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3	—	M-1	Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.
3	M0100	M-1	M0100: Determination of Pressure Ulcer/Injury Risk
3	M0100	M-1–M-2	**Item Rationale** **Health-related Quality of Life** • Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development. • The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries. • Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk. • Throughout this section, terminology referring to "healed" versus~~vs.~~ "unhealed" ulcers refers to whether or not the ulcer is "closed" versus~~vs.~~ "open." When considering this, recognize that Stage 1, ~~Suspected~~ Deep Tissue Injury (~~s~~DTI), and unstageable pressure ulcers, although "closed~~,~~" (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered "healed." • Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin

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			overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.
			DEFINITION HEALED PRESSURE ULCER Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.
3	M0100	M-2–M-3	**Steps for Assessment** 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing). **Coding Instructions** *For this item, check all that apply:* • Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Review descriptions of pressure ulcers/injuries ~~stages~~ and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
			DEFINITIONS PRESSURE ULCER/ INJURY RISK FACTOR Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care

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			and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, ~~under nutrition,~~ malnutrition, and hydration deficits; and a healed ulcer. PRESSURE ULCER/ INJURY RISK TOOLS Screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©.
			• Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*©. Other tools may be used. • Check C if the resident's risk for pressure ulcer/injury development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following: — impaired/decreased mobility and decreased functional ability — co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; — drugs, such as steroids, that may affect wound healing; — impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency); — resident refusal of some aspects of care and treatment; — cognitive impairment; — urinary and fecal incontinence; — ~~under nutrition,~~ malnutrition~~,~~ and hydration deficits; and — healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown. • Check Z if none of the above apply.
3	M0150	M-3	M0150: Risk of Pressure Ulcers/Injuries

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3	M0150	M-3–M-4	**Steps for Assessment** 4. Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer/injury. 5. If the medical record reveals that the resident currently has a ~~Stage 1 or greater~~ pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries. 6. Review formal risk assessment tools to determine the resident's "risk score." 7. Review the components of the clinical assessment conducted for evidence of pressure ulcer/injury risk. **Coding Instructions** • `Code 0, no`: if the resident is not at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100. • `Code 1, yes`: if the resident is at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.
3	M0210	M-4–M-6	**M0210: Unhealed Pressure Ulcer~~(s)~~/Injuries** **M0210. Unhealed Pressure Ulcers/Injuries** Enter Code ☐ **Does this resident have one or more unhealed pressure ulcers/injuries?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage **Item Rationale** **Health-related Quality of Life** • Pressure ulcers/injuries and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time- consuming treatments and dressing changes. **Planning for Care** • The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 20~~07~~16 Pressure Injury Staging System~~Ulcer Stages~~. • An existing pressure ulcer/injury identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.

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			• For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, ~~you cannot use the NPUAP definitions to code the MDS.~~ y~~Y~~ou must code the MDS according to the instructions in this manual. • Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times. • The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen. **Steps for Assessment** 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any skin ulcers/injuries are present. • Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries. • Without a full body skin assessment, a pressure ulcer/injury can be missed. • Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.

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			4. Identify any known or likely unstageable pressure ulcers/injuries. **Coding Instructions** *Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days.* • `Code 0, no`: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to ~~item~~ M1030, Number of Venous and Arterial Ulcers. ~~Items M0300–M0800.~~ • `Code 1, yes`: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage ~~item (M0300).~~ **Coding Tips** • If an ulcer/injury arises from a combination of factors that~~which~~ are primarily caused by pressure, then the area~~ulcer~~ should be included in this section as a pressure ulcer/injury. • Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue. • Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here. • If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed. • Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors. • If a resident with DM has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, code 1 and proceed to code items in M0300–~~M0900~~ as appropriate for the pressure ulcer/injury.

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			• If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location. • Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar. • ~~If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).~~ • If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately. • If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.~~but there was no documented pressure ulcer on the prior assessment, **code 0**.~~
3	M0300	M-7–M-10	M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage Steps for completing M0300A–G **Step 1: Determine Deepest Anatomical Stage** *For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.*

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			5. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved. 6. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item. 7. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown. 8. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or backstaging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing DEFINITIONS EPITHELIAL TISSUE New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound. GRANULATION TISSUE Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

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			homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care. **Step 2: Identify Unstageable Pressure Ulcers** 1. Visualization of the wound bed is necessary for accurate staging. 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable. 3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg. 4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable. 5. A pressure injury~~ulcer~~ with intact skin that is a ~~suspected~~ deep tissue injury (~~s~~DTI) should not be coded as a Stage 1 pressure injury~~ulcer~~. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg. 6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device. **Step 3: Determine "Present on Admission"** *For **each** pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry*

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			*and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.* 1. Review the medical record for the history of the ulcer/injury. 2. Review for location and stage at the time of admission/entry or reentry. 3. If the pressure ulcer/injury 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/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, the pressure ulcer/injury is coded at M0300F and **should not be coded as "present on admission."** 5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, ~~but~~ then 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~~coded as "present on admission."** 6. If a resident who has a pressure ulcer/injury that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury **should not be coded as "present on admission**" because it was present and acquired at the facility prior to the hospitalization. 7. If a resident who has a pressure ulcer/injury that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury 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. 8. If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable ~~as a result of~~ due to slough or eschar during the hospitalization, it **should be coded as "present on admission"** ~~at that higher stage~~ upon reentry. 9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.**

