIUM	mEq/L	5.0	5.0	5.3*
CO2	mEq/L	28	--	27
BUN	mg/dL	34*	--	39*
CREATININE	mg/dL	0.4*	--	0.5*
CALCIUM MG/DL BLOOD	mg/dL	8.2*	--	8.1*

Lab Results

Component	Value	Date
MAGNESIUM	1.9	09/04/2025
MAGNESIUM	1.7 (L)	08/31/2025
MAGNESIUM	1.8 (L)	08/18/2025
MAGNESIUM	1.7	08/08/2025

Scheduled/Continuous Medications**Scheduled**

aspirin chewable tablet 81 mg
 81 mg, PO, Once a day
atorvastatin (LIPITOR) tablet 40 mg
 40 mg, PO, Nightly
collagenase ointment
 No Dose/Rate, TOP, Once a day
DAPTOmycin (CUBICIN) 500 mg in sodium chloride 0.9% IVPB
 4 mg/kg, IV, Once a day
Diclofenac Sodium (VOLTAREN) 1 % gel 2 g
 2 g, TOP, 4x Daily
enoxaparin (LOVENOX) syringe 40 mg
 40 mg, SC, Once a day
ferrous sulfate 300 (60 Fe) MG/5ML syrup 300 mg
 300 mg, Tube, BID
fluticasone (FLONASE) 50 MCG/ACT nasal solution 100 mcg
 2 spray, EACH nostril, Once a day
hydrALAZINE (APRESOLINE) tablet 50 mg
 50 mg, Tube, Q6H SCH
insulin regular (HumuLIN R) injection 0-12 Units (And Linked Group #1)
 0-12 Units, SC, Q6H SCH
Iosartan (COZAAR) tablet 25 mg
 25 mg, Tube, Once a day
magnesium gluconate (MAGONATE) tablet 500 mg
 27 mg of magnesium, PO, BID
melatonin tablet 3 mg
 3 mg, Tube, Nightly
meropenem (MERREM) 1 g in sodium chloride 0.9% 100 mL IVPB-MBP
 1 g, IV, Q8H SCH
pantoprazole (PROTONIX) IV 40 mg
 40 mg, IV, Once a day
polyethylene glycol (MIRALAX) packet 17 g

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

17 g, PO, Once a day
spironolactone (ALDACTONE) tablet 25 mg
25 mg, Tube, Once a day

Continuous Infusions:

PRN Meds.:• glucose **OR** juice or non-diet carbonated beverage

- acetaminophen
- dextrose **OR** dextrose
- glucagon
- hydroxyzine
- ipratropium-albuterol
- midodrine
- ondansetron
- oxyCODONE
- traZODone

ASSESSMENT:**Principal Problem:**

Acute respiratory failure

Active Problems:

Acute urinary tract infection

Coronary arteriosclerosis

Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

Essential (primary) hypertension

Hyperlipidemia

Klebsiella pneumoniae infection in conditions classified elsewhere and of unspecified site

Pressure injury of left ankle stage III

Pressure injury of left heel stage III

Pressure injury of sacral region of back stage IV

Severe protein-calorie malnutrition

Osteomyelitis

Necrotizing fasciitis

Cardiac arrest

Plan:**Leukocytosis, persistent****UTI**

Remains afebrile

UA leuko 250, WBC >30, bacteria trace - urine culture was not completed

Leukocytosis trending down, unfortunately WBCs have increased to 16 K and patient is now afebrile

- s/p cefepime

UA 9/18- leuko 75, WBC 16-30, bacteria none observed. Cx prelim no growth

CXR- mild right lower lobe interstitial opacities at the lung base, likely atelectasis

- continue Merrem and Daptomycin for worsening wound, plan to transition to PO abx next week

Anemia**Iron deficiency**

S/p transfusion on 09/17, 9/24

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Iron 14, iron % 10, TIBC 140- will give IV iron x4 doses, cleared by Infectious Disease- now that patient is afebrile and white count is increase will hold on further IV iron p.o. supplement iron b.i.d.

