Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300	M-7	Numbering and content revised for Step 3: Determine "Present on Admission." 1. Review the medical record for the history of the ulcer. 2. Review for location and stage at the time of admission/entry or reentry. 3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."** 4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."** 5. If a resident who has a pressure ulcer that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as "present on admission**" because it was present and acquired at the facility prior to the hospitalization. 6. If a resident who has a pressure ulcer that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is **still coded as "present on admission"** because it was **originally acquired outside the facility** and has not changed in stage. 7. If a resident who has a ~~current~~ pressure ulcer is hospitalized and the ulcer increases in numerical stage during ~~a~~ the hospitalization, it ~~is coded at the higher stage upon reentry and~~ **should be coded as "present on admission~~.~~"** at that higher stage upon reentry.

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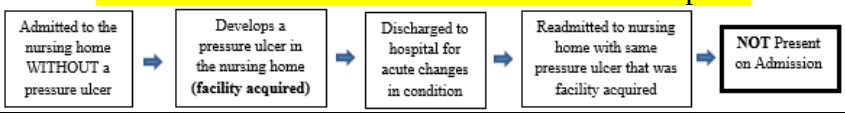
Chapter	Section	Page	Change
3	M0300	M-7	Added example and graphic. **Examples** 1. Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when she returns from the hospital. 
3	M0300–M0610	M-7–M-22	Page length changed due to revised content.
3	M0300	M-8	Added example and graphic. 2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed. 

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Chapter	Section	Page	Change
3	M0300B	M-10	**Coding Instructions for M0300B** **M0300B1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2. • **Enter 0** if no Stage 2 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C)~~M0300C, Stage 3. **M0300B2** • **Enter the number** of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital). • **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. **M0300B3** • **Enter the date of the oldest Stage 2 pressure ulcer.**
3	M0300C	M-12	**Coding Instructions for M0300C** **M0300C1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3. • **Enter 0** if no Stage 3 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressures Ulcers at Each Stage** item (M0300D)~~M0300D, Stage 4. **M0300C2** • **Enter the number** of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

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Chapter	Section	Page	Change
3	M0300D	M-14	Moved Definition box for Stage 4 Pressure Ulcer from M-13 to M-14 to be in alignment with content.
3	M0300D	M-14–M-15	**Coding Instructions for M0300D** **M0300D1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4. • **Enter 0** if no Stage 4 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E)~~M0300E, Unstageable – Non-removable dressing. **M0300D2** • **Enter the number** of these Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
3	M0300E	M-16	**Coding Instructions for M0300E** **M0300E1** • **Enter the number** of pressure ulcers that are unstageable related to non-removable dressing/device. • **Enter 0** if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300F)~~M0300F, Unstageable – Slough and/or eschar. **M0300E2** • **Enter the number** of these unstageable pressure ulcers related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).

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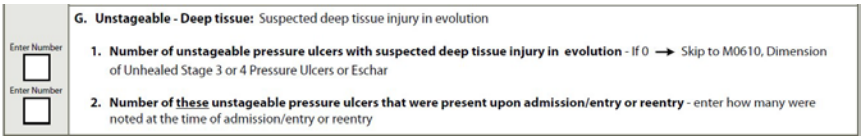
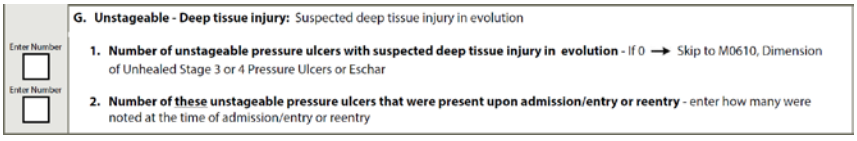
Chapter	Section	Page	Change
3	M0300F	M-17	**Coding Instructions for M0300F** **M0300F1** • **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar. • **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300G)~~M0300G, Unstageable – Deep tissue injury. **M0300F2** • **Enter the number** of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
3	M0300G	M-19	Replaced screenshot. OLD  NEW 

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Chapter	Section	Page	Change
3	M0300G	M-20	**Coding Instructions for M0300G** **M0300G1** • **Enter the number** of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury. • **Enter 0** if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610). **M0300G2** • **Enter the number** of these unstageable pressure ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).

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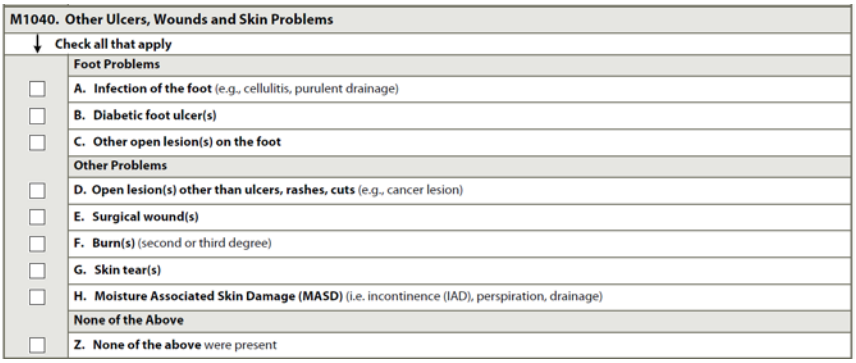
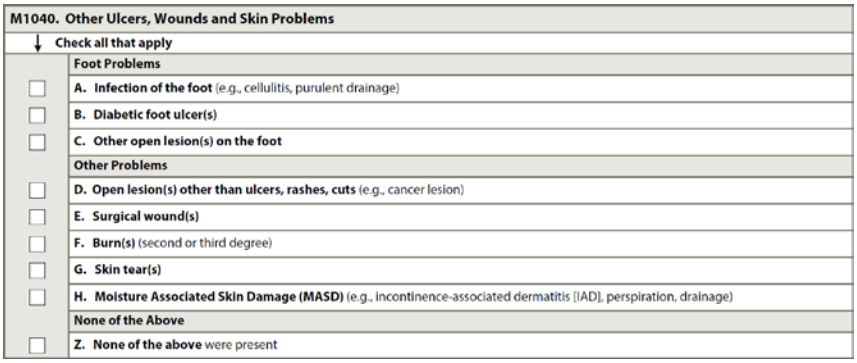
Chapter	Section	Page	Change
3	M1040	M-32	Replaced screenshot. OLD  NEW 
3	M1040	M-34	• M1040H, Moisture Associated Skin Damage (MASD) (~~i.e.~~e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
3	M1040	M-34	• Do **not** code rashes~~, skin tears,~~ or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
3	M1200	M-42	**Examples M0300, M0610, M0700 and M0800**