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			10. If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission." **Examples** 1. Ms. K is admitted to the facility without a pressure ulcer/injury. 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. Admitted to the nursing home WITHOUT a pressure ulcer/injury → Develops a pressure ulcer/injury in the nursing home **(facility acquired)** → Discharged to hospital for acute changes in condition → Readmitted to nursing home with same pressure ulcer/injury that was facility acquired → NOT Present on Admission 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. Admitted to the nursing home WITH a pressure ulcer/injury **(Not facility acquired)** → Discharged to hospital for acute changes in condition → Readmitted to nursing home with **same** pressure ulcer/injury that was not facility acquired → Present on Admission
3	M0300A	M-11	M0300A: Number of Stage 1 Pressure Injuries~~Ulcers~~ **M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** Enter Number ☐ **A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues **1. Number of Stage 1 pressure injuries** **Item Rationale**

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			## Health-related Quality of Care • Stage 1 pressure injuries~~ulcers~~ may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage. ## Planning for Care • Development of a Stage 1 pressure injury~~ulcer~~ should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.
			DEFINITIONS STAGE 1 PRESSURE INJURY~~ULCER~~ An observable, pressure- related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury~~ulcer~~ may appear with persistent red, blue, or purple hues. NON-BLANCHABLE
			Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. ## Steps for Assessment 1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.). 2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code here. 3. Reliance on only one descriptor is inadequate to determine the staging of a~~the~~ pressure ~~ulcer~~injury between Stage 1 and ~~suspected~~ deep tissue injury~~ulcers~~ (see definition of ~~suspected~~ "deep tissue injury" on page M-24). The descriptors are similar for these two types of ~~ulcers~~injuries (e.g., temperature [warmth or coolness]; tissue consistency [firm or boggy]). 4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing

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			it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site. 5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes as well as surrounding tissue that may be painful, firm, or soft. **Coding Instructions for M0300A** • Enter the number of Stage 1 pressure injuries~~ulcers~~ that are currently present. • Enter 0 if no Stage 1 pressure injuries~~ulcers~~ are currently present.
3	M0300B	M-12	M0300B: Stage 2 Pressure Ulcers Enter Number ☐ **B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister Enter Number ☐ **1. Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3 **2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
3	M0300B	M-12	DEFINITION STAGE 2 PRESSURE ULCER Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister.
3	M0300B	M-13	**Steps for Assessment** 1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.). 2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here. **3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to~~,~~ or surrounding the blister demonstrates signs of tissue damage~~,~~ (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a ~~suspected~~ deep**

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			tissue injury (~~s~~DTI) rather than a Stage 2 p~~P~~ressure u~~U~~lcer. 4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury. 5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-8). ~~6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.~~
3	M0300B	M-13	~~**M0300B3**~~ • ~~Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e. the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0." For example, January 2, 2012, should be entered as 01-02-2012.~~ **Coding Tips** • ~~A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.~~ • Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers. • ~~If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.~~ • Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here. • When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.
3	M0300C	M-14	**Planning for Care** • Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive. • An existing pressure ulcer may put residents at risk for further complications or skin injury.

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			• If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed. • Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices. • Changes in tissue characteristics over time are indicative of wound healing or degeneration.
			DEFINITION STAGE 3 PRESSURE ULCER Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-18).
3	M0300C	M-16–M-17	**Examples** 1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer. Coding: The current Stage 3 pressure ulcer would be coded at ~~item~~ M0300C1 as 1, and at ~~item~~ M0300C2 as 0, not present on admission/entry or reentry. Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location and not have increased in numerical stage or become unstageable due to slough or eschar. This pressure ulcer worsened from ~~a~~ Stage 2 to ~~a~~ Stage 3 after admission ~~Item~~ M0300C1 is coded as 1 and ~~item~~ M0300C2 is coded as 0 on the current assessment because the ulcer was not a Stage 3 pressure ulcer on admission. ~~This pressure ulcer would also be coded in M0800B as worsened.~~ 2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

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			Coding: The pressure ulcer would be coded at ~~item~~ M0300C1 as ~~Code~~ 1, and at ~~item~~ M0300C2 as 1, present on admission/entry or reentry. Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as ~~a~~ Stage 3, present on admission/entry or reentry. 3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer. Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry. Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, M0300B1 and M0300B2 would be coded as 1; the pressure ulcer that increased in numerical stage to a Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission. 4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed. Coding: The Stage 2 pressure ulcer would be coded at ~~item~~ M0300B1 as 1, and at ~~item~~ M0300B2 as 0, not present on admission/entry or reentry; the Stage 3 pressure ulcer would be coded at ~~item~~ M0300C1

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			as 1, and at ~~item~~ M0300C2 as 1, present on admission/entry or reentry. Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in ~~item~~ M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here. ~~but in Item M0900, Healed Pressure Ulcers.~~ 5. A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast. Two weeks after admission to the nursing facility, the cast is removed by the physician. At that time, it is determined that the resident has a Stage 3 pressure ulcer on his right heel from the cast, which remains until the subsequent assessment. Coding: Code **M0300C1 as 1**, and **M0300C2 as 1**, present on admission/entry or reentry. Rationale: The resident was admitted with a documented unstageable pressure ulcer/injury due to non-removable dressing/device. The cast was removed, and a Stage 3 pressure ulcer was assessed. Because this is the first time the ulcer has been numerically staged, this stage will be coded as present on admission/entry or reentry. 6. Mrs. P was admitted to the nursing facility with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains at Stage 3. Coding: Code **M0300C1 as 1**, and **M0300C2 as 1**, present on admission/entry or reentry. Rationale: This resident was admitted with an unstageable DTI that subsequently was debrided and could be numerically staged. The first numerical stage was 3, and it remained a Stage 3 for the subsequent assessment; therefore it is coded as present on admission/entry or reentry.

