

Wound and Pressure Injury

Standing F686 requirements, resident evidence, review worksheets, and an action plan.

REGULATION**42 CFR 483.25(b)****F-TAG****F686****SOURCES CHECKED****October 1, 2026****REVIEW FORMAT****Facility-led team review**

How to Use This Guide

1 Read the reference

Review each requirement, its source, and where surveyors look.

PAGES 2–3**2 Compare the evidence**

Check the written policy first, then records and observed practice.

WORKSHEETS · PAGES 4–7**3 Assign and follow up**

Log each gap with an owner, a target date, and a verification step.

ACTION PLAN · PAGE 8

Before You Begin

WHO TO INVOLVE

Administrator, director of nursing, wound lead, medical director, dietitian, rehabilitation, and QAPI lead.

WHAT TO BRING

Skin and wound policy, assessments, care plans, treatment orders, wound records, nutrition information, audits, and QAPI reports.

Review Areas at a Glance

NO.	REVIEW QUESTION	REFERENCE	WORKSHEET
01	Are skin and pressure-injury risks identified promptly?	Page 2	A · Page 4
02	Are preventive interventions individualized and implemented?	Page 2	A · Page 4
03	Is each wound assessed and described consistently?	Page 2	B · Page 5
04	Do orders, the care plan, and delivered treatment agree?	Page 2	B · Page 5
05	Is healing progress evaluated and the plan revised?	Page 3	C · Page 6
06	Are contributing factors addressed by the full care team?	Page 3	C · Page 6
07	Are infection, notification, and handoff risks controlled?	Page 3	D · Page 7

Scope. This evergreen guide reviews standing pressure-ulcer and pressure-injury requirements under 42 CFR 483.25(b) and F686, and prompts review of the broader wound workflow. Other wound types may involve additional requirements, standards, and F-tags.

Educational review aid; not a complete wound-care policy, treatment protocol, staging tool, or assurance of compliance. Use individualized clinical judgment, current professional standards, practitioner orders, CMS guidance, and state requirements. Escalate deterioration or suspected infection promptly.

PART 1 · REFERENCE

Key Review Areas Under F686

01 Are skin and pressure-injury risks identified promptly?

The facility should use comprehensive assessment and ongoing observation to identify pressure-injury risk, existing skin concerns, underlying causes, and changes in condition. [1, 2]

WHERE TO LOOK

Admission and comprehensive assessments, skin checks, risk tool, change-in-condition notes, transfer records, and staff interviews.

02 Are preventive interventions individualized and implemented?

Residents at risk must receive preventive care consistent with professional standards and their assessed needs. A pressure injury is not “unavoidable” merely because risk factors existed: the facility must show assessment, individualized interventions, monitoring, and appropriate revisions. [1, 2]

WHERE TO LOOK

Care plan, turning or mobility records, support-surface plan, continence care, device checks, observations, and staff interviews.

03 Is each wound assessed and described consistently?

Policy should define a consistent assessment process for location, wound type, size, tissue, drainage, surrounding skin, pain, and signs of infection. Use pressure-injury staging only for pressure injuries; classify other wounds with the appropriate separate system. [2, 3]

WHERE TO LOOK

Wound assessment forms, measurements, diagrams or approved photographs, progress notes, competencies, and discrepancy follow-up.

04 Do orders, the care plan, and delivered treatment agree?

A resident with a pressure ulcer or injury must receive necessary treatment and services consistent with professional standards to promote healing, prevent infection, and prevent new injuries. [1, 2]

WHERE TO LOOK

Practitioner orders, treatment administration record, care plan, supply record, observation, missed-treatment follow-up, and staff interview.

PART 1 · KEY REVIEW AREAS (CONTINUED)

05 Is healing progress evaluated and the plan revised?

The facility should reassess the effectiveness of interventions and revise the plan when the wound fails to improve, deteriorates, or the resident's condition changes. [2, 3]

WHERE TO LOOK

Serial measurements, wound trend report, progress notes, notification records, new orders, care-plan revisions, and QAPI review.

