



Minimum Data Set (MDS) 3.0  
Instructor Guide V1.00

## Section M

# Skin Conditions

### Objectives

- Review key components of pressure ulcer risk assessment.
- Discuss the new pressure ulcer staging.
- Describe how to measure pressure ulcers.
- Discuss importance of interdisciplinary collaboration for wound differentiation.
- Code Section M correctly and accurately.



### **Training Resources**

- Instructor Guide
- Slides 1 - 163

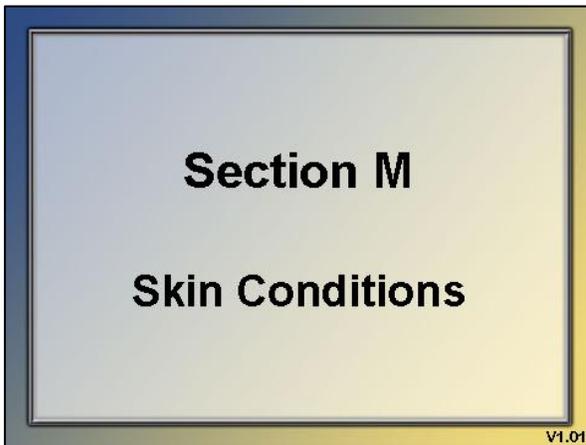
### **Instructor Preparation**

- Review the Instructor Guide for this lesson
- Consult the web addresses on some of the slides for more detailed information.
- Review learning objectives for the lesson.
- Think about ways to make each lesson interactive.
- Rehearse with slide presentation.
- Avoid reading the slides to the participants.



SLIDES	INSTRUCTIONAL GUIDANCE
Instructor Notes	
Notes	Notes
Instructor Notes	

Direct participants to turn to Section M in the MDS 3.0 instrument.



Slide 1

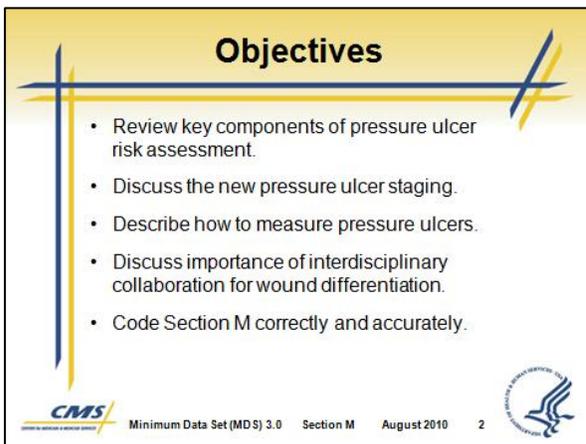
**I. Introduction/ Objectives**

*Introduce Section M on Skin Conditions.*

*Explain how this portion of MDS 3.0 is greatly expanded as it is now 3 full pages and almost double the number of items.*

*Tell the learners the time frame for the training session.*

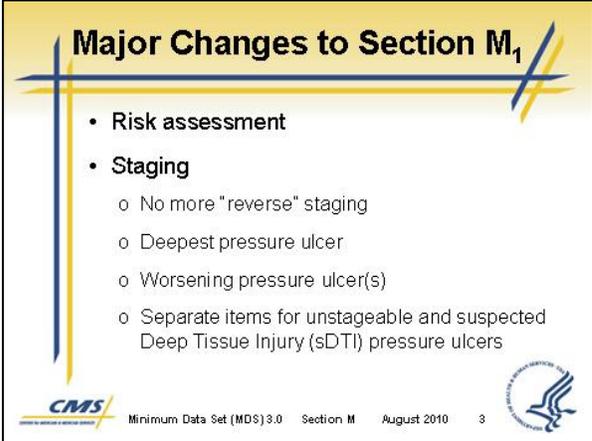
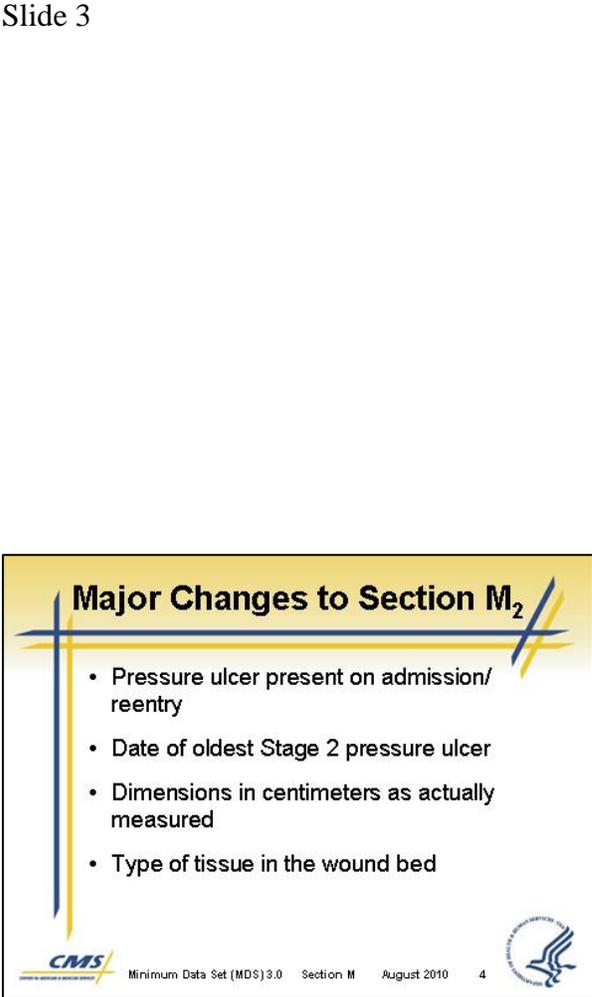
*Proceed to state the objectives you plan to cover during the learning session.*



Slide 2

**A. Objectives**

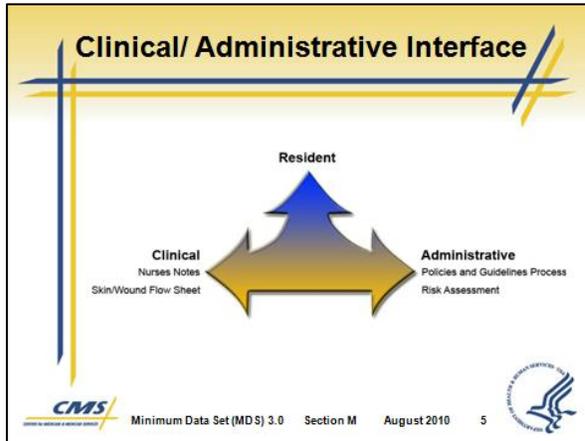
- Review key components of pressure ulcer risk assessment.
- Discuss the new pressure ulcer staging.
- Describe how to measure pressure ulcers.
- Discuss importance of interdisciplinary collaboration for wound differentiation.
- Code Section M correctly and accurately.

SLIDES	INSTRUCTIONAL GUIDANCE
 <p><b>Major Changes to Section M<sub>1</sub></b></p> <ul style="list-style-type: none"> <li>• Risk assessment</li> <li>• Staging             <ul style="list-style-type: none"> <li>○ No more "reverse" staging</li> <li>○ Deepest pressure ulcer</li> <li>○ Worsening pressure ulcer(s)</li> <li>○ Separate items for unstageable and suspected Deep Tissue Injury (sDTI) pressure ulcers</li> </ul> </li> </ul> <p>Minimum Data Set (MDS) 3.0 Section M August 2010 3</p>	<p>B. Major Changes to Section M</p> <ol style="list-style-type: none"> <li>1. Risk assessment             <ol style="list-style-type: none"> <li>a. Has been added to Section M.</li> </ol> </li> <li>2. Staging             <ol style="list-style-type: none"> <li>a. No more "reverse" staging                     <ul style="list-style-type: none"> <li>• This brings LTC into alignment with what other care settings have been doing clinically).</li> </ul> </li> <li>b. Deepest pressure ulcer                     <ul style="list-style-type: none"> <li>• Only one is recorded on MDS 3.0.</li> <li>• Will need a process for determining which one is the deepest.</li> </ul> </li> <li>c. Worsening pressure ulcer(s)</li> <li>d. Separate items for unstageable and suspected deep tissue injury (sDTI) pressure ulcers</li> </ol> </li> <li>3. Pressure ulcer present on admission/ reentry             <ol style="list-style-type: none"> <li>a. Begin to see what is happening in your facility.</li> </ol> </li> <li>4. Date of oldest Stage 2 pressure ulcer             <ol style="list-style-type: none"> <li>a. This is the only stage where the date of oldest pressure ulcer is required.</li> </ol> </li> <li>5. Dimensions in centimeters as actually measured</li> <li>6. Type of tissue in the pressure ulcer wound bed</li> </ol>
 <p><b>Major Changes to Section M<sub>2</sub></b></p> <ul style="list-style-type: none"> <li>• Pressure ulcer present on admission/ reentry</li> <li>• Date of oldest Stage 2 pressure ulcer</li> <li>• Dimensions in centimeters as actually measured</li> <li>• Type of tissue in the wound bed</li> </ul> <p>Minimum Data Set (MDS) 3.0 Section M August 2010 4</p>	

Slide 3

Slide 4

## SLIDES



Slide 5

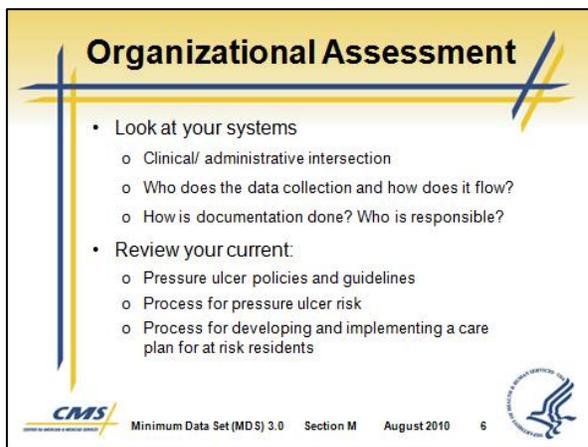
## INSTRUCTIONAL GUIDANCE

## C. Clinical/ Administrative Interface

1. Need to look at this from a holistic system point of view.
2. Includes three components:
  - a. Resident
    - Care processes center around the resident.
    - Requires clinical and administrative staff to review how each contributes to data for MDS 3.0.
  - b. Clinical staff
    - Do staff have skin/wound flow sheets that capture the relevant information now required for MDS 3.0?
    - How are nurses notes organized that will help provide the information now required on the enhanced Section M on MDS 3.0?
  - c. Administrative staff
3. Resident
  - a. Look at the resident's skin.
  - b. Look at the resident's wound.
  - c. Draw from resident's condition and goals of care.
4. Clinical support
  - a. What type of data collection sheets are being used?
    - Flow sheet

SLIDES	INSTRUCTIONAL GUIDANCE
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- Skin sheet
  - Wound sheet
  - b. Who is documenting information about the resident?
  - c. Is documentation complete and accurate?
  - d. What is being documented on a routine basis and how is it being documented?
  - e. Review of your current documentation practices is important so you can evaluate what areas can be enhanced.
5. Administrative support
- a. What policies/ procedures/ guidelines are in place to support wound care?
  - b. When were your facilities policies/ procedures/ guidelines last reviewed?
6. Maintain a dialog and partnership between the clinical and administrative support



Slide 6

- D. Organizational Assessment
1. The volume of data needed is greatly increased. Think about how you will need to manage it.
  2. Look at your systems.
    - a. Determine what is being done currently.
      - Are there any gaps?
      - How is data communicated?

SLIDES	INSTRUCTIONAL GUIDANCE
	<ul style="list-style-type: none"><li>b. Evaluate systems and procedures.</li><li>3. How do these intersect?</li><li>4. Make some decisions about how data is collected and used.<ul style="list-style-type: none"><li>a. Who does the data collection and how does it flow?</li><li>b. Is it working in your facility?</li><li>c. How is documentation done? (paper or electronic)</li><li>d. Who is responsible?<ul style="list-style-type: none"><li>• Nurse on unit</li><li>• Wound care nurse</li><li>• MDS Coordinator</li><li>• Outsourcing to a consultant and what is the interface</li></ul></li></ul></li><li>5. Review your current pressure ulcer policies and guidelines.<ul style="list-style-type: none"><li>a. Are they up-to-date especially since October 2009 NPUAP (<a href="http://www.npuap.org">www.npuap.org</a>) and June 2010 WOCN (<a href="http://www.wocn.org">www.wocn.org</a>)?</li></ul></li><li>6. Process for pressure ulcer risk<ul style="list-style-type: none"><li>a. How is your organization going to conduct risk assessment?</li></ul></li><li>7. Process for developing and implementing a care plan for at risk residents</li></ul>

**SLIDES**

**Clinician Skills Needed**

- Risk assessment
- New pressure ulcer staging
- Ulcer measurement
  - Using instrument according to CMS guidelines.
- Wound identification
  - Etiology of the wound is paramount.
  - Requires interdisciplinary collaboration.
  - Consider the whole person and underlying etiology.

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**INSTRUCTIONAL GUIDANCE**

- E. Clinician Skills Needed
1. Educational needs and skill set for staff are increased with the changes in Section M.
  2. Risk assessment
    - a. This is an opportunity to review your staff's competency in doing this assessment skill.
  3. New pressure ulcer staging as adapted from NPUAP 2007 by CMS
  4. Ulcer measurement
    - a. Must measure a wound using an instrument and according to CMS guidelines.
  5. Wound identification
    - a. Correctly identifying the etiology of the wound is paramount.
    - b. Differentiating wounds takes experience and sometimes interdisciplinary collaboration.
    - c. Must look at the whole person and consider the underlying etiology when identifying each wound.
  6. There are a variety of wound types, not just pressure ulcers.
    - a. Consider some of the wound identification training modules available including those available on the web if increased ability to differentiate among wound types is needed.
  7. A key concept is that this is a collaborative, interdisciplinary team effort.