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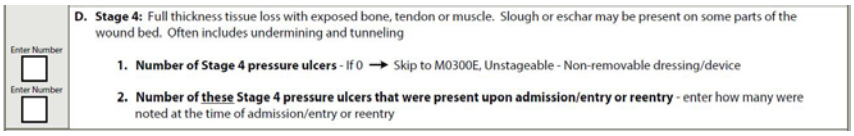
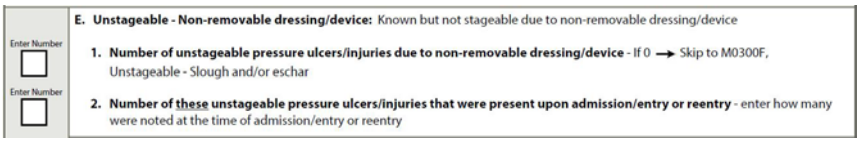
			7. Mr. H was admitted with a known pressure ulcer/injury due to a non-removable dressing. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3. It remained Stage 3 at the time of the next assessment. Coding: Code **M0300C1 as 1**, and **M0300C2 as 0**, not present onadmission/entry reentry. Rationale**:** This resident was admitted with an unstageable pressure ulcer due to non-removable dressing or device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage. Subsequent to this first stage, the ulcer worsened to Stage 3 and therefore is not coded as present on admission/entry or reentry.
3	M0300D	M-17	M0300D: Stage 4 Pressure Ulcers  Enter Number ☐ **D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device Enter Number ☐ 2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
3	M0300D	M-19	• Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS, but should be assessed, monitored, and treated as part of the comprehensive care plan.
3	M0300E	M-19–M-20	M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device  Enter Number ☐ **E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar Enter Number ☐ 2. **Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry **Item Rationale** **Health-related Quality of Life** • Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for residents because it may limit activity and may be painful.

			### Planning for Care • Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control. ### Steps for Assessment ~~*Documentation of an existing pressure ulcer/injury is needed to complete this item.*~~ 1. Review the medical record for documentation of a pressure ulcer/injury covered by a non- removable dressing/device. 2. Determine the number of documented unstageable pressure ulcers/injuries ~~unstageable related to~~ covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or an orthopedic device that is not to be removed per physician's order~~, an orthopedic device~~, or a cast. 3. Identify the number of these pressure ulcers/injuries that were present on admission/entry or reentry (see page M-8 for assessment process). ### Coding Instructions for M0300E #### M0300E1 • Enter the number of pressure ulcers/injuries that are unstageable related to non-removable dressing/device. • Enter 0 if no unstageable pressure ulcers/injuries related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar. #### M0300E2 • Enter the number of these unstageable pressure ulcers/injuries 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/injury related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).

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			• Enter 0 if no unstageable pressure ulcers/injuries related to non-removable dressing/device were first noted at the time of admission/entry or reentry.
3	M0300F	M-20	2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-8 for assessment process).
3	M0300F	M-21	**Coding Tips** • Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
3	M0300F	M-22–M-23	**Examples** 1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar. Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission. 2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone. Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry. Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D. ~~If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers~~

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			~~for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar.~~ 3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough. Coding: Code ~~at~~ M0300F1 as 1, and ~~at~~ M0300F2 as 0, not present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2. 4. Mr. M. was admitted to the nursing facility with eschar tissue covering both the right and left heels, as well as a Stage 2 pressure ulcer on the coccyx. Mr. M's pressure ulcers were reassessed before the subsequent assessment, and the Stage 2 coccyx pressure ulcer had healed. The left-heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer. The right-heel eschar remained stable and dry (i.e., remained unstageable). Coding: Code **M0300D1 as 1**, and **M0300D2 as 1**, present on admission/entry or reentry. Code **M0300F1 as 1**, and **M0300F2 as 1**, present on admission/entry or reentry. Rationale: Mr. M was admitted with an unstageable pressure injuriesdue to slough/eschar on each heel. One of the heels was subsequently debrided, and the first numerical stage was Stage 4; thus this is coded as present on admission/entry or reentry. The other heel eschar remained unstageable, and is coded as present on admission/entry or reentry.

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3	M0300G	M-24–M-25	

M0300G: Unstageable Pressure Injuries ~~Ulcers~~ Related to ~~Suspected~~ Deep Tissue Injury

Enter Number ☐ Enter Number ☐	**G. Unstageable - Deep tissue injury:** 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers 2. **Number of these unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds/injuries. Deep tissue injuries may sometimes indicate severe damage. Identification and management of ~~suspected~~ deep tissue injury (~~s~~DTI) is imperative.

DEFINITION

~~SUSPECTED~~ DEEP TISSUE INJURY
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Planning for Care

- ~~Suspected d~~Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

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			3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not** code as a ~~suspected~~ deep tissue injury. 4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue. 5. Determine the number of pressure injuries ~~ulcers~~ that are unstageable related to ~~suspected~~ deep tissue injury. 6. Identify the number of **these** pressure injuries ~~ulcers~~ that were present on admission/entry or reentry (see page M-8 for instructions). 7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management. **Coding Instructions for M0300G** **M0300G1** • Enter the number of unstageable pressure injuries ~~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 injuries ~~ulcers~~ related to ~~suspected~~ deep tissue injury are present and skip to ~~item~~ M1030, Number of Venous and Arterial Ulcers. ~~**Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).~~ **M0300G2** • Enter the number of these unstageable pressure injuries ~~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 injury ~~ulcer~~ related to ~~suspected~~ deep tissue injury was not acquired in the nursing facility prior to admission to the hospital). • Enter 0 if no unstageable pressure injuries~~ulcers~~ related to ~~suspected~~ deep tissue injury were first noted at the time of admission/entry or reentry.