Tunneled wound

Previous wound Dr. Tran sutured has opened back up- recommend cont packing we-to-dry dressing, no surgical intervention.

Wound RN managing

Ct abd/pelvis w/ IV/oral contrast to eval for fistula- showed no fistula or abscess

Hyperkalemia, recurrent

Monitor and treat as indicated.

Tube feeds have been changed. Lokelma p.r.n..

Aldactone on hold

Acute respiratory failure- chronic

Pulmonary following

Downsized to 6 cuffless, tolerated.

Sch duoneb, cough assist per family request

Pulmonary toilet.

Failed ready pathway, CXR Small bilateral pleural effusions and bilateral airspace opacities are unchanged Cont CATC w/ PMV- resumed ready pathway (initiated on 8/25)- stopped failed again d/t secretions.

Capping daily. Uncap at night.

incentive spirometry and flutter valve

Third-degree heart block

Continue to monitor on telemetry

Metoprolol discontinued

Need follow-up with Cardiology after discharge to evaluate for pacemaker

No issue reported since beta-blocker has been discontinued

Volume overload, stable.

Monitor fluid status, electrolytes and renal function

Aldactone 100 mg daily

Daily assessment of Bumex

Hypernatremia, improved

Now with hyponatremia, will decrease free water to 50 mL/hours and continue to monitor.

Coronary arteriosclerosis

Continue aspirin and Lipitor (monitor LFT levels)

Diabetes mellitus

Continue sliding scale, will monitor for hypoglycemia.

switched back to Glucerna. Blood glucose has improved

Continue to monitor insulin dosing and adjust if needed

Essential (primary) hypertension

Discontinue metoprolol due to heart block.

Losartan 25 mg daily and monitor potassium and renal function

Hydralazine 50 mg q.6

Hyperlipidemia

9/25/25, 2:39 PM

King, Robert D (MRN 8580) Printed by Denise Brown, SW [A2317696] at 9/25/2025 2:39 PM

Continue Lipitor (monitor LFT levels)

Pressure injury of left ankle stage III
Pressure injury of left heel stage III
Pressure injury of sacral region, worse
S/p sacral wound debridement
- Wound management
S/p wound debridement 7/31
S/p wound debridement 9/12

Osteomyelitis of sacrum**Necrotizing fasciitis**

Based on cultures from wound debridement recommended 6 weeks total of IV antibiotics- completed ID following
-s/p vancomycin, cefepime and Flagyl ended 8/21
Wound is not healing, new necrotic areas- **s/p debridement 9/12**

S/p Cardiopulmonary arrest d/t mucus plugs

Continue guaifenesin, pulmonary toilet measures, suction as needed.

Cont duonebs w/ Cough assist

Stable and improving

History of paraplegia d/t fall

PT/OT following

Dysphagia**Malnutrition**

Continue nutritional support via PEG tube

Speech and dietitian following

Passed FEE's- pureed diet for pleasure, cont tube feeds to meet caloric needs

Order CBC and BMP for am

Discharge planning remains ongoing-case manager is following. Working on discharge barriers. CM will reach out to Mcgarth wound care and PCP, since pt has not required any PRN pain medications

Scribed for Dr. Yaacoubagha by SOWDER, HILLARY L, APRN. 9/25/2025 9:46 AM EDT

History and exam and above plan exclusively by Dr. Yaacoubagha

I, Waddah Yaacoubagha MD, personally performed the services described in this documentation as scribed by Hillary Sowder, APRN ,and it is both accurate and complete.