## SLIDES

**NPUAP Pressure Ulcer Definition**

- CMS has **adapted** the NPUAP 2007 definition of a pressure ulcer as well as categories/ staging.
- A pressure ulcer is a localized injury to the skin and/ or underlying tissue *usually* over a bony prominence, as a result of pressure or pressure in combination with shear and/ or friction.

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## INSTRUCTIONAL GUIDANCE

## F. NPUAP Pressure Ulcer Definition

1. CMS has **adapted** the NPUAP 2007 definition of a pressure ulcer as well as categories/ staging.
2. You must use the CMS definitions.
3. A pressure ulcer is a localized injury to the skin and/ or underlying tissue *usually* over a bony prominence, as a result of pressure or pressure in combination with shear and/ or friction.
4. In addition, pressure in combination with shear and/ or friction contributes to pressure ulcers and skin injury.

## II. Items M0100 Determination of Ulcer Risk & M0150 Risk of Pressure Ulcers

- A. Let us begin by describing the two entirely new sections about assessment of the resident for pressure ulcer risk.

**Items M0100 & M0150**

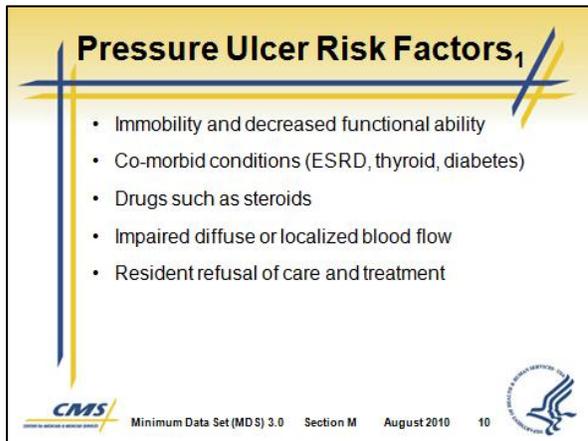
**Determination of Pressure Ulcer Risk**

**Risk of Pressure Ulcers**

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**SLIDES**

**INSTRUCTIONAL GUIDANCE**



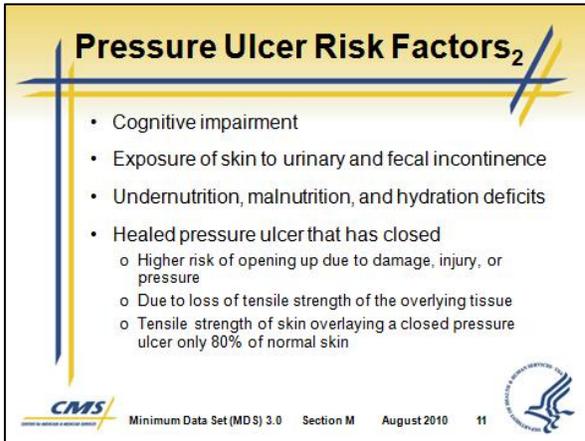
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**B. Pressure Ulcer Risk Factors**

1. There are many risk factors, and we will review some of them as listed.
2. Immobility and decreased functional ability
3. Co-morbid conditions
  - a. ESRD (fluid shifts especially during dialysis treatments)
  - b. Thyroid (persons with hypothyroidism can have dry skin while those with hyperthyroid can have skin problems from excess moisture)
  - c. Diabetes (blood vessels can become calcified so lack of adequate blood flow to the skin)
4. Drugs such as steroids
  - a. Steroids thin the skin and can cause immunosuppression.
5. Impaired diffuse or localized blood flow
  - a. For example, think about persons with cardiac disease.
6. Resident refusal of care and treatment
  - a. Make sure resident understands what a pressure ulcer is and ramifications of decisions
  - b. For example, if the resident chooses not to turn or reposition.
  - c. This is an ongoing effort.

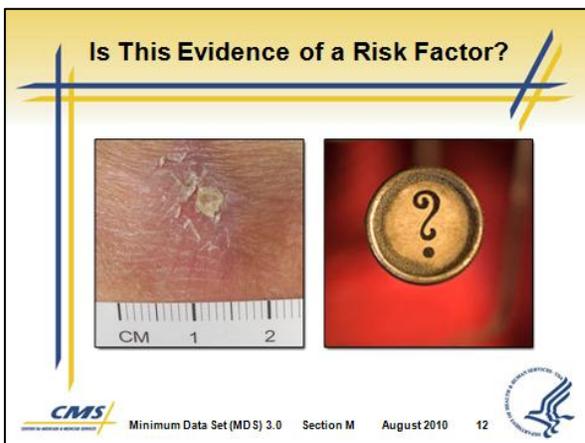
**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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7. Cognitive impairment
8. Exposure of skin to urinary and fecal incontinence
  - a. Develop plan to treat the incontinence or protect the skin.
9. Undernutrition, malnutrition, and hydration deficits
10. Healed pressure ulcer
  - a. This may require you to ask the resident about any history of having a previous pressure ulcer.
11. Healed pressure ulcer that has closed
  - a. Higher risk of opening up due to damage, injury, or pressure
  - b. Due to loss of tensile strength of the overlying tissue
  - c. Tensile strength of skin overlaying a closed pressure ulcer only 80% of normal skin

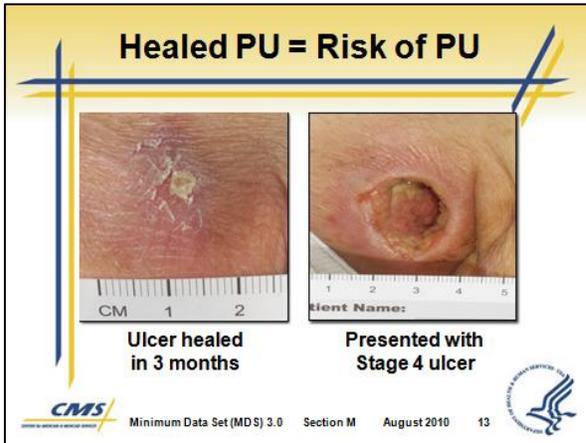


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- C. Is This Evidence of a Risk Factor
  1. What is this an image of?

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



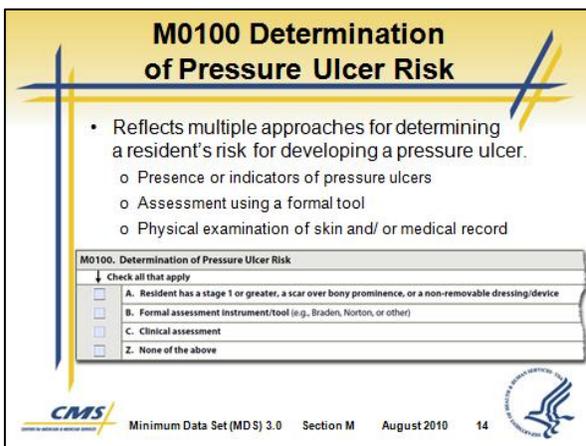
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**D. Healed Pressure Ulcer Equals Risk of a Pressure Ulcer**

1. The photo now reveals a healed Stage 4 pressure ulcer whose skin is vulnerable to pressure injury, making this resident at risk for a future pressure ulcer in this area.
2. Increases the risk for a pressure ulcer at the same location.
  - a. Skin is not filled in with the same skin as pre-wounding.
  - b. New skin has about 80% tensile strength.
  - c. This area is more vulnerable to another pressure ulcer occurring.
3. Someone who already has a pressure ulcer is at risk of additional pressure ulcers.

**E. M0100 Determination of Pressure Ulcer Risk**

1. Reflects multiple approaches for determining a resident's risk for developing a pressure ulcer.
  - a. Presence or indicators of pressure ulcers
  - b. Assessment using a formal tool
  - c. Physical examination of skin and/ or medical record
2. Check each item that applies.
3. You can check A, B, C or all that are applicable.
4. If you don't use any of these approaches in determining the resident's pressure ulcer risk, then check Z.

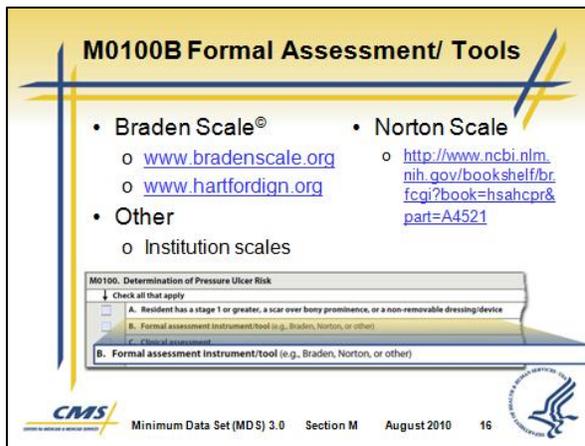


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## SLIDES



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## INSTRUCTIONAL GUIDANCE

## F. M0100A Risk Factors

1. Healed pressure ulcer  
*Same image as used in a previous slide.*
2. Previous Stage 1 or greater pressure ulcer
3. Non-removable dressing or device

## G. M0100B Formal Assessment/ Tools

1. Braden Scale<sup>®</sup> for predicting pressure sore risk
  - a. [www.bradenscale.org](http://www.bradenscale.org)
    - See information about levels of risk linked to prevention interventions at this web site.
    - Make sure staff knows the onset of risk score.
  - b. [www.hartfordign.org](http://www.hartfordign.org)
    - For additional information, see the one page free educational material on the Braden Scale available as one of the “Try this” series.
2. Norton Scale
  - a. <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hsahcpr&part=A4521>
3. Other
  - a. Institution scales

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**INSTRUCTIONAL GUIDANCE**

**M0100C Clinical Assessment**

- Observe the resident's skin.
- Review the medical record.
- Imperative to determine etiology of all wounds and lesions.
- Consider using mnemonics that capture key risk factors.
  - o HALT® is one example.

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- b. Make sure any institutional-developed tools are valid and reliable.

H. M100C Clinical Assessment

1. Clinical assessment requires actual observation of the resident's skin and a review of the medical record.
2. Without looking at the resident's skin, a pressure ulcer can be missed.
3. Consider using mnemonics that capture key risk factors.
4. Mnemonics are a useful tool to help the clinician remember key components of a clinical assessment.
5. HALT© is one example of a helpful mnemonic. It is not required by CMS to be used as part of a clinical assessment.

**HALT©<sub>1</sub>**

- **H** – History of pressure ulcer/ patient events
  - o Immobility
  - o Decreased functional ability
  - o Undernutrition, malnutrition hydration deficits
- **A** – Associated diagnoses/ co-morbidities
  - o Advancing age
  - o Medications (e.g. steroids)
  - o Hemodynamic instability, blood flow impairment
  - o ESRD, thyroid disease
  - o Diastolic pressure below 60

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I. HALT

1. History of pressure ulcer and patient events
  - a. Immobility
  - b. Decreased functional ability
  - c. Undernutrition, malnutrition hydration deficits
2. **A** – Associated diagnoses/ co-morbidities
  - a. Advancing age
  - b. Medications (e.g. steroids)
  - c. Hemodynamic instability, blood flow impairment
  - d. ESRD, thyroid disease
  - e. Diastolic pressure below 60

## SLIDES

**HALT©<sub>2</sub>**

- **L** – Look at the skin
- **T** – Touch the skin
  - o Temperature changes of the skin
  - o Exposure to incontinence

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## INSTRUCTIONAL GUIDANCE

3. **L** – Look at the skin
4. **T** – Touch the skin
  - a. Temperature changes of the skin
    - Warmer
    - Cooler
  - b. Exposure to incontinence

**M0150 Risk of Pressure Ulcers**

- Determine if resident is at risk for pressure ulcers.
- Recognize/ evaluate each resident's risk factors.
- Identify/ evaluate all areas at risk of constant pressure.
- Determine if resident is at risk.

**M0150. Risk of Pressure Ulcers**

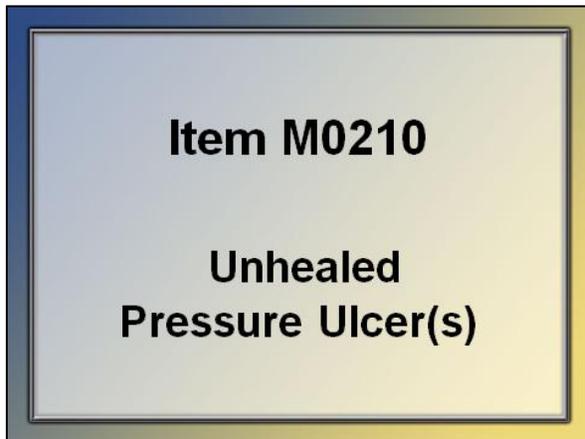
Enter Code	Is this resident at risk of developing pressure ulcers?
<input type="checkbox"/>	0. No
	1. Yes

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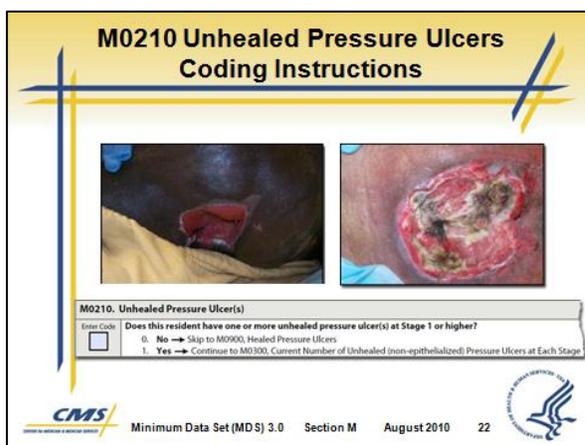
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- J. M0150 Risk of Pressure Ulcers
  1. Based on the information gathered in M0100, a decision is made in M0150 as to whether the resident is or is not at risk for pressure ulcers.
  2. Recognize and evaluate each resident's risk factors.
  3. Identify and evaluate all areas at risk related to constant pressure.
  4. Based on the assessment of risk factors determined in section M0100, determine if resident is at risk.
    - **Code 0. No.**  
If the resident is not at risk for developing pressure ulcers based on a review of information gathered for M0100.
    - **Code 1. Yes.**  
If the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100.