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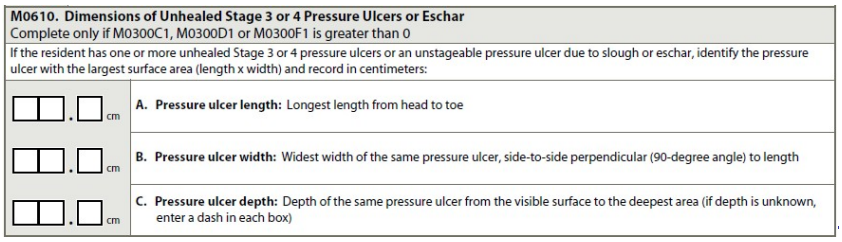
			Coding Tips • Once ~~suspected~~ deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage. • Deep tissue injury may be difficult to detect in individuals with dark skin tones. • Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. • When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here (see definition of Stage 2 pressure ulcer on page M-12).
3	M0610–M0900	M-23–M-32	~~**M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar**~~  **M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar** Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0 If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters: ☐☐.☐ cm — **A. Pressure ulcer length:** Longest length from head to toe ☐☐.☐ cm — **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length ☐☐.☐ cm — **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box) ~~**Item Rationale**~~ ~~**Health-related Quality of Life**~~ • ~~Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.~~ ~~**Planning for Care**~~ • ~~Evaluating the dimensions of the pressure ulcer is one aspect of the process of monitoring response to treatment.~~ • ~~Pressure ulcer measurement findings are used to plan interventions that will best prepare the wound bed for healing.~~ ~~**Steps for Assessment**~~ ~~*If the resident has **one or more** unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, **identify the pressure ulcer with the largest surface area***~~

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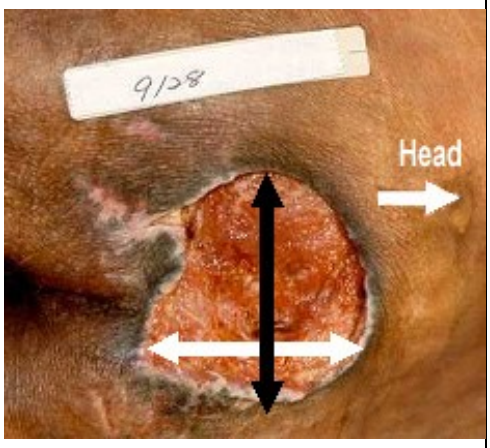
			~~*(length × width) and record in centimeters.* **Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1.** *The Figure (right) illustrates the measurement process.*~~  ~~1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar after the dressing and any exudate are removed.~~ ~~2. Use a disposable measuring device or a cotton-tipped applicator.~~ ~~3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar.~~ ~~4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.~~ ~~5. Using a similar approach, measure the longest width (perpendicular to the length forming a "+," side to side).~~ ~~6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest. Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.~~ ~~7. Considering **only** the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.~~ ~~8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as~~

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			~~two separate pressure ulcers. Stage and measure each pressure ulcer separately.~~ ~~**Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar**~~ • ~~Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).~~ • ~~Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.~~ • ~~Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.~~ ~~**Coding Tips**~~ • ~~Place the resident in the most appropriate position which will allow for accurate wound measurement.~~ • ~~Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.~~ • ~~Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.~~ ~~M0700: Most Severe Tissue Type for Any Pressure Ulcer~~ **M0700. Most Severe Tissue Type for Any Pressure Ulcer** Enter Code ☐ Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. **Eschar** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. **None of the Above**

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			~~**Item Rationale**~~ ~~**Health-related Quality of Life**~~ • ~~The presence of a pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.~~ • ~~Identify tissue type.~~ ~~**Planning for Care**~~ • ~~Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.~~ • ~~Changes in tissue characteristics over time are indicative of wound healing or degeneration.~~
			~~DEFINITIONS~~ ~~EPITHELIAL TISSUE~~ ~~New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.~~ ~~GRANULATION TISSUE~~ ~~Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured.~~ ~~SLOUGH TISSUE~~ ~~Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.~~ ~~ESCHAR~~ ~~Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar is usually firmly adherent to the base of the wound and often the sides/edges of the wound.~~
			~~**Steps for Assessment**~~ ~~1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.~~ ~~2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).~~ ~~**Coding Instructions for M0700**~~

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			• ~~Code 1, Epithelial tissue: if the wound is superficial and is re-epithelializing.~~ • ~~Code 2, Granulation tissue: if the wound is clean (e.g., free of slough and eschar tissue) and contains granulation tissue.~~ • ~~Code 3, Slough: if there is any amount of slough tissue present and eschar tissue is absent.~~ • ~~Code 4, Eschar: if there is any eschar tissue present.~~ • ~~Code 9, None of the above: if none of the above apply.~~ ~~**Coding Tips and Special Populations**~~ • ~~Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough or eschar tissue and should be **coded as 1** for this item.~~ • ~~Code for the most severe type of tissue present in the pressure ulcer wound bed.~~ • ~~If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar and slough) is present, code for eschar.~~ • ~~Code this item with **Code 9, None of the above**, in the following situations:~~ — ~~Stage 1 pressure ulcer~~ — ~~Stage 2 pressure ulcer with intact blister~~ — ~~Unstageable pressure ulcer related to non-removable dressing/device~~ — ~~Unstageable pressure ulcer related to suspected deep tissue injury~~ ~~Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.~~ ~~**Examples**~~ ~~1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.~~ ~~Coding: Code M0700 as 2, Granulation tissue.~~