Ephraim McDowell Regional Med Center
217 South Third Street
Danville, KY 40422
(859) 239-1000

Patient: Number	DOB:	Location:	Med. Rec.
KING,ROBERT D	06/14/1952	EOR	E000357161

Date of Admission:

KING, ROBERT D BED: 401-A
 DOB: 06/14/1952 AGE: 73 y.o. SEX: M
 ADMIIT: 7/28/2025 EMPI: 2553753
 ATT: Waddah Yancoubagha, MD HSV: V
 MRN: 8580 ACCT #: 1009484

PCM OPERATIVE REPORT

OPERATIVE REPORT

DATE OF SURGERY

9/12/25

SURGEON

Tran MD, Tin

PREOPERATIVE DIAGNOSIS

Stage IV decubitus ulceration

Multiple medical problems with bedridden respiratory failure

Status post colostomy

POSTOPERATIVE DIAGNOSIS

The same

PROCEDURE PERFORMED

Sacral decubitus sharp debridement with osteotomy in preparation for closure

Findings

10 x 15 x 10 cm deep ulceration with necrotic tissue skin subcutaneous and coccyx bone

SPECIMEN

Coccyx bone specimen

INDICATION FOR PROCEDURE

Necrotic tissue in the sacral area

COMPLICATIONS

No complication

ANESTHESIA

General

ESTIMATED BLOOD LOSS

50ml

DESCRIPTION OF PROCEDURE

Risks and benefits of procedure were explained to the patient in detail including not limited to bleeding infection nonhealing incision. Informed medical consent was signed by the patient. Patient with took to the OR timeout performed properly received physician without complication. Patient under general right side up left side. Very large sacral tissue defect 10 x 10 x 15 cm multiple necrotic tissue involve the skin subcutaneous tissue muscle fascia and coccyx bone. Patient has gastrectomy before with bone exposure but some infection at the bone level. #15 scalpel and #10 scalpel was used to remove all dead necrotic tissue involving skin and subcutaneous tissue. Partial necrotic bone were removed send no hematolgy to rule out osteomyelitis. The wound irrigated on this foul-smelling wound gone. Wound packed with Betadine and dressing were applied. The patient tolerated well procedure no immediate complication transferred to PACU in stable condition

TRAN,TIN C MD

Sep 12, 2025 11:01

<Electronically signed by TIN C TRAN MD>

Dictation Date/Time: 09/12/25 1101

Page:1

Operative Record (EMRMC)

TIN C TRAN MD

09/15/25 1326

KING, ROBERT D BED: 401-A
DOB: 06/14/1952 AGE: 73 y.o. SEX: M
ADMIT: 7/28/2025 EMPL: 2553753
ATT: Weddah Ymacoubaigha, MD HISV: V
MRN: 8580 ACCT #: 1009184

Dictation Date/Time: 09/12/25 1101
Page:2

Operative Record (EMRMC)



M00007264886

DOS: 07/31/25

DOB: 06/14/1952

AGE: 73

KING,ROBERT D

SEX: M

OT

Authorization: Operative and Other ProceduresProcedure Debridement of carpal Debriditus

1. I authorize Tran and his/her assistant(s) none
 (Provider's name and credentials doing procedure) (Medical Assistant)
- to perform upon + Debridement the following procedure:
 (Patient)
 (have patient state in his/her own words the nature of the procedure)

I have had explained to me the nature, purpose, and goals of the procedure, the likelihood of achieving those goals, any possible alternative methods of treatment, the risks involved - both in undergoing and in deciding not to undergo the proposed treatment or procedure, and the possibility of complications with any of the above situations. I acknowledge that no guarantee has been made as to the results that may be obtained.

If any unexpected condition arises during the procedure, which in my physician's judgment, requires a different or additional procedure, including the administration of blood or blood products, I further request the physician to do whatever he/she considers necessary or advisable. Yes No If no, list exception:

2. I consent to the administration of such anesthetics as may be considered necessary or advisable by the anesthesiologist or CRNA.
3. I consent to the disposal of any tissue or body parts by the hospital authorities.
4. I do I do not N/A consent to the making or use of photography, recordings, films, or other images of the operation or procedure for medical, scientific, or educational purposes.