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**III. Item M0210 Unhealed Pressure Ulcer(s)**

A. Code this item to indicate whether or not the resident has any unhealed pressure ulcers.

B. M0210 Unhealed Pressure Ulcers Coding Instructions

1. This slide illustrates two different residents with pressure ulcers.
2. Review the etiology of each wound to determine the correct code.
3. Only wounds whose primary etiology is pressure are coded in this item.

- **Code 0. No.**

If the resident did not have a pressure ulcer in the 7-day look-back period.

Then skip Items M0300–M0800.

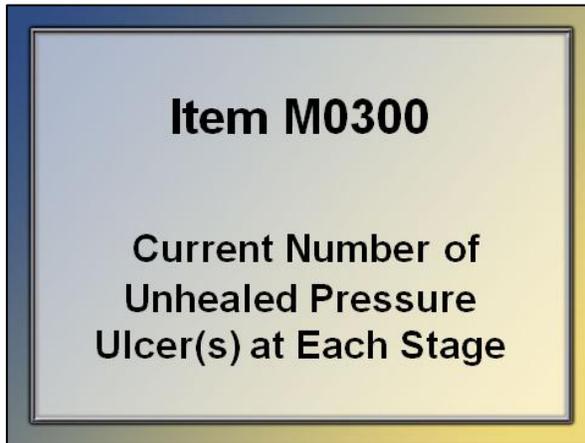
*Emphasize skip pattern here.*

- **Code 1. Yes.**

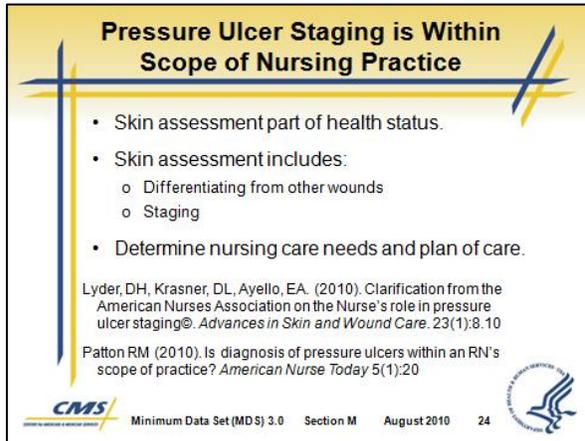
If the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100.

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## INSTRUCTIONAL GUIDANCE



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4. Do not indicate the **number of pressure ulcers in M0210**, just whether or not an unhealed ulcer is present.
5. The number of pressure ulcers is coded in the next item (M0300A-G).

#### IV. Item M0300 Current Number of Unhealed Pressure Ulcer(s) at Each Stage

- A. After visual inspection and palpation of the deepest type of tissue, code the current **number** of unhealed pressure ulcers for each stage.
- B. Pressure Ulcer Staging is Within Scope of Nursing Practice
  1. Skin assessment is part of health status.
  2. Skin assessment includes:
    - a. Differentiating from other wounds
    - b. Staging
  3. Determine nursing care needs and plan of care.

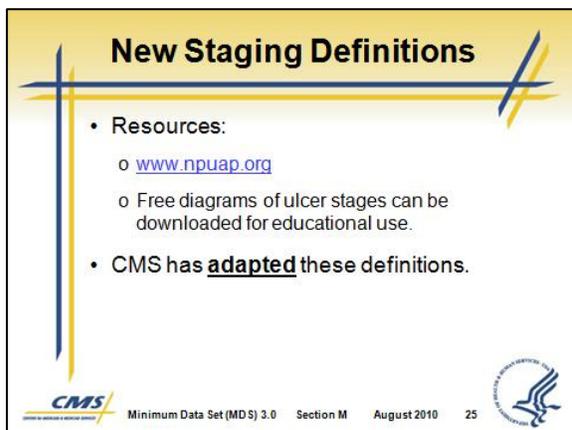
**SLIDES**

**INSTRUCTIONAL GUIDANCE**

4. References
  - a. Lyder, DH, Krasner, DL, Ayello, EA. (2010). Clarification from the American Nurses Association on the Nurse’s role in pressure ulcer staging©. *Advances in Skin and Wound Care*. 23(1):8.10
  - b. Patton RM (2010). Is diagnosis of pressure ulcers within an RN’s scope of practice? *American Nurse Today* 5(1):20

C. New Staging Definitions

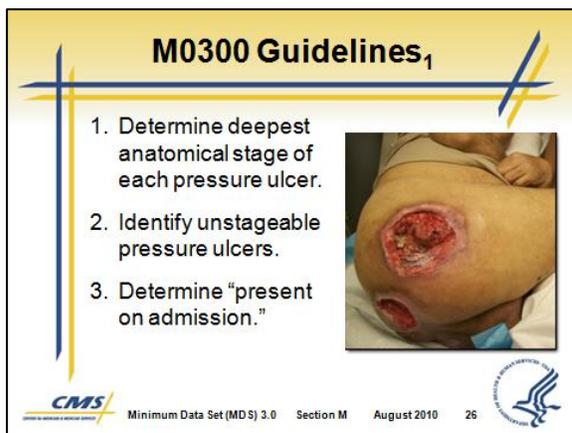
1. Resources:
  - a. [www.npuap.org](http://www.npuap.org)
  - b. Free diagrams of ulcer stages can be downloaded for educational use.
2. CMS has **adapted** the 2007 NPUAP definitions.



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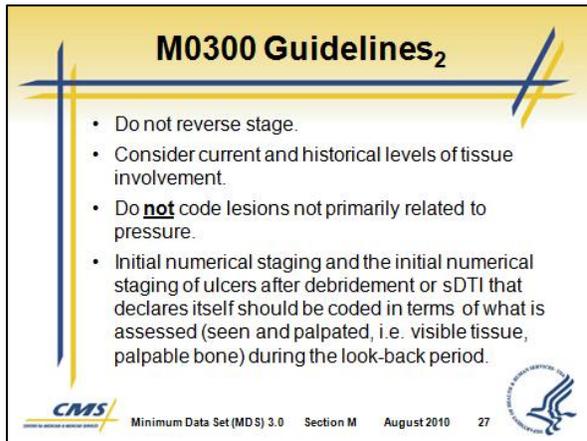
D. M0300 Guidelines

1. For each of the 7 items (A-G) in M0300, code the number of ulcers and if the ulcer was present on admission.
2. Determine deepest anatomical stage of each pressure ulcer.
  - a. Identify the type of tissue in the deepest part of the ulcer.
  - b. This requires visual inspection of the ulcer and the surrounding skin.



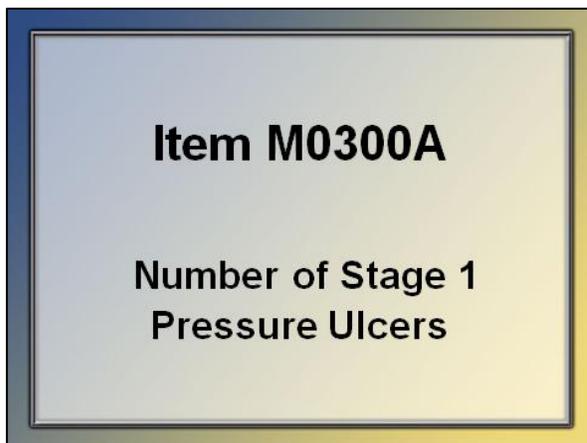
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3. Identify unstageable pressure ulcers.
4. Determine “present on admission.”
5. Do not reverse stage.
6. Consider current and historical levels of tissue involvement.
7. Do **not** code lesions not primarily related to pressure in this item.
8. Code in the appropriate section.
9. Initial numerical staging and the initial numerical staging of ulcers after debridement or sDTI that declares itself should be coded in terms of what is assessed (seen and palpated, i.e. visible tissue, palpable bone) during the look-back period.



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**V. Item M0300A Number of Stage 1 Pressure Ulcers**

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300A Number of Stage 1 Pressure Ulcers**

- Document number of Stage 1 pressure ulcers.
- Stage 1 pressure ulcers may deteriorate without adequate intervention.
- They are an important risk factor for further tissue damage.

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

**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.

**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.

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**M0300A Conduct the Assessment<sub>1</sub>**

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas, such as:
  - o Sacrum
  - o Heels
  - o Buttocks
  - o Ankles

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- A. M0300A Number of Stage 1 Pressure Ulcers
1. Document number of Stage 1 pressure ulcers.
  2. Stage 1 pressure ulcers may deteriorate without adequate intervention.
  3. They are an important risk factor for further tissue damage.
  4. Coding Instructions:
    - a. Indicate the **number** of Stage 1 pressure ulcers present in the space.
    - b. If none, enter zero.
- B. M0300A Conduct the Assessment
1. Perform a head-to-toe, full body skin assessment.
  2. Focus on bony prominences and pressure-bearing areas, such as:
    - a. Sacrum
      - This is the number one location for pressure ulcers in the adult resident.
    - b. Buttocks
    - c. Heels
    - d. Ankles

## SLIDES

**M0300A Conduct the Assessment<sub>2</sub>**

- Check any reddened areas for ability to blanch.
  - Firmly press finger into tissue then remove
  - Non-blanchable: no loss of skin color or pressure-induced pallor at the compressed site
- Search for other areas of skin that differ from surrounding tissue.
  - Painful
  - Firm
  - Soft
  - Warmer or cooler
  - Color change

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## INSTRUCTIONAL GUIDANCE

3. Check any reddened areas for ability to blanch.
  - a. Firmly press finger into tissue then remove
  - b. Non-blanchable: no loss of skin color or pressure-induced pallor at the compressed site

*Ask participants to do this on their own hand or arm.*

4. Search for other areas of skin that differ from surrounding tissue.
  - a. Painful
  - b. Firm
  - c. Soft
  - d. Warmer or cooler
  - e. Color change
    - Adequate lighting is needed to see color changes.
5. Assessment to determine staging should be holistic.
6. Stage 1 may be difficult to detect in individuals with dark skin tones, especially if only looking for color changes.
7. Determine whether an ulcer is a Stage 1 pressure ulcer or suspected deep tissue injury.
  - a. This is not always easy.
8. Do not rely on only one descriptor as the descriptors for these two types of ulcers are similar.

**M0300A Assessment Guidelines**

- Assessment to determine staging should be holistic.
- Stage 1 may be difficult to detect in individuals with dark skin tones.
- Determine whether an ulcer is a Stage 1 pressure ulcer or suspected deep tissue injury.
- Do not rely on only one descriptor as the descriptors for these two types of ulcers are similar.
- Code pressure ulcers with intact skin that are suspected deep tissue injury in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.

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**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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9. Code pressure ulcers with intact skin that are suspected deep tissue injury in M0300G  
*Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.*

C. Category/ Stage 1 Pressure Ulcer

1. Intact skin with **non-blanchable redness** of a localized area usually over a bony prominence.

2. **Darkly pigmented skin** may not have visible blanching.

*Point out the extent of this ulcer as indicated by the dashed lines.*

3. Color may differ from the surrounding area.

D. Is This a Stage 1 Pressure Ulcer?

1. Based on this image, would this be considered a Stage 1 pressure ulcer?

*Give participants time to think of their answer before moving to the next slide.*

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Not a Stage 1 Pressure Ulcer**

- This is moisture associated skin damage from incontinence.
- Do not document in M0300A.



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- E. Not a Stage 1 Pressure Ulcer
1. This is moisture associated skin damage (MASD) from incontinence.
  2. Do not document in M0300A. as this is not a pressure ulcer.

**Item M0300B**

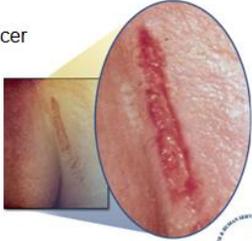
**Stage 2 Pressure Ulcers**

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**VI. Item M0300B Stage 2 Pressure Ulcers**

**Category/ Stage 2 Pressure Ulcer<sub>1</sub>**

- **Partial thickness** loss of dermis presenting as:
  - Shallow open ulcer
  - Red or pink wound bed
  - Without slough



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- A. Category/ Stage 2 Pressure Ulcer
1. **Partial thickness** loss of dermis presenting as:
    - a. Shallow open ulcer
    - b. Red or pink wound bed
    - c. Without slough

*Emphasize that if there is ANY slough, it is not a Stage 2 pressure ulcer.*

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Category/ Stage 2 Pressure Ulcer<sub>2</sub>**



- May also present as an intact or open/ ruptured **blister**.

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2. May also present as an intact or open/ ruptured **blister**.

**Category/ Stage 2 Pressure Ulcer<sub>3</sub>**

- Do **NOT** code as a Stage 2 when a deep tissue injury **is** determined.
- Code in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.
- Clearly document assessment findings in the resident's medical record.
- Facilities may adapt NPUAP guidelines in their clinical practice and nursing documentation.

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3. Do **NOT** code as a Stage 2 when a deep tissue injury **is** determined.
4. Code in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.
5. Clearly document assessment findings in the resident's medical record.
6. Facilities may adapt NPUAP guidelines in their clinical practice and nursing documentation.

**M0300B Conduct the Assessment**

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Examine the area adjacent to or surrounding any intact blister for evidence of tissue damage.
- Determine if lesion being assessed is primarily related to pressure.
- Rule out other conditions.
- Do not code here if pressure is not the primary cause.