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			~~Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.~~ ~~2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.~~ ~~Coding: Code M0700 as 1, Epithelial tissue.~~ ~~Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.~~ ~~3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.~~ ~~Coding: Code M0700 as 4, Eschar.~~ ~~Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, Eschar).~~ ~~M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry~~ **M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry** Complete only if A0310E = 0 Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0. Enter Number ☐ **A. Stage 2** Enter Number ☐ **B. Stage 3** Enter Number ☐ **C. Stage 4** ~~**Item Rationale**~~ ~~**Health-related Quality of Life**~~ • ~~This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have increased in numerical stage (worsened) since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.~~ ~~**Planning for Care**~~ • ~~The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure~~

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			~~ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.~~
			~~DEFINITION~~ ~~WORSENING IN PRESSURE ULCER STATUS~~ ~~Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.~~
			~~**Steps for Assessment**~~ ~~*Look-back period for this item is back to the ARD of the prior assessment. If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.*~~ ~~1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.~~ ~~2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS assessment was completed.~~ ~~**Coding Instructions for M0800**~~ ~~• Enter the number of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.~~ ~~• Code 0: if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.~~ ~~**Coding Tips**~~ ~~• Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.~~ ~~• If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.~~

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			• ~~Specific guidance regarding coding worsening of pressure ulcers:~~ — ~~If an unstageable pressure ulcer that was present on admission/entry or reentry is subsequently able to be numerically staged, do not consider it to be worsened because this would be the first time that the pressure ulcer was able to be numerically staged. However, if subsequent to this numerical staging, the pressure ulcer further deteriorates and increases in numerical stage, the ulcer would be considered worsened.~~ — ~~If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.~~ — ~~If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.~~ — ~~If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.~~ — ~~If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item.~~ — ~~If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a~~

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			~~subsequent MDS assessment, it would be considered as worsened and would be coded in this item.~~ ~~**Examples**~~ ~~1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage to a Stage 3 pressure ulcer.~~ ~~Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0.~~ ~~Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment.~~ ~~2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.~~ ~~Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.~~ ~~Rationale: The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it numerically staged as a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.~~ ~~3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a new Stage 2 pressure ulcer on the left trochanter.~~ ~~Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1.~~ ~~Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging of both the sacrum and right heel pressure ulcers.~~ ~~4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the~~

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			~~pressure ulcer is reassessed and determined to still be a Stage 3 pressure ulcer.~~ ~~Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.~~ ~~Rationale: M0800B would be coded 0 because the numerical stage of the pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.~~ ~~M0900: Healed Pressure Ulcers~~ **M0900. Healed Pressure Ulcers** Complete only if A0310E = 0 Enter Code ☐ **A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0900B, Stage 2 Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0. Enter Number ☐ **B. Stage 2** Enter Number ☐ **C. Stage 3** Enter Number ☐ **D. Stage 4** ~~**Item Rationale**~~ ~~**Health-related Quality of Life**~~ • ~~Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.~~
			~~DEFINITION~~ ~~HEALED PRESSURE ULCER~~ ~~Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.~~
			~~**Planning for Care**~~ • ~~Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.~~ • ~~**Most Stage 2** pressure ulcers should heal within a reasonable timeframe (e.g., 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.~~ • ~~Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not~~

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			~~accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.~~ ~~**Steps for Assessment**~~ ~~*Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment.* **If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***~~ ~~1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have healed by the ARD (A2300) of the current assessment.~~ ~~2. Identify the deepest anatomical stage (see definition on page M-5) of each healed pressure ulcer.~~ ~~3. Count the number of healed pressure ulcers for each stage.~~ ~~**Coding Instructions for M0900A**~~ ~~*Complete on **all** residents (**even if M0210 = 0**)*~~ ~~• Enter 0: if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).~~ ~~• Enter 1: if there were pressure ulcers noted on the prior assessment.~~

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			~~**Coding Instructions for M0900B, C, and D**~~ ~~• Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.~~ ~~• Enter 0: if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.~~ ~~**Coding Tips**~~ ~~• Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.~~ ~~• If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.~~
3	M1030	M-27	**Coding Instructions** *Check all that apply in the last 7 days.* *Pressure ulcers coded in M0210 through M03~~9~~00 should **not** be coded here.*
3	M1040	M-29	**Coding Instructions** ***Check all that apply** in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.* *Pressure ulcers/injuries coded in items M0200 through M0300~~900~~ should **not** be coded here.*
3	M1040	M-29	DEFINITIONS DIABETIC FOOT ULCERS Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful. SURGICAL WOUNDS

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			Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites. OPEN LESION OTHER THAN ULCERS, RASHES, CUTS Most typically skin lesions~~ulcers~~ that develop as a result of diseases and conditions such as syphilis and cancer. BURNS (SECOND OR THIRD DEGREE) Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
3	M1040B	M-30	**Coding Tips** **M1040B Diabetic Foot Ulcers** • Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound. • Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot. • Do **not** include pressure ulcers/injuries that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.
3	M1040D	M-30	**M1040D Open Lesion Other than Ulcers, Rashes, Cuts** • Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item. • Do **not** code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care. • Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

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3	M1040G	M-31	**M1040G Skin Tear(s)** • Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B. • Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.
3	M1040H	M-31–M-32	**M1040H Moisture Associated Skin Damage (MASD)** • ~~Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection.~~ MASD is also referred to as maceration and includes incontinence-associated dermatitis~~, and can cause other conditions such as~~ intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. DEFINITION Moisture Associated Skin Damage Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration. • Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown. • MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. • MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges.