The risks and benefits have been explained to me and I have had the opportunity to ask questions. I certify that I understand the above consent and that all blanks were completed before signing my name.

Signature S. J. S. POA Date 7/31/25 Time 1050
 (patient, legal guardian, or power of attorney)

Witness signature R. P. S. Date 7/31/25 Time 1050

Witness signature _____ Date _____ Time _____
 (2 signatures required for phone consent or "X" signature)

I certify that I have fully explained to the patient, and believe the patient (or legal guardian or power of attorney) understands the nature and purpose of the procedure, alternate methods of treatment, and the risks involved.

Provider signature S. J. S. Date 7/31/25 Time 1050
 (provider signature required prior to onset of procedure)

CONSENT #4072 (3.25)



KING, ROBERT D BED: 401-A
 DOB: 06/14/1952 AGE: 73 y.o. SEX: M
 ADMIT: 7/28/2025 EMPI: 2553753
 ATT: Waddah Yalcoubaglu, MD HSV: V
 MRN: 8580 ACCT #: 1009484

Ephraim McDowell Regional Med Center
217 South Third Street
Danville, KY 40422
(859) 239-1000

Patient Number	DOB:	Location:	Med. Rec.
KING,ROBERT D	06/14/1952	EOR	E000357161

Date of Admission:

PREANESTHESIA EVAL

GENERAL

Assessment Date: Jul 31, 2025

Assessment Time: 12:30

NPO Since MN: Yes

ASA Physical Status

4

Proposed Procedure

Sacral Wound Debridement

Allergies:

Coded Allergies:

No Known Allergies (Unverified, 7/30/25)

Home Meds

Reported Medications

[vancomycin ivpb] No Conflict Check, 750 MG IVPB DAILY

7/30/25

Potassium Bicarbonate/Cit Ac (Effer-K 20 Meq Tablet Eff) 20 Meq Tablet.eff, 2 TAB PO DAILY for 30 Days, TAB 0 Refills

7/30/25

Polyethylene Glycol 3350 (Miralax) 17 Gram Powd.pack, 1 PACKET PO DAILY for constipation for 2 Days, PACKET 0 Refills

dissolve in water

7/30/25

Pantoprazole Sodium (Pantoprazole Sodium) 40 Mg Tablet.dr, 1 TAB PO DAILY, TAB 3 Refills

7/30/25

Metronidazole (Metronidazole) 500 Mg Tablet, 1 TAB PO BID for 7 Days, TAB 0 Refills

7/30/25

Ipratropium/Albuterol Sulfate (Iprat-Albut 0.5-3(2.5) mg/3 ml) 0.5 Mg-3 Mg (2.5 Mg Base)/3 ML Ampul.neb, 1 VIAL NEB QID for 30 Days, ML 0 Refills

7/30/25

[insulin regular] No Conflict Check

7/30/25

Hydralazine Hcl (Hydralazine Hcl) 25 Mg Tablet, 1 TAB PO TID, TAB 3 Refills

7/30/25

Guaifenesin (Guaifenesin) 100 Mg/5 ML Liquid, 5 ML PO TID for cough for 6 Days, ML 0 Refills

7/30/25

[lovenox] No Conflict Check, 30 MG SQ BID

7/30/25

Cefepime Hcl/Dextrose, Iso-Osm (Cefepime 2 Gm Injection) 2 Gram/100 ML Froz.piggy, 2 GM IV TID, EA

7/30/25

Atorvastatin Calcium (Atorvastatin Calcium) 40 Mg Tablet, 1 TAB PO QHS, TAB 3 Refills

7/30/25

Aspirin (Aspirin) 81 Mg Tab.chew, 1 TAB PO DAILY, TAB 0 Refills

7/30/25

Dictation Date/Time: 07/31/25 1256

Page:1

PREANESTHESIA EVAL

KING, ROBERT D DED: 401-A
 DOB: 06/14/1952 AGE: 73 y.o. SEX: M
 ADMIT: 7/28/2025 EMPI: 2553753
 ATT: Waddah Yiacoubagha, MD HSV: V
 MRN: 8580 ACCT #: 1009484

REVIEW OF SYSTEMS

Airway/Teeth/Head/Neck: Additional Comments (Unable to Assess Trach Present)

Anesthesia Type: General

Anesthesia Plan

Inhalational Anesthetic via Trach

RISKS/BENEFITS

Options and risks have been explained to the patient.