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- B. M0300B Conduct the Assessment
  1. Perform a head-to-toe, full body skin assessment.
  2. Focus on bony prominences and pressure-bearing areas.
  3. Examine the area adjacent to or surrounding any intact blister for evidence of tissue damage.
    - a. This is a change from previous CMS instructions regarding coding of blister pressure ulcers when all blisters were a Stage 2.

## SLIDES

## INSTRUCTIONAL GUIDANCE

**M0300B Assessment Guidelines<sub>1</sub>**

- Assessment to determine staging should be holistic.
- Determine if tissue adjacent to or surrounding the blister demonstrates signs of tissue damage:
  - Color change
  - Tenderness
  - Bogginess or firmness
  - Warmth or coolness

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**M0300B Assessment Guidelines<sub>2</sub>**

- Stage 2 ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
- Blood-filled blisters related primarily pressure are more likely than serous filled blisters to be associated with a suspected deep tissue injury.
- Ensure, again, a complete, and comprehensive, assessment of the resident and the site of injury.
- Do **not** code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury in M0300B.

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- b. Now a holistic assessment is needed to determine if it is a Stage 2 or unstageable sDTI (see section M0300G)
4. Determine if the lesion being assessed is primarily related to pressure.
5. Rule out other conditions.
6. Do not code here if pressure is not the primary cause.
7. Assessment to determine staging should be holistic.
8. Determine if tissue adjacent to or surrounding the blister demonstrates signs of tissue damage:
  - a. Color change
  - b. Tenderness
  - c. Bogginess or firmness
  - d. Warmth or coolness
9. Clinicians should be documenting these assessment findings in their notes.
10. Stage 2 ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
11. Blood-filled blisters related primarily to pressure are more likely than serous-filled blisters to be associated with a suspected deep tissue injury.
12. Ensure, again, a complete, and comprehensive, assessment of the resident and the site of injury

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300B Stage 2 Pressure Ulcers Coding Instructions**

1. **Number** of Stage 2 pressure ulcers
2. Number of Stage 2 pressure ulcers **present upon admission/ reentry**
  - o Number of pressure ulcers first noted at time of admission
  - o Number of pressure ulcers acquired during a hospital stay if being readmitted
3. **Date** of **oldest** Stage 2 pressure ulcer
  - o Code suspected deep tissue injury at M0300G.

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13. Do **not** code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury in M0300B.

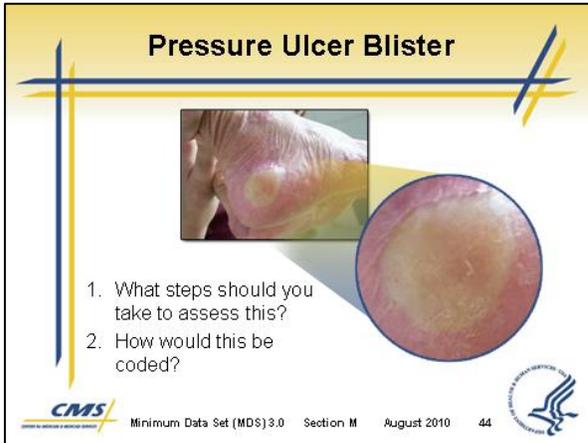
C. M0300B Stage 2 Pressure Ulcers Coding Instructions

1. **Number** of Stage 2 pressure ulcers
2. Number of Stage 2 pressure ulcers **present upon admission/ reentry**
  - a. Number of pressure ulcers first noted at time of admission
  - b. Number of pressure ulcers acquired during a hospital stay if being readmitted
3. **Date** of **oldest** Stage 2 pressure ulcer
  - a. 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.
  - b. This is why a facility must look at the flow of pressure ulcer data so the date of the oldest Stage 2 pressure ulcer can be found in the medical record.
  - c. Wound/ skin flow sheets that record this data are helpful in retrieving this information.
  - d. Do not leave the boxes blank.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

- e. Enter a dash in every block if unable to determine the actual date that the Stage 2 pressure ulcer was first identified, (i.e. the date is unknown).



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**D. Pressure Ulcer Blister**

1. What steps should you take to assess this?

*Ask participants to repeat the steps for holistic assessment as described earlier.*

2. How would this be coded?
3. Stage 2 as there are no signs of sDTI, so code under M0300B.

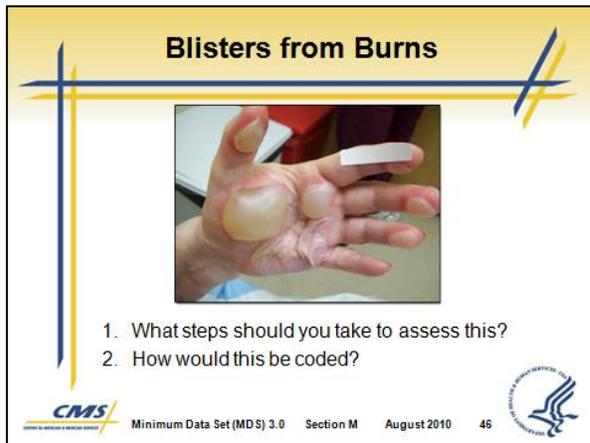
**E. Blood-Filled Blister**

1. What steps should you take to assess this?

*Again, emphasis is on a holistic assessment.*

2. How would this be coded?
3. Since there *are* signs of sDTI, this is an unstageable pressure ulcer.
4. Do not code here; code under M0300G.

SLIDES	INSTRUCTIONAL GUIDANCE
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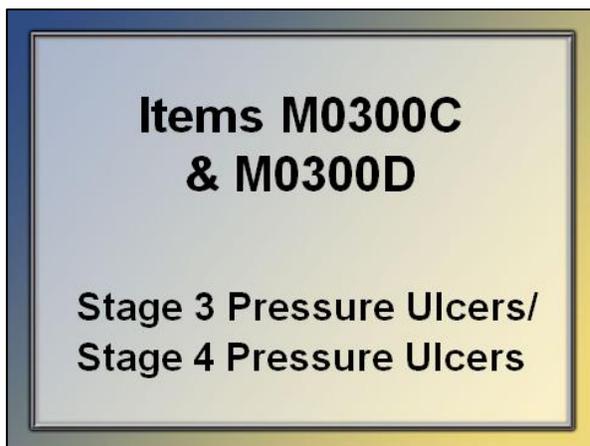
F. Blisters from Burns

*Point out that not all blisters are from pressure.*

1. What steps should you take to assess this?

*Again, emphasis is on a holistic assessment.*

2. How would this be coded?
3. This is a burn as this person put their hand on a hot surface.
4. Do not code here; this is coded under M01040E burns.
5. If pressure is not the primary cause, do not code in M0300.
6. That's why understanding the history and a holistic assessment to determine the cause of the blisters are important.



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**VII. Items M0300C Stage 3 Pressure Ulcers/ M0300D Stage 4 Pressure Ulcers**

- A. Full thickness pressure ulcers are either Stage 3 or 4.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300C Conduct the Assessment**

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Determine if lesion being assessed is primarily related to pressure.
  - o Rule out other conditions.
  - o Do not code here if pressure is not the primary cause.

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- B. M0300C Conduct the Assessment
1. Perform a head-to-toe, full body skin assessment.
  2. Focus on bony prominences and pressure-bearing areas.
  3. Determine if lesion being assessed is primarily related to pressure.
    - a. Rule out other conditions.
    - b. Do not code here if pressure is not the primary cause.

**Category/ Stage 3 Pressure Ulcer**

- **Full thickness** tissue loss.
- Subcutaneous **fat may be visible** but bone, tendon or muscle are **not** exposed.
- **Slough may be present** but does not obscure the depth of tissue loss.
- **May** include undermining and tunneling.



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- C. Category/ Stage 3 Pressure Ulcer
1. Full thickness tissue loss.
  2. Subcutaneous **fat may be visible** but bone, tendon or muscle are **not** exposed.
  3. **Slough may be present** but does not obscure the depth of tissue loss.
  4. **May** include undermining and tunneling.

**M0300C Stage 3 Pressure Ulcers Coding Instructions**

1. **Number of Stage 3 pressure ulcers**
  - o Identify all Stage 3 pressure ulcers currently present.
2. **Number of Stage 3 pressure ulcers present upon admission/ reentry**
  - o Code the number of pressure ulcers first noted at time of admission.
  - o Code number of pressure ulcers acquired during a hospital stay if being readmitted.

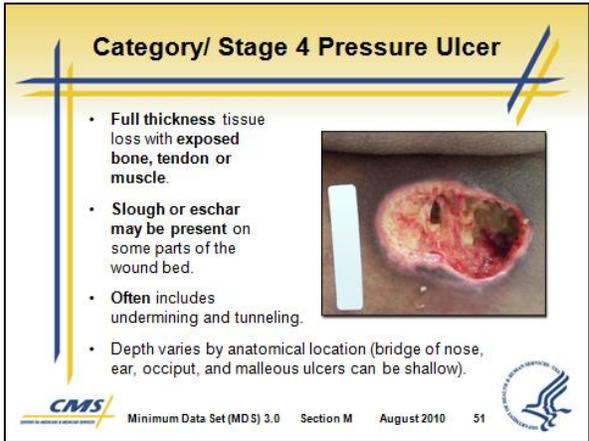
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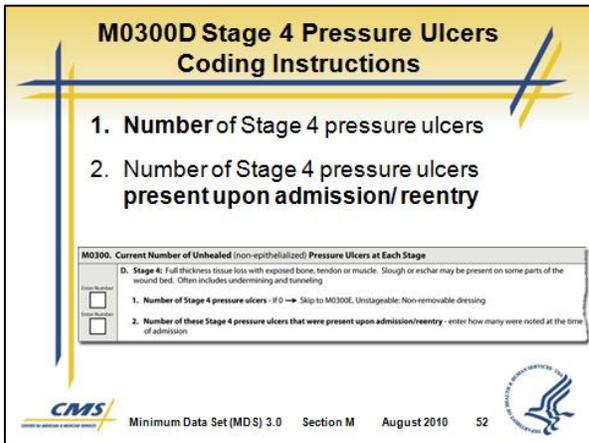
- D. M0300C Stage 3 Pressure Ulcers Coding Instructions
1. **Number** of Stage 3 pressure ulcers
    - a. Identify all Stage 3 pressure ulcers currently present.
  2. **Number of Stage 3 pressure ulcers present upon admission/ reentry**
    - a. Code the number of pressure ulcers first noted at time of admission.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- b. Code number of pressure ulcers acquired during a hospital stay if being readmitted.

E. Category/ Stage 4 Pressure Ulcer

1. **Full thickness** tissue loss with **exposed bone, tendon or muscle**.
2. **Slough or eschar may be present** on some parts of the wound bed.
3. **Often** includes undermining and tunneling.
4. Depth varies by anatomical location (bridge of nose, ear, occiput, and malleous ulcers can be shallow).

F. M0300D Stage 4 Pressure Ulcers Coding Instructions

1. **Number** of Stage 4 pressure ulcers
2. Number of Stage 4 pressure ulcers **present upon admission/ reentry**

*Now that definitions for 4 stages of pressure ulcers have been reviewed, let's look at some clinical situations and how they would be coded.*

## SLIDES

**M0300A - D Scenario #1**

- A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record at the time of admission.
- On a later assessment, the wound is noted to be a full thickness ulcer.
- Thus it is now a Stage 3 pressure ulcer.

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**M0300A - D Scenario #1 Coding**

- Code M0300C1. Number of Stage 3 pressure ulcers as **1**.
- Code M0300C2 as **0** (not present on admission).
- The designation of "present on admission" requires that the pressure ulcer be at the same location and not have worsened to a deeper anatomical stage.
- This pressure ulcer worsened after admission.

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**M0300A - D Scenario #2**

- 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.
- The third has worsened to a Stage 3 pressure ulcer.

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## INSTRUCTIONAL GUIDANCE

## G. M0300A - D Scenario #1

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record at the time of admission.
2. On a later assessment, the wound is noted to be a full thickness ulcer.
3. Thus it is now a Stage 3 pressure ulcer.

## H. M0300A - D Scenario #1 Coding

1. Code M0300C1. Number of Stage 3 pressure ulcers as **1**.
2. Code M0300C2 as **0** not present on admission.
3. The designation of "present on admission" requires that the pressure ulcer be at the same location and not have worsened to a deeper anatomical stage.

## I. M0300A - D Scenario #2

1. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx.
2. Two weeks later, the coccyx is assessed.
3. Two of the Stage 2 pressure ulcers have merged.
4. The third has worsened to a Stage 3 pressure ulcer.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300A - D Scenario #2 Coding<sub>1</sub>**

- Code the two merged pressure ulcers:
  - M0300B1. Number of Stage 2 pressure ulcers as **1**.
  - M0300B2 as **1** present upon admission.
- Two of the pressure ulcers on the coccyx have merged.
- They have remained at the same stage as they were at the time of admission.



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**M0300A - D Scenario #2 Coding<sub>2</sub>**

- Code the Stage 3 pressure ulcer:
  - M0300C1. Number of Stage 3 pressure ulcers as **1**.
  - M0300C2 as **0** (not present on admission).
- The pressure ulcer has increased to a Stage 3 since admission.
- Therefore, it cannot be coded as present on admission.



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**M0300A - D Scenario #3**

- A resident develops a Stage 2 pressure ulcer while at the nursing facility.
- The resident is hospitalized due to pneumonia for 8 days.
- The resident returns with a Stage 3 pressure ulcer in the same location.



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J. M0300A - D Scenario #2 Coding

1. Code the two merged pressure ulcers:
  - a. M0300B1. Number of Stage 2 pressure ulcers as **1**.
  - b. M0300B2 as **1** present upon admission.