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			Inflammation of the skin may also be present. Necrosis is not found in MASD. • If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300. • If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300. **Examples** 1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure. Coding: This ulcer is not checked at M1040B. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210–M0300~~900~~).
3	M1200	M-33	**M1200: Skin and Ulcer/Injury Treatments** **M1200. Skin and Ulcer/Injury Treatments** ↓ Check all that apply ☐ A. **Pressure reducing device for chair** ☐ B. **Pressure reducing device for bed** ☐ C. **Turning/repositioning program** ☐ D. **Nutrition or hydration intervention** to manage skin problems ☐ E. **Pressure ulcer/injury care** ☐ F. **Surgical wound care** ☐ G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet ☐ H. **Applications of ointments/medications** other than to feet ☐ I. **Application of dressings to feet** (with or without topical medications) ☐ Z. **None of the above** were provided
3	M1200	M-33	**Planning for Care** • These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
3	M1200	M-34	• M1200E, Pressure ulcer/injury care
3	M1200A/ M1200B	M-35	**Coding Tips** **M1200A/M1200B Pressure Reducing Devices** • Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing ~~(redistribution)~~ device should be selected based on the individualized needs of the resident.

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3	M1200D	M-36	**M1200D Nutrition or Hydration Intervention to Manage Skin Problems** • Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment ~~(AMDA PU Guideline, page 6)~~. If it is determined that nutritional supplementation, that is, ~~i.e.~~ adding additional protein, calories, or nutrients, is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and ~~"~~tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.~~" AMDA PU Therapy Companion, page 4).~~ • It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis ~~(AMDA PU Therapy Companion, page 11)~~.
3	M1200E	M-36	**M1200E Pressure Ulcer/Injury Care** • Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (~~items~~ M0300A~~–~~G). Examples may include the use of topical dressings;~~,~~ enzymatic, mechanical, or surgical debridement;~~,~~ wound irrigations;~~,~~ negative pressure wound therapy (NPWT) ;~~,~~ and/or hydrotherapy.
3	M1200G	M-37	**M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet** • Do **not** code application of non-surgical dressings for pressure ulcers/injuries~~(s)~~ other than to feet in this item; use M1200E, Pressure u~~U~~lcer/i~~I~~njury c~~C~~are. • Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the

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			MDS definitions was applied even once during the 7-day look- back period, the assessor should check that MDS item. • This category may include but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND- AID® bandages, wound closure strips).
3	M1200H	M-37	**M1200H Application of Ointments/Medications Other than to Feet** • Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure u~~U~~lcer/i~~I~~njury c~~C~~are.
3	M1200I	M-37	**M1200I Application of Dressings to the Feet (with or without Topical Medications)** • Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer/injury**. • Do **not** code application of dressings to pressure ulcers/injuries on the foot;~~,~~ use M1200E, Pressure u~~U~~lcer/i~~I~~njury c~~C~~are.
3	M1200	M-38	**Examples** 1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing ~~(redistribution)~~ pad on the resident's wheelchair. The medical record documents delivery of care and notes that the resident is on a two~~2~~-hour turning/repositioning program that is organized, planned, documented, monitored, and evaluated based on an individualized assessment of her needs. The physician documents~~, that~~ after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, dietician's nutritional assessment, and laboratory results, that the resident has protein-calorie ~~under~~ malnutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients, and

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			micronutrients. All mattresses in the nursing home are pressure reducing ~~(redistribution)~~ mattresses. Coding: Check items M1200A, M1200B, M1200C, M1200D, and M1200E. Rationale: Interventions include pressure reducing ~~(redistribution)~~ pad ~~i~~on the wheelchair (M1200A) and pressure reducing ~~(redistribution)~~ mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E). 2. A resident has a venous ulcer on the right leg. During the ~~past~~ last 7 days the resident has had a three-layer compression-bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure reducing ~~redistributing~~ mattress and pad for the wheelchair. Coding: Check items M1200A, M1200B, and M1200G. Rationale: Treatments include pressure reducing ~~(redistribution)~~ mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression-bandaging system (M1200G).
3	—	M-44-M-47	~~**Example M0300, M0610, M0700 and M0800**~~ ~~1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.~~ ~~Admission Assessment:~~ ~~Coding:~~ • ~~M0300A (Number of Stage 1 pressure ulcers), Code 0.~~ • ~~M0300B1 (Number of Stage 2 pressure ulcers), Code 1.~~ • ~~M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.~~