HX SUBJ**REVIEW OF SYSTEMS**

Respiratory: Tracheotomy Present

Cardiovascular: Abnormal EKG, Additional Comment (Cardiac Arrest)

Hepato/Gastrointestinal: Denies

Neuro/Musculoskeletal: Additional Comments (Paralyzed after cardiac arrest contracted)

Renal/Endocrine: IDDM

Hematologic/Lymphatic: Anticoagulant RX

History of Substance Use/Abuse: Other (Unknown:)

HX OBJ**IMMEDIATE PRE-OPERATIVE**

Cardiopulmonary Assessment: Rales, Crackles, RRR, S1/S2 w/o Murmur

GLENN, ALYSSA M CRNA

Jul 31, 2025 12:56

<Electronically signed by ALYSSA M GLENN CRNA>

ALYSSA M GLENN CRNA

07/31/25 1256

KING, ROBERT O BID: 401-A
DOB: 06/14/1952 AGE: 73 y.o. SEX: M
ADMIT: 7/28/2025 EMPI: 2553753
ATT: Waddah Yaaconbagha, MD HSV: V
MRN: 8580 ACCT #: 1009484



**Ephraim McDowell
Regional Medical Center**

M00007264886
DOB: 06/14/1952
KING, ROBERT D
SEX: M

DOS: 07/31/25
AGE: 73

OT

Record: SURGICAL

(Immediate Post Operative Note)

OR ROOM _____ CASE# _____

PRE-OPERATIVE DIAGNOSIS

KING, ROBERT D BED: 401-A
DOB: 06/14/1952 AGE: 73 y.o. SEX: M
ADMIT: 7/28/2025 EMPI: 2553753
ATT: Waddah Yacobubagha, MD HSY: V
MRN: 8580 ACCT#: 1009484

OPERATION PROPOSED

POST OPERATIVE DIAGNOSIS AND FINDINGS:

- Closure of P bulle der
- Clean of per
- Saal der der + de
wne boc

OPERATION PERFORMED

ANESTHESIA (Schem) / Anysa / Jard

PATIENT STATUS

A3A N

ENDOTRACHEAL

WOUND CLASSIFICATION CIII

ESTIMATED BLOOD LOSS: 10 ml

MISCELLANEOUS

SPECIMENS: YES NO

ASST SURGEON

DISPOSITION OF SPECIMENS:

OPERATIVE REPORT DICTATED _____

JOB #

DRAGON

SURGEON'S SIGNATURE:

DATE: 7/31/15

TIME: 3:00

WHITE-CHART YELLOW-ANESTHESIA PINK-PHYSICIAN

#1632 1021

SURGERY NOTES



ACCT NO



Ephraim McDowell Regional Med Center
217 South Third Street
Danville, KY 40422
(859) 239-1000

Patient Number	DOB:	Location:	Med. Rec.
KING,ROBERT D	06/14/1952	EOR	E000357161

Date of Admission:

POST ANESTHESIA ASSESSMENT

Vital Signs: RN Vital Signs have been reviewed: Yes, Temperature: 97.5, Source: Skin, Heart Rate: 61, Respiratory Rate: 18, BP: 148/72, Pulse Oximetry: 100, Weight: 291.0

PONV: No

Hydration Status: Hydration Adequate

Pain Controlled: Yes

Post Anesthesia Condition: Satisfactory

Post Anesthesia: Awake

Remarks:

Patient has returned to baseline. No further anesthetic intervention needed.