2. Two of the pressure ulcers on the coccyx have merged.
3. They have remained at the same stage as they were at the time of admission.

4. Code the Stage 3 pressure ulcer:
  - a. M0300C1. Number of Stage 3 pressure ulcers as **1**.
  - b. M0300C2 as **0** not present on admission.

5. The pressure ulcer has increased to a Stage 3 since admission.
6. Therefore, it cannot be coded as present on admission.

K. M0300A - D Scenario #3

1. A resident develops a Stage 2 pressure ulcer while at the nursing facility.
2. The resident is hospitalized due to pneumonia for 8 days.
3. The resident returns with a Stage 3 pressure ulcer in the same location.



**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300E Unstageable Non-Removable Device**

- Ulcer covered with eschar under plaster cast
- **Known** but not stageable because of the non-removable device



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- D. M0300E Unstageable Non-Removable Device
1. Ulcer covered with eschar under plaster cast
  2. **Known** but not stageable because of the non-removable device

**M0300E Unstageable Non-Removable Dressing**

- **Known** but not stageable because of the non-removable dressing



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- E. M0300E Unstageable Non-Removable Dressing
1. **Known** but not stageable because of the non-removable dressing

**M0300F Unstageable Slough and/ or Eschar**

- **Known** but not stageable related to coverage of wound bed by slough and/ or eschar
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed



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- F. M0300F Unstageable Slough and/ or Eschar
1. **Known** but not stageable related to coverage of wound bed by slough and/ or eschar
  2. Full thickness tissue loss
  3. Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed
  4. Once unstageable pressure ulcers are debrided and the depth of tissue involved can be assessed, the ulcer can be numerically staged.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300G Unstageable Suspected Deep Tissue Injury<sub>1</sub>**

- Localized area of discolored (darker than surrounding tissue) intact skin.
- Related to damage of underlying soft tissue from pressure and/ or shear.
- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.



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**M0300G Unstageable Suspected Deep Tissue Injury<sub>2</sub>**

- Quality health care begins with prevention and risk assessment.
- 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.

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**M0300G Unstageable Suspected Deep Tissue Injury<sub>3</sub>**

- Clearly document assessment findings in the resident's medical record.
- Track and document appropriate wound care planning and management.
- Deep tissue injuries can indicate severe damage.
- Identification and management is imperative.

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- G. M0300G Unstageable Suspected Deep Tissue Injury
1. Localized area of discolored (darker than surrounding tissue) intact skin.
  2. Related to damage of underlying soft tissue from pressure and/ or shear.
  3. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
  4. Deep tissue injury may be difficult to detect in individuals with dark skin tones.
  5. Quality health care begins with prevention and risk assessment.
  6. Care planning begins with prevention.
  7. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds.
  8. Clearly document assessment findings in the resident's medical record.
  9. Track and document appropriate wound care planning and management.
  10. Deep tissue injuries can indicate severe damage.
  11. Identification and management is imperative.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300E, M0300F, M0300G  
Coding Instructions**

- Code **number** of each type of pressure ulcer.
- Code number of each type of ulcer **present upon admission/ reentry**.
- Do not code M0300G when a lesion related to pressure presents with an intact blister **and** the surrounding or adjacent soft tissue does **not** have the characteristics of Deep Tissue Injury.
- Code under M0300B Unhealed Pressure Ulcers – Stage 2.


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- H. M0300E, M0300F, M0300G Coding Instructions
1. Code **number** of each type of pressure ulcer.
  2. Code number of each type of ulcer **present upon admission/ reentry**.
  3. Do not code M0300G when a lesion related to pressure presents with an intact blister **and** the surrounding or adjacent soft tissue does **not** have the characteristics of Deep Tissue Injury.
    - a. Code under M0300B Unhealed Pressure Ulcers - Stage 2.

**M0300E - G Scenario #1**

- 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.


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- I. M0300E - G Scenario #1
1. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar.
  2. On the admission assessment, it was coded as unstageable and present on admission.
  3. The pressure ulcer is later debrided using conservative methods, and after 4 weeks, the ulcer has 50% to 75% eschar present.
  4. The assessor can now see that the damage extends down to the bone.

## SLIDES

**M0300E–G Scenario #1 Coding**

- Reclassify as a Stage 4 pressure ulcer.
- On the subsequent MDS:
  - Code M0300D1 Number of Stage 4 pressure ulcers as 1.
  - Code M0300D2 as 1 present on admission.
- After debridement, the pressure ulcer is no longer unstageable because it can be observed to be a Stage 4 pressure ulcer.
- Enter this pressure ulcer's dimensions at M0610 if it has the largest surface area of all Stage 3 or Stage 4 pressure ulcers for this resident.

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**M0300E – G Scenario #2**

- 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.
- The wound bed is covered with slough.

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## INSTRUCTIONAL GUIDANCE

- J. M0300E - G Scenario #1 Coding
1. Reclassify from an unstageable pressure ulcer due eschar to a numerical Stage 4 pressure ulcer.
  2. On the subsequent MDS:
    - a. Code M0300D1 Number of Stage 4 pressure ulcers as **1**.
    - b. Code M0300D2 as **1** present on admission.
  3. After debridement, the pressure ulcer is no longer unstageable because it can be observed to be a Stage 4 pressure ulcer.
  4. Enter this pressure ulcer's dimensions at M0610 if it has the largest surface area of all Stage 3 or Stage 4 pressure ulcers for this resident.
- K. M0300E - G Scenario #2
1. Miss J. was admitted with one small Stage 2 pressure ulcer.
  2. Despite treatment, it is not improving.
  3. In fact, it now appears deeper than originally observed.
  4. The wound bed is covered with slough.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0300E – G Scenario #2 Coding**

- Code M0300F1 Number of unstageable pressure ulcers related to coverage of wound bed by slough and/ or eschar as **1**.
- Code M0300F2 as **0** not present on admission.
- The pressure ulcer is coded as unstageable due to coverage of the wound bed by slough.
- It is not coded as present on admission because it can no longer be coded as a Stage 2.



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- L. M0300E - G Scenario #2 Coding
1. Code M0300F1 Number of unstageable pressure ulcers related to coverage of wound bed by slough and/ or eschar as **1**.
  2. Code M0300F2 as **0** not present on admission.
  3. The pressure ulcer is coded as unstageable due to coverage of the wound bed by slough.
  4. It is not coded as present on admission because it can no longer be coded as a Stage 2.

**Pressure Ulcer Staging Quiz**

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**IX. Pressure Ulcer Staging Quiz**

**Pressure Ulcer Quiz #1**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI




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- A. Pressure Ulcer Quiz #1
1. Correct answer is Stage 3 (M0300C).
  2. Has some slough but visible enough for staging

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Pressure Ulcer Quiz #2**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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**B. Pressure Ulcer Quiz #2**

1. Correct answer is Stage 4 (M0300D).
2. Can feel bone.

**Pressure Ulcer Quiz #3**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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**C. Pressure Ulcer Quiz #3**

1. Correct answer is Unstageable related to slough or eschar (M0300F).
2. Can not see the wound bed as it is totally covered with eschar.

**Pressure Ulcer Quiz #4**



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

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**D. Pressure Ulcer Quiz #4**

1. Correct answer is Stage 4 (M0300D).
2. Although there is quite an amount of slough in covering this wound, the part of the wound bed that is visible indicates that it is deep into muscle and could feel bone.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Pressure Ulcer Quiz #5**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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- E. Pressure Ulcer Quiz #5
1. Correct answer is Unstageable related to slough or eschar (M0300F).
  2. Wound bed covered with eschar, so it is unstageable until wound bed is visible.

**Pressure Ulcer Quiz #6**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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- F. Pressure Ulcer Quiz #6
1. Correct answer is Stage 4 (M0300D).
  2. This full thickness wound is deep into muscle.

**Pressure Ulcer Quiz #7**

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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- G. Pressure Ulcer Quiz #7
1. The pressure-related blood blister ulcer that appears on the upper (right) heel needs to be assessed further as there is a possibility that this wound is sDTI.
    - If this is determined to be a blood-filled blister, then code M0300B Stage 2.
    - If sDTI, code M0300G Unstageable -- sDTI.
  2. The lower (left) heel should be coded as M0300F Unstageable – Slough and/ or eschar.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Pressure Ulcer Quiz #8**



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

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**Pressure Ulcer Quiz #9**



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

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**Item M0610**

**Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar**

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**H. Pressure Ulcer Quiz #8**

1. Correct answer is Unstageable related to suspected deep tissue injury.
2. Dark purple intact skin is characteristic of a typical sDTI.

**I. Pressure Ulcer Quiz #9**

1. Correct answer is Stage 2 (M0300B).
2. Always know what you are looking at when assessing the wound.
3. Retains some residual dressing appearing to be slough, that's why you clean the wound first, then stage the wound

**X. Item M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar**

- A. Another new component of MDS 3.0 is the dimensions of the largest unhealed Stage 3, or 4 pressure ulcers, or one covered with eschar

**SLIDES**

**Dimensions of a Pressure Ulcer -- What to Measure**

- Identify pressure ulcer with the largest surface area from the following:
  - o Unhealed (nonepithelialized) Stage 3 or 4
  - o Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest.

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**INSTRUCTIONAL GUIDANCE**

**B. Dimensions of a Pressure Ulcer -- What to Measure**

1. Identify pressure ulcer with the largest surface area from the following:
  - a. Unhealed (nonepithelialized) Stage 3 or 4
  - b. Unstageable pressure ulcer related to slough or eschar

*Ask participant to recall the earlier discussion about this being a systems issue and that having a good tracking form or sheet to record dimensions for each pressure ulcer will make it easier to select which ulcer, if resident has multiple ulcers, has the largest dimensions which must now be coded on M0610.*

2. Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest.

*Emphasize the point that it is necessary to know dimensions of these pressure ulcers in order to select the largest for recording on this section of MDS 3.0.*

3. Need to use a measuring device to obtain the ulcer dimensions.
4. This is not about guessing or estimating the size.
5. Do NOT compare to fruits, coins or other objects.
6. DO measure in centimeters.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0610A Length**

- Measure the longest length from head to toe using a disposable device.

Head

Longest Length 8 cm

Toe

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**M0610B Width**

- Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.
- The depth of this pressure ulcer is 3.7 cm.

Head

Longest Length 8 cm

Width 8.2 cm

Toe

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**M0610 Coding Instructions**

- Enter pressure ulcer dimensions in centimeters.
- If depth is unknown, enter a dash in each space.

**M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar**  
Complete only if M0300CL, 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.

8	0	cm	A. Pressure ulcer length: Longest length from head to toe
8	2	cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
3	7	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)

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C. M0610A Length

1. Measure the longest length from head to toe using a disposable device.

D. M0610B Width

1. Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.
2. The depth of this pressure ulcer is 3.7 cm.

*Indicate to participants that the method to obtain the ulcer depth will be explained in upcoming slides.*

E. M0610 Coding Instructions

1. Enter pressure ulcer dimensions in centimeters.
2. If depth is unknown, enter a dash in each space.
  - a. If, for example, the ulcer bed is covered with eschar or slough.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0610C Depth**

- Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
- Place applicator tip in deepest aspect of the wound and measure distance to the skin level.



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**F. M0610C Depth**

- Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
- Place applicator tip in deepest aspect of the wound and measure distance to the skin level.
- Remove applicator from the wound and compare against a measuring device to obtain the depth dimension.

**Item M0700**

**Most Severe Tissue Type for Any Pressure Ulcer**

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**XI. Item M0700 Most Severe Tissue Type for Any Pressure Ulcer**

A. This item documents the most severe tissue type present in the resident's pressure ulcer(s).

**M0700 Most Severe Tissue Type for Any Pressure Ulcer**

- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in pressure ulcer wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

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

Select Code

- Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.
- Granulation tissue** - pink or red tissue with shiny, moist, granular appearance.
- Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.
- 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.