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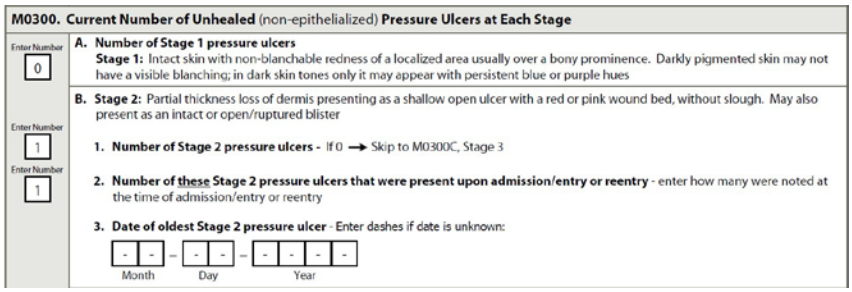
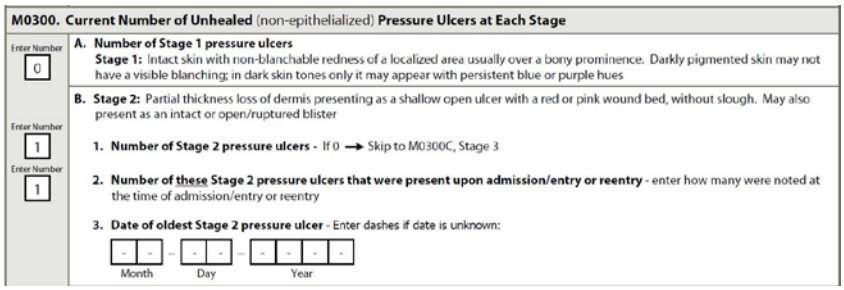
			• ~~M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.~~ ~~Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.~~  **M0300. Current Number of Unhealed** (non-epithelialized) **Pressure Ulcers at Each Stage** Enter Number 0 — **A. Number of Stage 1 pressure ulcers** **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues **B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister Enter Number 1 — **1. Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3 Enter Number 1 — **2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry **3. Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown: - - – - - – - - - - Month Day Year ~~Quarterly Assessment #1:~~ ~~Coding:~~ • ~~M0300A (Number of Stage 1 pressure ulcers), Code 0.~~ • ~~M0300B1 (Number of Stage 2 pressure ulcers), Code 1.~~ • ~~M0300B2 (Number of these Stage 2 pressure ulcers present upon admission/entry or reentry), Code 1.~~ • ~~M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.~~ ~~Rationale: On the quarterly assessment the Stage 2 pressure ulcer is still present and date was unknown. Therefore, M0300B3 is still coded with dashes.~~  **M0300. Current Number of Unhealed** (non-epithelialized) **Pressure Ulcers at Each Stage** Enter Number 0 — **A. Number of Stage 1 pressure ulcers** **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues **B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister Enter Number 1 — **1. Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3 Enter Number 1 — **2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry **3. Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown: - - – - - – - - - - Month Day Year ~~Quarterly Assessment #2:~~ ~~Coding:~~ • ~~M0300A (Number of Stage 1 pressure ulcers), Code 0.~~ • ~~M0300B1 (Number of Stage 2 pressure ulcers), Code 0 and skip to M0300C, Stage 3 pressure ulcers.~~ • ~~M0300C1 (Number of Stage 3 pressure ulcers). Code 1.~~ • ~~M0300C2 (Number of these Stage 3 pressure ulcers that were present upon admission//entry or reentry). Code 0.~~

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			• ~~M0300D1, M0300E1, M0300F1, and M0300G1 Code 0's and proceed to code M0610 (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.~~ • ~~M0610A (Pressure ulcer length), Code 03.0, M0610B (Pressure ulcer width),~~ ~~Code 02.4, M0610C (Pressure ulcer depth) Code 00.2.~~ • ~~M0700 (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.~~ • ~~M0800 (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled PPS or Last Admission/Entry or Reentry) – M0800A (Stage 2) Code 0, M0800B (Stage 3) Code 1, M0800C (Stage 4) Code 0.~~ ~~Rationale:~~ • ~~M0300B1 is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to M0300C (Stage 3 pressure ulcer).~~ • ~~M0300C1 is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.~~ • ~~M0300C2 is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.~~ • ~~M0300D1, M0300E1, M0300F1, and M0300G1 are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code M0610 with the dimensions of the Stage 3 ulcer.~~ • ~~M0610A is coded, 03.0 for length, M0610B is coded 02.4 for width, and M0610C is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.~~ • ~~M0700 is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.~~ • ~~M0800A is coded as 0, M0800B is coded as 1, and M0800C is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.~~

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number [0]
A. Number of Stage 1 pressure ulcers
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number [0]
1. **Number of Stage 2 pressure ulcers -** If 0 → Skip to M0300C, Stage 3

Enter Number [ ]
2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number [1]
1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number [0]
2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number [0]
1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number [ ]
2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

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M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number [0]
1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number [ ]
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number [0]
1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number [ ]
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number [0]
1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number [ ]
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

[0][3].[0] cm **A. Pressure ulcer length:** Longest length from head to toe

[0][2].[4] cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

[0][0].[2] cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code [2]
Select the best description of the most severe type of tissue present in any pressure ulcer bed
1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
9. **None of the Above**

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry
Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number [0] **A. Stage 2**

Enter Number [1] **B. Stage 3**

Enter Number [0] **C. Stage 4**

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3	—	M-39–M-45	**Example M0100-M1200** 1. Mrs. P was~~is~~ admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing~~redistribution~~ devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. ~~On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/2010. Upon reentry the 5- day PPS ARD was set at 11/19/2010. In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx, however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth. It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.~~ 5-Day PPS #1: Coding: • M0100B (Formal assessment instrument), Check box. • M0100C (Clinical assessment), Check box. • M0150 (Risk of Pressure Ulcers/Injuries), Code 1. • M0210 (One or more unhealed pressure ulcers/injuries)~~(s) at Stage 1 or higher)~~, Code 0 and skip to ~~item~~ M1030 (Number of Venous and Arterial Ulcers).~~M0900 (Healed pressure ulcers).~~ • ~~M0900 (Healed pressure ulcers). Skip to M1030 since this item is only completed if A0310E=0. The 5-Day PPS Assessment is the first assessment since the most~~

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~~recent admission/entry or reentry, therefore, A0310E=1.~~

- M1030 (Number of Venous and Arterial U~~u~~lcers), Code 0.
- M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).
- M1200 (Skin and Ulcer Treatments), Check Z (None of the above were provided).