GLENN,ALYSSA M CRNA

Jul 31, 2025 15:00

<Electronically signed by ALYSSA M GLENN CRNA>

ALYSSA M GLENN CRNA

07/31/25 1500

KING, ROBERT D BED: 401-A
DOB: 06/14/1952 AGE: 73 y.o. SEX: M
ADMIT: 7/28/2025 EMPI: 2553753
ATT: Waddah Yancoubiha, MD HSV: V
MRN: 8580 ACCT #: 1009484

Ephraim McDowell Regional Med Center
217 South Third Street
Danville, KY 40422
(859) 239-1000

Patient: Number	DOB:	Location:	Med. Rec.
KING,ROBERT D	06/14/1952 EOR		E000357161

Date of Admission:

PCM OPERATIVE REPORT

OPERATIVE REPORT

DATE OF SURGERY

7/31/25

SURGEON

Tran MD, Tin

PREOPERATIVE DIAGNOSIS

Stage IV sacral decubitus ulceration

Open perineal wound

Open right buttock wound

Respiratory failure with tracheostomy

Colostomy codition

POSTOPERATIVE DIAGNOSIS

The same

PROCEDURE PERFORMED

Sacral decubitus debridement with wound VAC application 10 x 10 x 10 cm

Perineal wound closure 10 x 3 cm, with local rotational skin flap

Right buttock wound close 7 x 2 cm with local rotational skin flap

Findings

Patient had 3 open wounds in the buttock area.

10 x 3 cm at the perineum granulating tissue no infection at all. The wound was closed with 2-0 chromic interrupted fashion after under my rotational flap developed.

7 x 2 cm right buttock bleeding open wound from prior debridement and easy to closed with 2-0 chromic catgut Interrupted fashion

10 x 10 x 10 cm deep wound in the sacral area very close to the anus informed to the skin. The superior inferior and lateral side had some necrotic tissue it were removed with scalpel and Metzenbaum scissors

INDICATION FOR PROCEDURE

Please see consultation note

COMPLICATIONS

No complication

ANESTHESIA

General

ESTIMATED BLOOD LOSS

20ml

DESCRIPTION OF PROCEDURE

Risk and benefit of procedure were explained to the patient and family detail informed medical consent was signed by the family. Patient with took the OR timeout performed properly received physician without complication return to the left side up right side. The perineum was prepped and draped in sterile fashion. Patient had a 3 open wound in the buttock area:

Perineal wound : There is open wound from priors debrdlement very good and translating tissue. There were irrigated with saline and undermined and then closed with interrupted fashion The

Dictation Date/Time: 07/31/25 1325

Page:1

Operative Record (EMRMC)

wound was closed with 2-0 chromic interrupted fashion after under my rotational flap developed.

Right buttock wound : This open wound from prior debridement no further good tissue evaluating tissue ready for closure. This was 7 x 2 cm right buttock granulating open wound from prior debridement and easy to closed with 2-0 chromic catgut interrupted fashion after tissue was undermined and rotational flaps were created

Sacral wound : 10 x 10 x 10 cm deep wound In the sacral area very close to the anus informed to the skin. The superior inferior and lateral side had some necrotic tissue it were removed with scalpel and Metzenbaum scissors after all necrotic tissue were removed wound irrigated with saline without the wound was involved to the bone fascia and muscle. Wound VAC was applied at thigh without any problem patient tolerated well procedure note milligram patient transferred to PACU in stable condition

TRAN,TIN C MD

Jul 31, 2025 13:25

<Electronically signed by TIN C TRAN MD>

TIN C TRAN MD

07/31/25 1333

KING, ROBERT D BED: 401-A
DOB: 06/14/1952 AGE: 73 y.o. SEX: M
ADMIT: 7/28/2025 EMPI: 2553753
ATT: Waddah Yacoboubaghi, MD HSV: V
MRN: 8580 ACCT #: 1009484