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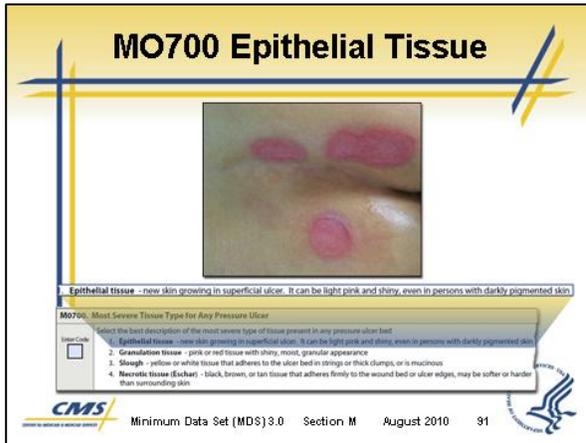
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B. M0700 Most Severe Tissue Type for Any Pressure Ulcer

- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in pressure ulcer wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



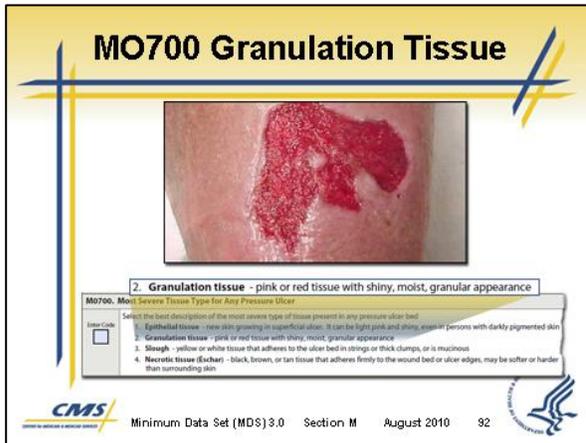
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C. M0700 Epithelial Tissue

1. Epithelial tissue is new skin that is light pink and shiny (even in person's with darkly pigmented skin).
2. In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer.
3. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

- **Code 1. Epithelial tissue**

If the wound is superficial and is re-epithelializing



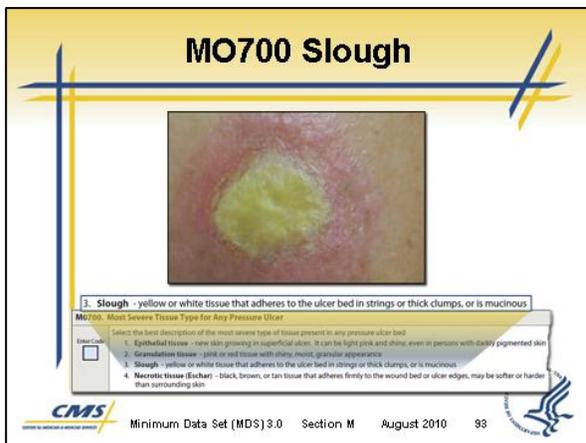
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D. M0700 Granulation Tissue

1. Granulation tissue is red tissue with "cobblestone" or bumpy appearance.
2. Bleeds easily when injured.

- **Code 2. Granulation tissue**

If the wound is clean (e.g., free of slough and necrotic tissue) and contains granulation tissue



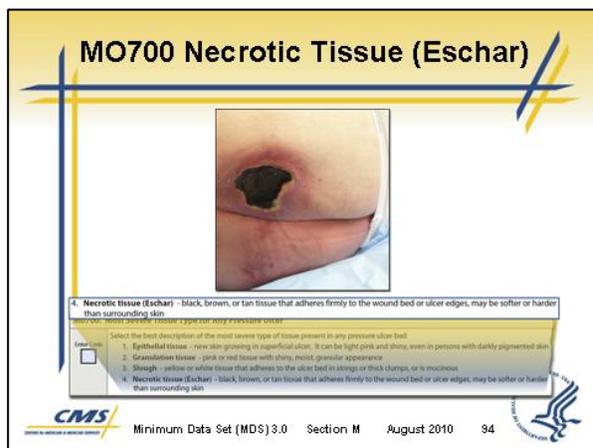
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E. M0700 Slough

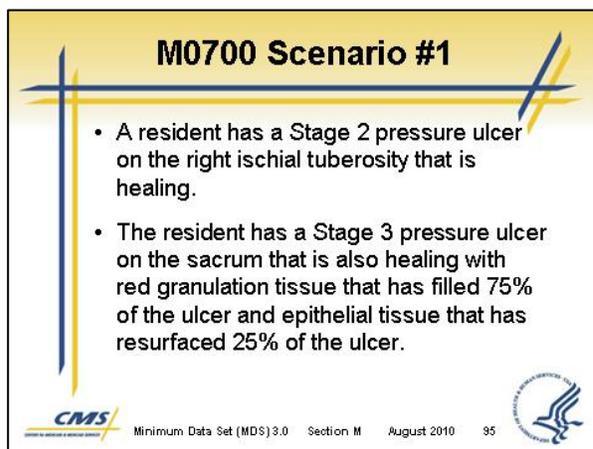
1. Slough is non-viable yellow, tan, gray, green, or brown tissue.
2. Slough is usually moist and can be soft, stringy, and mucinous in texture.
3. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- **Code 3. Slough**

If there is any amount of slough present and necrotic tissue is absent

F. M0700 Necrotic Tissue (Eschar)

1. Eschar is dead or devitalized tissue that is hard or soft in texture.
2. Eschar is usually black, brown, or tan in color and may appear scab-like.
3. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

- **Code 4. Necrotic tissue (eschar)**

If there is any necrotic tissue (eschar) present

G. M0700 Scenario #1

1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing.
2. The resident has 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.

## SLIDES

**M0700 Scenario #1 Coding**

- Code M0700 Most Severe Tissue Type for Any Pressure Ulcer as **2. Granulation tissue**.
- 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.

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**M0700 Scenario #2**

- A resident has a pressure ulcer on the left trochanter that has:
  - 25% black necrotic tissue present
  - 75% granulation tissue present
  - Some epithelialization at the edges of the wound

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**M0700 Scenario #2 Coding**

- Code M0700 as **4. Necrotic tissue (Eschar)**.
- Coding is for the most severe tissue type present.
- This is not always the majority of type of tissue.
- Therefore, code M0700 as **4. Necrotic tissue**.

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## INSTRUCTIONAL GUIDANCE

## H. M0700 Scenario #1 Coding

1. Code M0700 Most Severe Tissue Type for Any Pressure Ulcer as **2. Granulation tissue**.
2. Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type.
3. Code **2. Granulation tissue** is selected because this is the most severe tissue present in the wound.

## I. M0700 Scenario #2

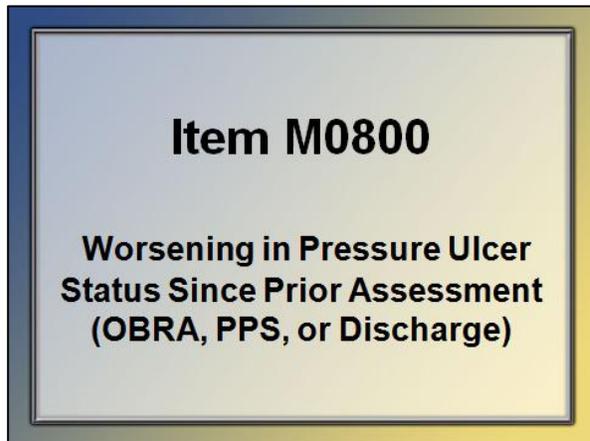
1. A resident has a pressure ulcer on the left trochanter that has:
  - a. 25% black necrotic tissue present
  - b. 75% granulation tissue present
  - c. Some epithelialization at the edges of the wound

## J. M0700 Scenario #2 Coding

1. Code M0700 as **4. Necrotic tissue (Eschar)**.
2. Coding is for the most severe tissue type present.
3. This is not always the majority of type of tissue.
4. Therefore, code M0700 as **4. Necrotic tissue (Eschar)**.

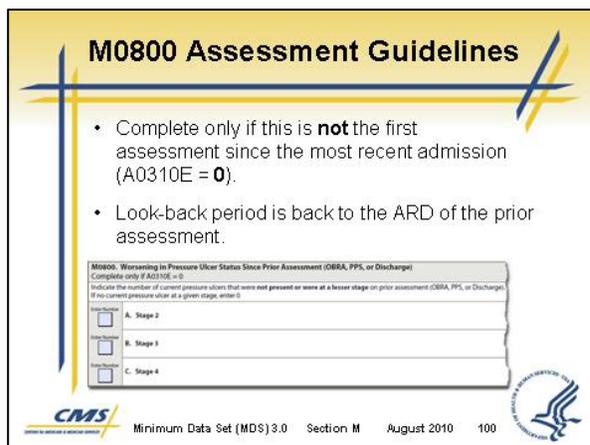
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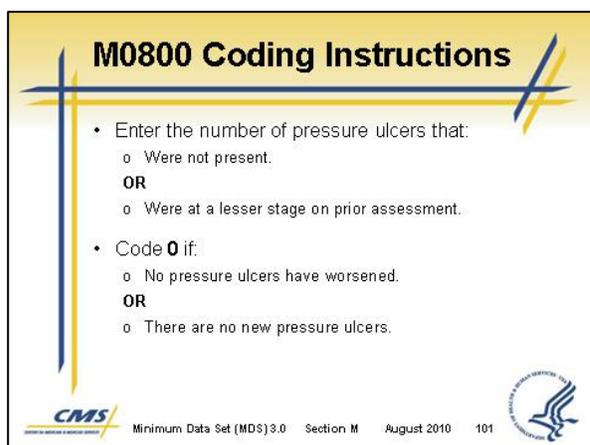
**XII. Item M0800 Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)**



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A. M0800 Assessment Guidelines

- Complete only if this is **not** the first assessment since the most recent admission (A0310E = 0).
- Look-back period is back to the ARD of the prior assessment.



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B. M0800 Coding Instructions

- Enter the number of pressure ulcers that:
  - Were not present.**OR**
  - Were at a lesser stage on prior assessment.
- Code **0** if:
  - No pressure ulcers have worsened.**OR**
  - There are no new pressure ulcers.

## SLIDES

**M0800 Scenario #1**

- A resident is admitted with an unstageable pressure ulcer on the sacrum.
- The pressure ulcer is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later.
- The initial MDS assessment listed the pressure ulcer as unstageable.

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**M0800 Scenario #1 Coding**

- Code M800A Stage 2 as **0**.
- Code M800B Stage 3 as **0**.
- Code M800C Stage 4 as **0**.
- The unstageable pressure ulcer was present on the initial MDS assessment.
- After debridement, it was a Stage 4.
- This is the first staging since debridement and should not be counted as worsening on the MDS assessment.

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**M0800 Scenario #2**

- 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:
  - Stage 3 pressure ulcer on the sacrum
  - Stage 4 pressure ulcer on the right heel
  - Stage 2 pressure ulcer on the left trochanter

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## INSTRUCTIONAL GUIDANCE

## C. M0800 Scenario #1

1. A resident is admitted with an unstageable pressure ulcer on the sacrum.
2. The pressure ulcer is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later.
3. The initial MDS assessment listed the pressure ulcer as unstageable.

## D. M0800 Scenario #1 Coding

1. Code M800A Stage 2 as **0**.
2. Code M800B Stage 3 as **0**.
3. Code M800C Stage 4 as **0**.
4. The unstageable pressure ulcer was present on the initial MDS assessment.
5. After debridement, it was a Stage 4.
6. This is the first staging since debridement and should not be counted as worsening on the MDS assessment.

## E. M0800 Scenario #2

1. 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.
2. Current skin care flow sheets indicate:
  - a. Stage 3 pressure ulcer on the sacrum
  - b. Stage 4 pressure ulcer on the right heel

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M0800 Scenario #2 Coding**

- Code M0800A Stage 2 as **1**.
- Code M0800B Stage 3 as **1**.
- Code M0800C Stage 4 as **1**.
- M0800A is coded **1** because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment.
- M0800B and M0800C are coded **1** for the worsening in pressure ulcer status (i.e. increased severity) of the sacrum and right heel pressure ulcers.

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**Item M0900**  
**Healed Pressure Ulcers**

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c. Stage 2 pressure ulcer on the left trochanter

F. M0800 Scenario #2 Coding

1. Code M0800A Stage 2 as **1**.
2. Code M0800B Stage 3 as **1**.
3. Code M0800C Stage 4 as **1**.
4. M0800A is coded **1** because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment.
5. M0800B and M0800C are coded **1** for the worsening in pressure ulcer status (i.e. increased severity) of the sacrum and right heel pressure ulcers.

**XIII. Item M0900 Healed Pressure Ulcers**

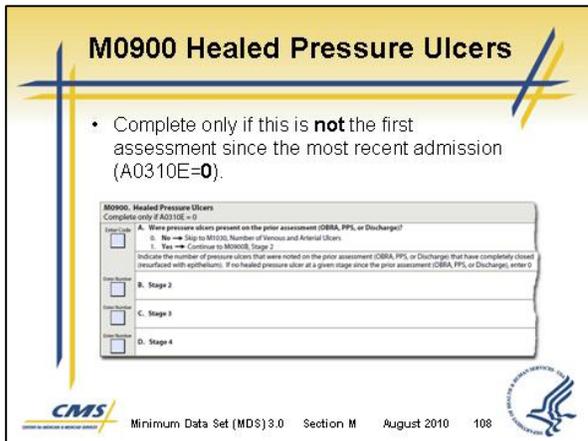
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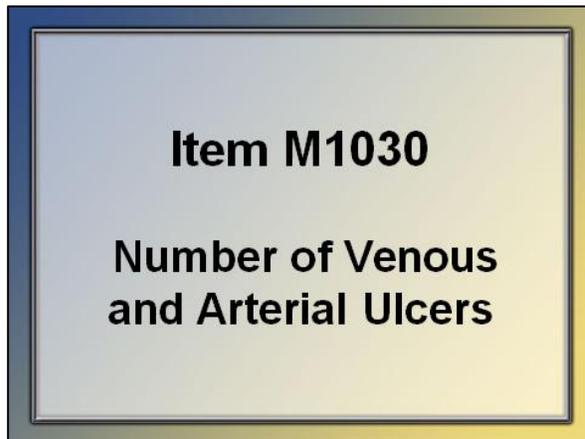
- A. Healed Pressure Ulcers
1. A healed pressure ulcer is:
    - a. Completely closed
    - OR
    - b. Fully epithelialized
    - OR
    - c. Covered completely with epithelial tissue
    - OR
    - d. Resurfaced with new skin
  2. Even if the area continues to have some surface discoloration.



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- B. M0900 Healed Pressure Ulcers
1. Complete only if this is **not** the first assessment since the most recent admission (A0310E=**0**).
  2. Complete for all residents.
    - a. Even if M0210 = **0**.
  3. Enter the number of pressure ulcers that have healed since the last assessment for each Stage 2 through 4.
  4. Enter **0** if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

SLIDES	INSTRUCTIONAL GUIDANCE
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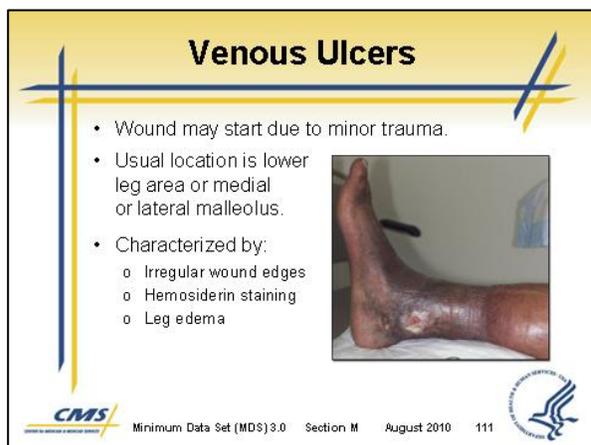
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**XIV. Item M1030 Number of Venous and Arterial Ulcers**



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- A. M1030 Conduct the Assessment
1. Review the medical record.
    - a. Skin care flow sheet or other skin tracking form
  2. Speak with direct care staff and treatment nurse.
    - a. Confirm conclusions from the medical record review.
  3. Examine the resident.