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident's skin was noted to be intact, therefore, ~~item~~ M0210 was coded 0. ~~M0900 was skipped because the 5-Day PPS is the first assessment.~~ M1030 was coded 0 due to the resident not having any of these conditions. ~~Item~~M1040Z was checked since none of these problems were noted. ~~Item~~ M1200Z was checked because none of these treatments were provided.

M1030. Number of Venous and Arterial Ulcers	
Enter Number [0]	Enter the total number of venous and arterial ulcers present

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☒	**Z. None of the above** were present

M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☒	**Z. None of the above** were provided

14-Day PPS:

Coding:

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			• M0100A (Resident has a pressure ulcer/injury~~Stage 1 or greater~~, a scar over bony prominence, or a non-removable dressing/device), Check box. • M0100B (Formal assessment instrument), Check box. • M0100C (Clinical assessment), Check box. • M0150 (Risk of Pressure Ulcers/Injuries), Code 1. • M0210 (One or more unhealed pressure ulcers/injuries~~(s) at Stage 1 or higher~~), Code 1. • M0300A (Number of Stage 1 pressure injuries~~ulcers~~), Code 0. • M0300B1 (Number of Stage 2 pressure ulcers), Code 1. • M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0. • ~~M0300B3 (Date of the oldest Stage 2 pressure ulcer), Enter 11 01 2010.~~ • M0300C1 (Number of Stage 3 pressure ulcers), Code 0 and skip to ~~item~~ M0300D (Stage 4). • M0300D1 (Number of Stage 4 pressure ulcers), Code 0 and skip to ~~item~~ M0300E (Unstageable ~~–~~: Non-removable dressing/device). • M0300E1 (Unstageable ~~–~~:Non-removable dressing/device), Code 0 and skip to ~~item~~ M0300F (Unstageable ~~–~~:Slough and/or eschar). • M0300F1 (Unstageable ~~–~~:slough and/or Eschar), Code 0 and skip to ~~item~~ M0300G (Unstageable ~~–~~:Deep tissue injury). • M0300G1 (Unstageable ~~–~~:Deep tissue injury), Code 0 and skip to ~~item~~ M1030 (Number of Venous and Arterial Ulcers)~~M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar)~~. • ~~M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is not completed, as the resident has a Stage 2 pressure ulcer.~~ • ~~M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).~~ • ~~M0800 (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because the 14-Day PPS is not the first assessment since the most recent admission/entry or~~

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			~~reentry. Therefore, A0310E=0. M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.~~ • ~~M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is not the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.~~ • M1030 (Number of Venous and Arterial U~~u~~lcers), Code 0. • M1040 (Other U~~u~~lcers, W~~w~~ounds and S~~s~~kin P~~p~~roblems), Check Z (None of the above). • M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (Pressure ulcer/injury care) are all checked. Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-~~D~~day PPS assessment, the resident's skin was noted to be intact, however, on the 14-~~D~~day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-~~D~~day PPS completed, the 14-day PPS would be coded 0 at A0310E. This is because the 14-~~D~~day PPS is **not** the first assessment since the most recent admission/entry or reentry. ~~Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS).~~ There were no other skin problems noted. However, the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, ~~has~~ had preventative measures put in place, with pressure reducing~~redistribution~~ devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items M1200A, M1200B, and M1200C were all checked.

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			She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings [with or without topical medications]) would not be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).

M0100. Determination of Pressure Ulcer/Injury Risk

↓ Check all that apply

- ☒ **A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**
- ☒ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☒ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers/Injuries

Enter Code [1] **Is this resident at risk of developing pressure ulcers/injuries?**
0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code [1] **Does this resident have one or more unhealed pressure ulcers/injuries?**
0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number [0]
1. **Number of Stage 1 pressure injuries**

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number [1]
1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number [0]
2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number [0]
1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number [ ]
2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number [0]
1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device

Enter Number [ ]
2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

Enter Number [0]
1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

Enter Number [ ]
2. **Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number [0]
1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury

Enter Number [ ]
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. Unstageable - Deep tissue injury:

Enter Number [0]
1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Enter Number [ ]
2. **Number of these unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

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M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code [1]

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
9. **None of the Above**

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry
Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number	
[1]	**A. Stage 2**
[0]	**B. Stage 3**
[0]	**C. Stage 4**

M0700–M0800 image deleted.

M0900. Healed Pressure Ulcers
Complete only if A0310E = 0

Enter Code [0]

A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?
0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.

Enter Number	
[ ]	**B. Stage 2**
[ ]	**C. Stage 3**
[ ]	**D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number [0]

Enter the total number of venous and arterial ulcers present

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

	Foot Problems
[ ]	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
[ ]	**B. Diabetic foot ulcer(s)**
[ ]	**C. Other open lesion(s) on the foot**
	Other Problems
[ ]	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
[ ]	**E. Surgical wound(s)**
[ ]	**F. Burn(s)** (second or third degree)
[ ]	**G. Skin tear(s)**
[ ]	**H. Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage)
	None of the Above
[X]	**Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

[X]	**A. Pressure reducing device for chair**
[X]	**B. Pressure reducing device for bed**
[X]	**C. Turning/repositioning program**
[ ]	**D. Nutrition or hydration intervention** to manage skin problems
[X]	**E. Pressure ulcer care**
[ ]	**F. Surgical wound care**
[ ]	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
[ ]	**H. Applications of ointments/medications** other than to feet
[ ]	**I. Application of dressings to feet** (with or without topical medications)
[ ]	**Z. None of the above** were provided