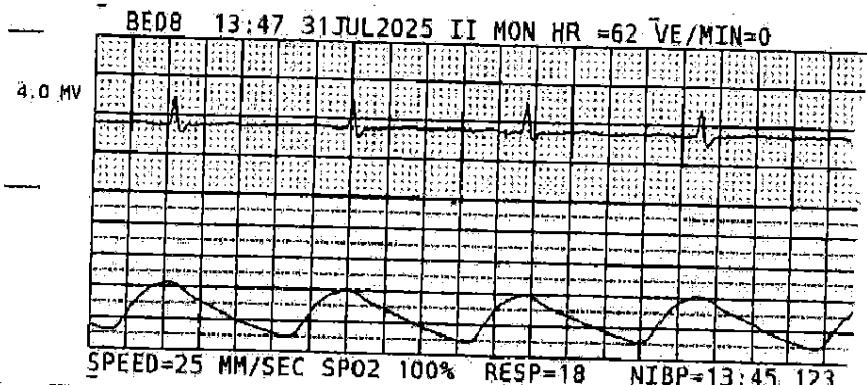
**Ephraim McDowell
Regional Medical Center**

M00007264886 DOS: 07/31/25
 DOB: 06/14/1952 AGE: 73
 KING,ROBERT D
 SEX: M

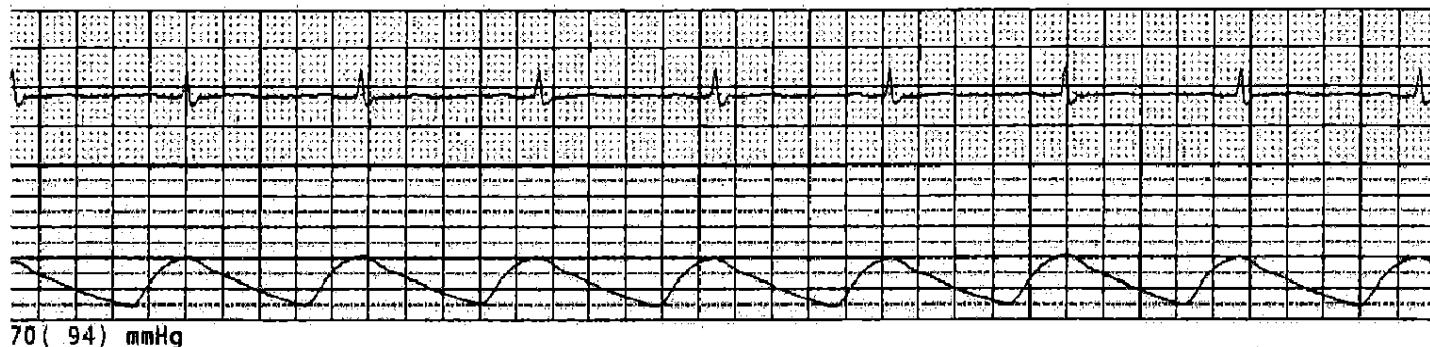
OT

Record: TELEMETRY RECORDING STRIPS

BED8
 13:47 31JUL2025
 II MON HR =62 VE/MIN=0
 RESP=18 SPO2 100%
 NIBP=13:45 123/ 70(94)mmHg



PLACE TOP OF REPORT #3 HERE



KING, ROBERT D BED: 401-A
 DOB: 06/14/1952 AGE: 73 y.o. SEX: M
 ADMIT: 7/28/2025 EMPI: 2553753
 ATT: Waddah Yacobougnah, MD HSV: V
 MRN: 8580 ACCT #: 1009484

PLACE TOP OF REPORT #4 HERE

INSTRUCTIONS: TO ATTACH REPORT, REMOVE
 PROTECTIVE TAPE BACKING, ALIGN REPORT
 AND PRESS DOWN FIRMLY.
 REPEAT PROCEDURE FOR SUBSEQUENT REPORTS

#S4297

12/20

TELEMETRY STRIP



ACCT_NO.