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- B. Venous Ulcers
1. Wound may start due to minor trauma.
  2. Usual location is lower leg area or medial or lateral malleolus.
  3. Characterized by:
    - a. Irregular wound edges
    - b. Hemosiderin staining
    - c. Leg edema

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Arterial Ulcers<sub>1</sub>**

- Wound may start due to minor trauma.
- Usual location:
  - Toes
  - Top of foot
  - Distal to medial malleolus



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**Arterial Ulcers<sub>2</sub>**

- Characterized by:
  - Necrotic tissue or pale pink wound bed
  - Diminished or absent pulses
- Trophic skin changes:
  - Dry skin
  - Loss of hair
  - Brittle nails
  - Muscle atrophy

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**M1030 Coding Instructions**

- Enter the total number of venous and arterial ulcers present.

**M1030. Number of Venous and Arterial Ulcers**

Enter Number  Enter the total number of venous and arterial ulcers present

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C. Arterial Ulcers

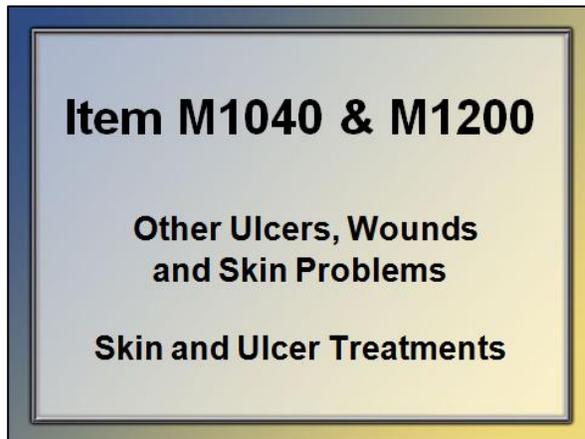
1. Wound may start due to minor trauma.
2. Usual location:
  - a. Toes
  - b. Top of foot
  - c. Distal to medial malleolus

3. Characterized by:
  - a. Necrotic tissue or pale pink wound bed
  - b. Diminished or absent pulses
4. Trophic skin changes:
  - a. Dry skin
  - b. Loss of hair
  - c. Brittle nails
  - d. Muscle atrophy

D. M1030 Coding Instructions

1. Enter the total number of venous and arterial ulcers present.

SLIDES	INSTRUCTIONAL GUIDANCE
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**XV. Item M1040 Other Ulcers, Wounds and Skin Problems & M1200 Skin and Ulcer Treatments**

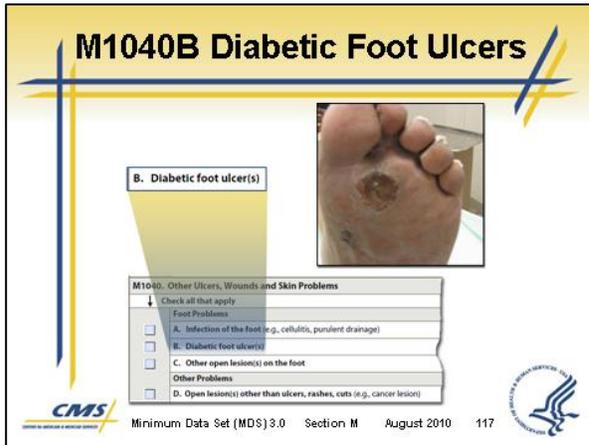


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- A. M1040. M1200 Conduct the Assessment
1. Review the medical record.
    - a. Skin care flow sheet or other skin tracking form
    - b. Treatment records and orders for documented treatments in the look-back period
  2. Speak with direct care staff and treatment nurse.
    - a. Confirm conclusions from the medical record review.
  3. Examine the resident.
    - a. Determine if ulcers, wounds, or skin problems are present.
    - b. Observe skin treatments.

**SLIDES**

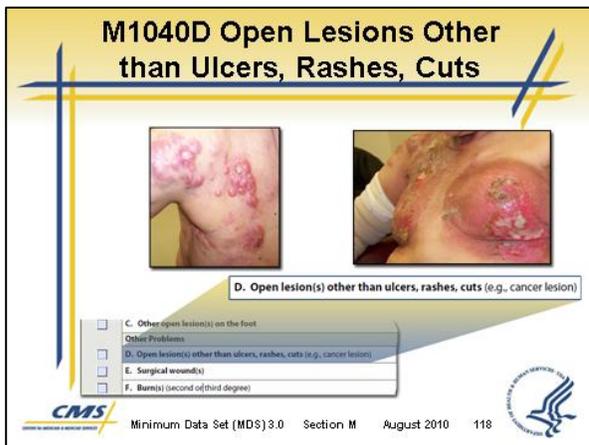
**INSTRUCTIONAL GUIDANCE**



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**B. M1040B Diabetic Foot Ulcers**

1. Ulcers caused by the neuropathic and small blood vessel complications of diabetes.
2. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot.
3. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges.
4. The wounds are very regular in shape and the wound edges are even with a punched-out appearance.
5. These wounds are typically not painful.



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**C. M1040D Open Lesions Other than Ulcers, Rashes, Cuts**

1. Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M1040E Surgical Wounds**

Failed Flap

**E. Surgical wound(s)**

- C. Other open lesion(s) on the foot
- Other Problem:
- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burn(s) (second or third degree)

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- D. M1040E Surgical Wounds
1. Any healing and non-healing, open or closed surgical incisions, skin grafts, or drainage sites.

**M1040F Burns**

**F. Burn(s) (second or third degree)**

- C. Other open lesion(s) on the foot
- Other Problem:
- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burn(s) (second or third degree)
- None of the Above
- Z. None of the above were present

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- E. M1040F Burns
1. Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
  2. Document second or third degree burns.

**M1200 Skin and Ulcer Treatments<sub>1</sub>**

**M1200. Skin and Ulcer 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. 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

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- F. M1200 Skin and Ulcer Treatments
1. Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

## SLIDES

**M1200 Skin and Ulcer Treatments<sub>2</sub>**

- Pressure-relieving devices do not include:
  - Egg crate cushions of any type
  - Doughnut or ring devices in chairs
- Turning/ repositioning program
  - Specific approaches for changing resident's position and realigning the body
  - Program should specify intervention and frequency
- Nutrition and hydration
  - High calorie diets with added supplements to prevent skin breakdown
  - High protein supplements for wound healing

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## INSTRUCTIONAL GUIDANCE

## G. M1200 Skin and Ulcer Treatments

1. Pressure-relieving devices do not include:
  - a. Egg crate cushions of any type
  - b. Doughnut or ring devices in chairs
2. Turning/ repositioning program
  - a. Specific approaches for changing resident's position and realigning the body
  - b. Program should specify intervention and frequency
3. Nutrition and hydration
  - a. High calorie diets with added supplements to prevent skin breakdown
  - b. High protein supplements for wound healing

## H. M1200E Ulcer Care

1. Ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).
2. Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/ or hydrotherapy.

**M1200E Ulcer Care**

M1200. Skin and Ulcer Treatments

↓ Check all that apply

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

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**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- I. Initial Presentation Then Went for Surgical Debridement



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- J. Debrided Surgically



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- K. Slough Returned After Surgical Debridement
  1. Used enzyme for maintenance debridement.
  2. Used Negative Pressure Wound Therapy (NPWT).

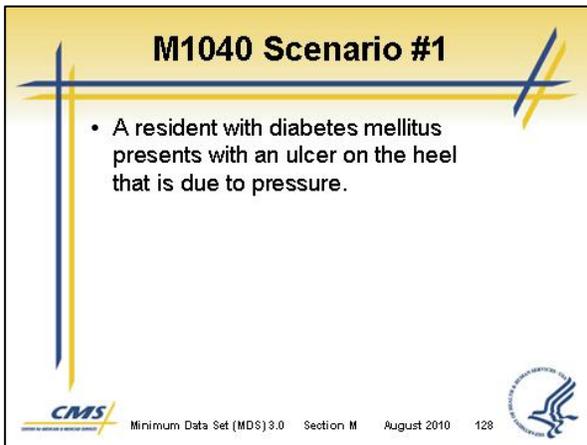
**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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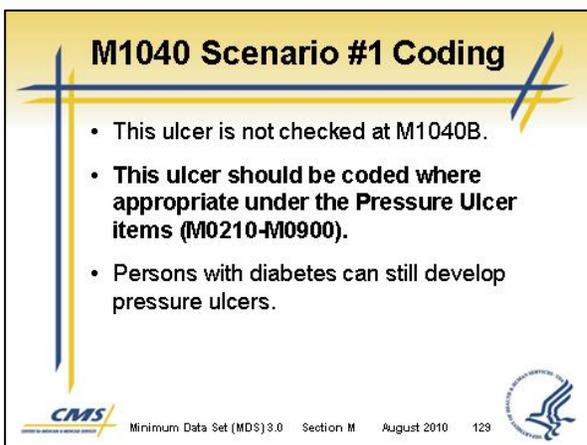
L. Closed After 6 Months



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M. M1040 Scenario #1

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.



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N. M1040 Scenario #1 Coding

1. This ulcer is not checked at M1040B.
2. **This ulcer should be coded where appropriate under the Pressure Ulcer items (M0210-M0900).**
3. Persons with diabetes can still develop pressure ulcers.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**M1040 Scenario #2**

- A resident is readmitted from the hospital after flap surgery to repair a sacral pressure ulcer.

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- O. M1040 Scenario #2
1. A resident is readmitted from the hospital after flap surgery to repair a sacral pressure ulcer.

**M1040 Scenario #2 Coding**

- Check M1040E. Surgical Wound(s).
- A surgical flap procedure to repair pressure ulcers changes the coding to a surgical wound.

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- P. M1040 Scenario #2 Coding
1. Check M1040E. Surgical Wound(s).
  2. A surgical flap procedure to repair pressure ulcers changes the coding to a surgical wound.

**M1200 Scenario #1**

- A resident has a venous ulcer on the right leg.
- During the past 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 redistributing mattress and pad for the wheelchair.

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- Q. M1200 Scenario #1
1. A resident has a venous ulcer on the right leg.
  2. During the past 7 days the resident has had a three-layer compression bandaging system applied once.
  3. Orders are to reapply the compression bandages every 5 days.
  4. The resident also has a pressure redistributing mattress and pad for the wheelchair.

## SLIDES

**M1200 Scenario #1 Coding**

- **Check items:**
  - o M1200A Pressure reducing device for chair
  - o M1200B Pressure reducing device for bed
  - o M1200G Application of nonsurgical dressings
- **Treatments include pressure reducing (redistribution) mattress and pad in the wheelchair and application of the compression bandaging system.**

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**M1200 Scenario #2**

- **Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care.**
- **His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.**

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**M1200 Scenario #2 Coding**

- Do **not** check item M1200C. Turning/ Repositioning Program.
- Treatments provided do not meet the criteria for a turning/ repositioning program.
- There is no notation in the medical record about an assessed need for turning/ repositioning, nor is there a specific approach or plan related to positioning and realigning of the body.
- There is no reassessment of the resident's response to turning and repositioning.
- There are not any skin or ulcer treatments being provided.

 Minimum Data Set (MDS) 3.0 Section M August 2010 135 

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## INSTRUCTIONAL GUIDANCE

## R. M1200 Scenario #1 Coding

1. Check items:
  - a. M1200A Pressure reducing device for chair
  - b. M1200B Pressure reducing device for bed
  - c. M1200G Application of nonsurgical dressings
2. Treatments include pressure reducing (redistribution) mattress and pad in the wheelchair and application of the compression bandaging system.

## S. M1200 Scenario #2

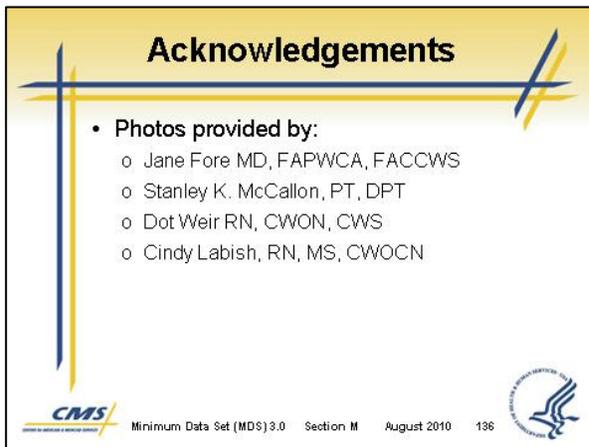
1. Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care.
2. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

## T. M1200 Scenario #2

1. Do **not** check item M1200C. Turning/ Repositioning Program.
2. Treatments provided do not meet the criteria for a turning/ repositioning program.

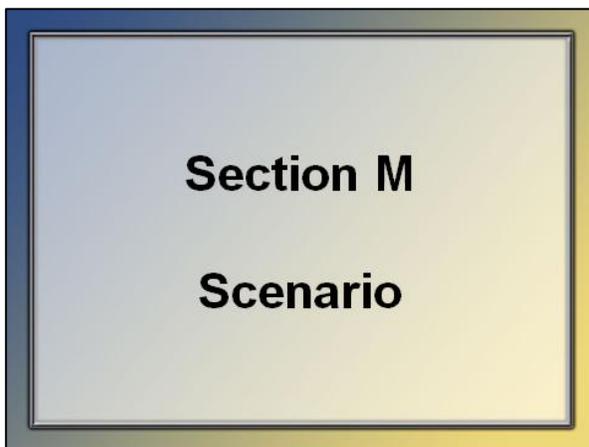
SLIDES	INSTRUCTIONAL GUIDANCE
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3. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body.
4. There is no reassessment of the resident's response to turning and repositioning.
5. There are not any skin or ulcer treatments being provided.