06 Are contributing factors addressed by the full care team?

Prevention and healing may require coordinated attention to nutrition and hydration, mobility, pain, circulation, continence, diagnoses, medications, equipment, and treatment tolerance. [2]

WHERE TO LOOK

Dietitian and rehabilitation notes, labs when ordered, pain record, care conference notes, resident preferences, and interdisciplinary plan.

07 Are infection, notification, and handoff risks controlled?

Wound care should include infection-prevention practices, timely response to concerning findings, required notification, and accurate information at transfer or discharge. [1, 2, 3]

WHERE TO LOOK

Treatment observation, infection assessment, practitioner and representative notification, transfer form, discharge instructions, and receiving-provider handoff.

TEAM DISCUSSION · FICTIONAL EXAMPLE

A resident's wound measurements vary across notes, the care plan has not changed despite deterioration, and the record does not show when the practitioner or representative was notified. What would a surveyor be able to verify?

Sources and Resources

[1] [42 CFR 483.25\(b\): skin integrity](#)

[2] [CMS Appendix PP: F686 guidance](#)

[3] [CMS survey resources and pathways](#)

[4] [CMS QAPI resources and prevention tools](#)

Sources checked October 1, 2026. This guide reviews standing requirements rather than a new monthly policy release.

PART 2 · REVIEW WORKSHEET A OF D

Review Areas 1–2

FACILITY _____ REVIEWERS _____ DATE _____

POLICY / PROCEDURE TITLE AND VERSION _____

REVIEW AREA 01

Are skin and pressure-injury risks identified promptly?

WHAT TO CHECK

When risk and skin assessments occur, who completes them, what triggers reassessment, and how findings reach the care team. [1, 2]

WHERE TO LOOK

Admission and comprehensive assessments, skin checks, risk tool, change-in-condition notes, transfer records, and staff interviews.

1 What does your policy or procedure say?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

REVIEW AREA 02

Are preventive interventions individualized and implemented?

WHAT TO CHECK

Whether prevention addresses mobility, repositioning, pressure redistribution, moisture, continence, nutrition, devices, and resident preferences. [1, 2]

WHERE TO LOOK

Care plan, turning or mobility records, support-surface plan, continence care, device checks, observations, and staff interviews.

1 What does your policy or procedure say?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

Status key. Supported = found in the material reviewed · Gap = missing, unclear, or inconsistent · N/A = explain why · Not checked = review remains open. Review the written policy first, then the evidence. Carry every gap to the action plan on page 8.

PART 2 · REVIEW WORKSHEET B OF D

Review Areas 3–4

FACILITY _____ REVIEWERS _____ DATE _____
 POLICY / PROCEDURE TITLE AND VERSION _____

REVIEW AREA 03

Is each wound assessed and described consistently?

WHAT TO CHECK

Whether entries are comparable over time, staging is used only for pressure injuries, photographs follow policy, and discrepancies are resolved. [2, 3]

WHERE TO LOOK

Wound assessment forms, measurements, diagrams or approved photographs, progress notes, competencies, and discrepancy follow-up.

1 What does your policy or procedure say?

STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?

STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

REVIEW AREA 04

Do orders, the care plan, and delivered treatment agree?

WHAT TO CHECK

That current orders, care-plan interventions, supplies, treatment records, and bedside practice match. [1, 2]

WHERE TO LOOK

Practitioner orders, treatment administration record, care plan, supply record, observation, missed-treatment follow-up, and staff interview.

1 What does your policy or procedure say?

STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?

STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

Status key. Supported = found in the material reviewed · Gap = missing, unclear, or inconsistent · N/A = explain why · Not checked = review remains open. Review the written policy first, then the evidence. Carry every gap to the action plan on page 8.

PART 2 · REVIEW WORKSHEET C OF D

Review Areas 5–6

FACILITY _____ REVIEWERS _____ DATE _____

POLICY / PROCEDURE TITLE AND VERSION _____

REVIEW AREA 05

Is healing progress evaluated and the plan revised?