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- U. Photos provided by:
1. Jane Fore MD, FAPWCA, FACCWS
  2. Stanley K. McCallon, PT, DPT
  3. Dot Weir RN, CWON, CWS
  4. Cindy Labish, RN, MS, CWOCN



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**XVI. Section M Scenario**

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section M Scenario Instructions**

- Turn to **Section M** in the MDS 3.0 item set.
- Review the **Section M** scenario.
- Code the MDS for the three assessments in the scenario:
  - Admission assessment
  - Quarterly #1 assessment
  - Quarterly #2 assessment

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- A. Section M Scenario Instructions
1. Turn to Section M in the MDS 3.0 item set.
  2. Review the Section M scenario.
  3. Code the MDS for the three assessments in the scenario:
    - a. Admission assessment
    - b. Quarterly #1 assessment
    - c. Quarterly #2 assessment

**Section M Scenario<sub>1</sub>**

- 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.

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- B. Section M Scenario
1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer.
  2. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home.

**Section M Scenario<sub>2</sub>**

- On Mr. S' first quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved.

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3. On Mr. S' first quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section M Scenario<sub>3</sub>**

- On the second quarterly assessment, the Stage 2 pressure ulcer was noted to have worsened to a Stage 3.
- The dimensions of the Stage 3 pressure ulcer are:
  - L 3.0cm
  - W 2.4cm
  - D 0.2cm with 100% granulation tissue noted in the wound bed

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4. On the second quarterly assessment, the Stage 2 pressure ulcer was noted to have worsened to a Stage 3.
5. The dimensions of the Stage 3 pressure ulcer at the 2nd quarterly assessment are:
  - a. L 3.0cm
  - b. W 2.4cm
  - c. D 0.2cm with 100% granulation tissue noted in the wound bed

**Section M Scenario Coding Admission Assessment<sub>1</sub>**

- Code M0300A. Number of Stage 1 pressure ulcers as **0**.
- Code M0300B1. Number of Stage 2 pressure ulcers as **1**.
- Code M0300B2. Number of Stage 2 pressure ulcers present on admission/ reentry as **1**.
- The resident had one Stage 2 pressure ulcer on admission.

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- C. Section M Scenario Coding Admission Assessment
1. Code M0300A. Number of Stage 1 pressure ulcers as **0**.
  2. Code M0300B1. Number of Stage 2 pressure ulcers as **1**.
  3. Code M0300B2. Number of Stage 2 pressure ulcers present on admission/ reentry as **1**.
  4. The resident had one Stage 2 pressure ulcer on admission.
  5. Code M0300B3. Date of the oldest Stage 2 pressure ulcer with dashes.
  6. The date of the oldest pressure ulcer was unknown.

**Section M Scenario Coding Admission Assessment<sub>2</sub>**

- Code M0300B3. Date of the oldest Stage 2 pressure ulcer with dashes.
- The date of the oldest pressure ulcer was unknown.

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## SLIDES

**Section M Scenario Coding Quarterly Assessment #1<sub>1</sub>**

- Code M0300A. Number of Stage 1 pressure ulcers as **0**.
- Code M0300B1. Number of Stage 2 pressure ulcers as **1**.
- Code M0300B2. Number of Stage 2 pressure ulcers present on admission/ reentry as **1**.
- The Stage 2 pressure ulcer is still present on the quarterly assessment.

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**Section M Scenario Coding Quarterly Assessment #1<sub>2</sub>**

- Code M0300B3. Date of the Oldest Stage 2 pressure ulcer with dashes (-).
- The pressure ulcer history for this resident is not available.
- Therefore, the date of the oldest Stage 2 pressure ulcer is unknown.

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**Section M Scenario Coding Quarterly Assessment #2<sub>1</sub>**

- Code M0300A. Number of Stage 1 pressure ulcers as **0**.
- Code M0300B1. Number of Stage 2 pressure ulcers as **0**.
- Skip to M0300C. Stage 3 pressure ulcers.
- Resident no longer has a Stage 2 pressure ulcer but now has a Stage 3 pressure ulcer.

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## INSTRUCTIONAL GUIDANCE

## D. Section M Scenario Coding Quarterly Assessment #1

1. Code M0300A. Number of Stage 1 pressure ulcers as **0**.
2. Code M0300B1. Number of Stage 2 pressure ulcers as **1**.
3. Code M0300B2. Number of Stage 2 pressure ulcers present on admission/ reentry as **1**.
4. The Stage 2 pressure ulcer is still present on the quarterly assessment.

5. Code M0300B3 Date of the Oldest Stage 2 pressure ulcer with dashes.
  - a. The pressure ulcer history for this resident is not available due to the resident being admitted to the hospital prior to entry to the nursing home.
  - b. Therefore, the date of the oldest Stage 2 pressure ulcer is unknown.

## E. Section M Scenario Coding Quarterly Assessment #2

1. Code M0300A. Number of Stage 1 pressure ulcers as **0**.
2. Code M0300B1. Number of Stage 2 pressure ulcers as **0**.
3. Skip to M0300C. Stage 3 pressure ulcers.
4. Resident no longer has a Stage 2 pressure ulcer but now has a Stage 3 pressure ulcer.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section M Scenario Coding Quarterly Assessment #2<sub>2</sub>**

- Code M0300C1. Number of Stage 3 pressure ulcers as **1**.
- Code M0300C2. Number of Stage 3 pressure ulcers that were present upon admission/ reentry as **0**.
- Code M0300D1, M0300E1, M0300F1, and M0300G1 as **0**.
- Resident now has one Stage 3 pressure ulcer.
- The Stage 3 pressure ulcer was not present on admission or reentry, but worsened from a Stage 2 to a Stage 3 in the facility.
- Resident does not have any Stage 4 or unstageable ulcers.

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**Section M Scenario Coding Quarterly Assessment #2<sub>3</sub>**

- Proceed to M0610.
- Code M0610A. Pressure ulcer length as **03.0**.
- Code M0610B. Pressure ulcer width as **02.4**.
- Code M0300C. Pressure ulcer depth as **00.2**.
- Resident had only one Stage 3 pressure ulcer at the time of the second quarterly assessment.
- Code these dimensions as the largest ulcer.

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5. Code M0300C1. Number of Stage 3 pressure ulcers as **1**.
6. Code M0300C2. Number of Stage 3 pressure ulcers that were present upon admission/ reentry as **0**.
7. Code M0300D1, M0300E1, M0300F1, and M0300G1 as **0**.
8. Resident now has one Stage 3 pressure ulcer.
9. The Stage 3 pressure ulcer was not present on admission or reentry, but worsened from a Stage 2 to a Stage 3 in the facility.
10. Resident does not have any Stage 4 or unstageable ulcers.
11. Proceed to M0610.
12. Code M0610A. Pressure ulcer length as **03.0**.
13. Code M0610B. Pressure ulcer width as **02.4**.
14. Code M0300C. Pressure ulcer depth as **00.2**.
15. Resident had only one Stage 3 pressure ulcer at the time of the second quarterly assessment.
16. Code these dimensions as the largest ulcer.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section M Scenario Coding Quarterly Assessment #2<sub>4</sub>**

- Code M0700. Most Severe Tissue Type for Any Pressure Ulcer as **2**. Granulation tissue.
- This is the most severe type of tissue present.

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17. Code M0700. Most Severe Tissue Type for Any Pressure Ulcer as **2**. Granulation tissue.
18. This is the most severe type of tissue present.

**Section M Scenario Coding Quarterly Assessment #2<sub>5</sub>**

- M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge):
  - Code M0800A. Stage 2 as **0**.
  - Code M0800B. Stage 3 as **1**.
  - Code M0800C. Stage 4 as **0**.
- The Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

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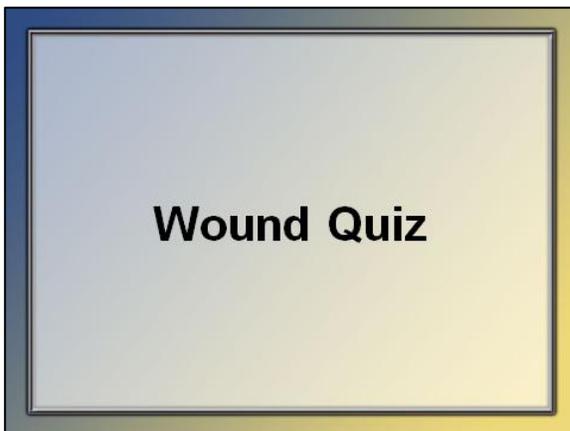


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19. M0800 Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
  - a. Code M0800A. Stage 2 as **0**.
  - b. Code M0800B. Stage 3 as **1**.
  - c. Code M0800C. Stage 4 as **0**.

20. The Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

**Wound Quiz**

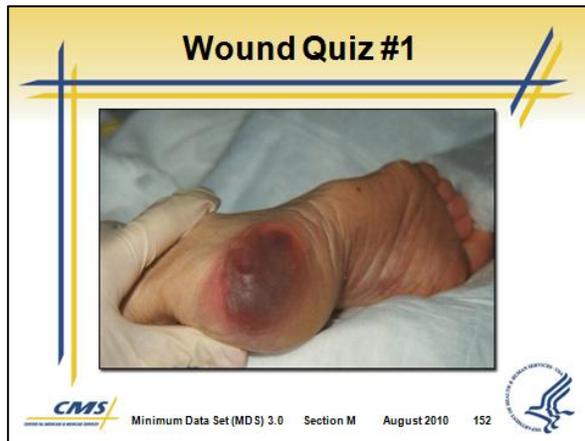


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**XVII. Wound Quiz**

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- A. Wound Quiz #1
1. Evaluate to determine if a blood-filled blister or suspected Deep Tissue Injury.



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- B. Wound Quiz #2
1. Resident with ESRD, on dialysis for many years.
  2. This is an ulcer that is created when calcium leaches out and causes necrosis of the skin.
  3. Code as an other wound.



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- C. Wound Quiz #3
1. Evaluate to determine if a Stage 1 pressure ulcer or suspected deep tissue injury.

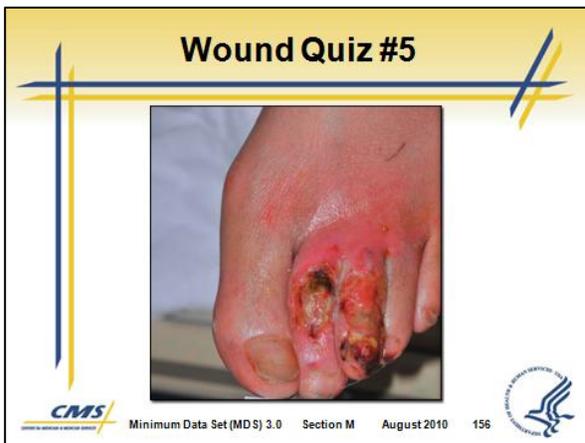
**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- D. Wound Quiz #4
1. Stage 4 pressure ulcer



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- E. Wound Quiz #5
1. Arterial ulcer based on etiology of the patient.



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- F. Wound Quiz #6
1. Stage 4 pressure ulcer
  2. This is considered two pressure ulcers due to skin bridge.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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- G. Wound Quiz #7
  - 1. Arterial ulcer



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- H. Wound Quiz #8
  - 1. Diabetic foot ulcer

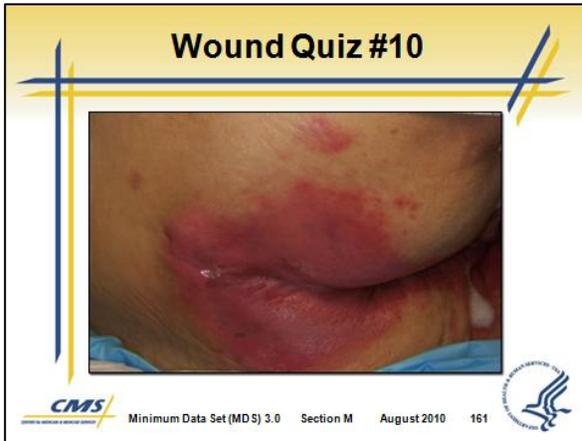


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- I. Wound Quiz #9
  - 1. Venous ulcer

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



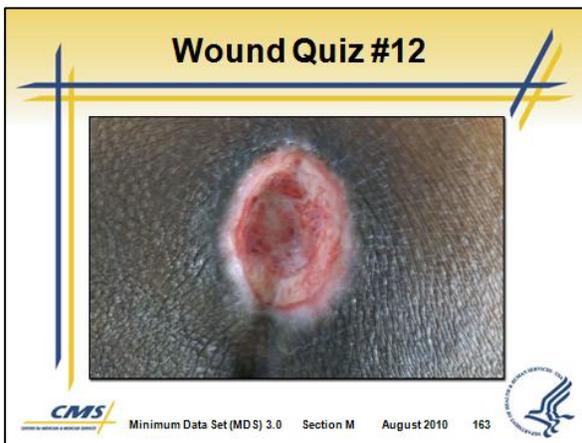
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- J. Wound Quiz #10
1. Not a pressure ulcer.
  2. This is a skin condition related to incontinence.



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- K. Wound Quiz #11
1. Not a pressure ulcer.
  2. This resident fell, and this area is a hematoma.
  3. This would be coded in Section J as an injury due to a fall.



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- L. Wound Quiz #12
1. Stage 3 pressure ulcer