WHAT TO CHECK

Trend review, expected goals, reassessment frequency, escalation criteria, practitioner notification, and documented response. [2, 3]

WHERE TO LOOK

Serial measurements, wound trend report, progress notes, notification records, new orders, care-plan revisions, and QAPI review.

1 What does your policy or procedure say?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

REVIEW AREA 06

Are contributing factors addressed by the full care team?

WHAT TO CHECK

How disciplines share findings, set measurable goals, address barriers, and incorporate resident or representative choices. [2]

WHERE TO LOOK

Dietitian and rehabilitation notes, labs when ordered, pain record, care conference notes, resident preferences, and interdisciplinary plan.

1 What does your policy or procedure say?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

Status key. Supported = found in the material reviewed · Gap = missing, unclear, or inconsistent · N/A = explain why · Not checked = review remains open. Review the written policy first, then the evidence. Carry every gap to the action plan on page 8.

PART 2 · REVIEW WORKSHEET D OF D

Review Area 7 and Summary

FACILITY _____ REVIEWERS _____ DATE _____

POLICY / PROCEDURE TITLE AND VERSION _____

REVIEW AREA 07

Are infection, notification, and handoff risks controlled?

WHAT TO CHECK

Wound-care technique, supply handling, signs of infection, notification pathways, emergency escalation, and continuity information sent with the resident. [1, 2, 3]

WHERE TO LOOK

Treatment observation, infection assessment, practitioner and representative notification, transfer form, discharge instructions, and handoff.

1 What does your policy or procedure say?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

POLICY SECTION

2 What does your evidence show?STATUS ☐ Supported ☐ Gap ☐ N/A ☐ Not checked

EVIDENCE LOCATION

Review Summary

Circle one per column: S = Supported · G = Gap · N/A = explain why · NC = Not checked

NO.	REVIEW AREA	POLICY				EVIDENCE				TARGET DATE	OWNER
01	Risk identification	S	G	N/A	NC	S	G	N/A	NC		
02	Individualized prevention	S	G	N/A	NC	S	G	N/A	NC		
03	Consistent wound assessment	S	G	N/A	NC	S	G	N/A	NC		
04	Orders, care plan, treatment	S	G	N/A	NC	S	G	N/A	NC		
05	Healing progress and revision	S	G	N/A	NC	S	G	N/A	NC		
06	Interdisciplinary factors	S	G	N/A	NC	S	G	N/A	NC		
07	Infection, notification, handoff	S	G	N/A	NC	S	G	N/A	NC		

Status key. Supported = found in the material reviewed · Gap = missing, unclear, or inconsistent · N/A = explain why · Not checked = review remains open. Carry every gap to the action plan on page 8.

PART 3 · ACTION PLAN

Action Plan and Follow-Up

Log each gap or unresolved question from the review summary. Copy this page as needed.

FACILITY _____ SHEET _____ OF _____

REVIEW AREA NO. / NAME _____	IDENTIFIED _____	REVIEWER _____
GAP / UNRESOLVED QUESTION + EVIDENCE REFERENCE _____		
PLANNED ACTION / POLICY WORDING OR WORKFLOW TO REVISIT _____		
OWNER _____	TARGET DATE _____	FOLLOW-UP DATE _____
HOW WE WILL VERIFY THE CHANGE IS WORKING _____		
FOLLOW-UP RESULT / REMAINING ACTION _____		
STATUS ☐ Open ☐ In progress ☐ Verified complete		

REVIEW AREA NO. / NAME _____	IDENTIFIED _____	REVIEWER _____
GAP / UNRESOLVED QUESTION + EVIDENCE REFERENCE _____		
PLANNED ACTION / POLICY WORDING OR WORKFLOW TO REVISIT _____		
OWNER _____	TARGET DATE _____	FOLLOW-UP DATE _____
HOW WE WILL VERIFY THE CHANGE IS WORKING _____		
FOLLOW-UP RESULT / REMAINING ACTION _____		
STATUS ☐ Open ☐ In progress ☐ Verified complete		

Escalate deterioration or suspected infection promptly — do not hold it for the next review cycle.