Section M Activity Sheet #2

Instructions

1. Read the scenario below.
2. Code Section M in your item set as appropriate for each assessment.
3. You may work individually or in pairs/ groups.

Scenario

- Mrs. P is admitted to the nursing home on 10/23/2010 for a Medicare stay.
- In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin break down.
- On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010.
  - This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed.
  - Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth.
- Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems.
- She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer.
- Mrs. P. also has pressure redistribution devices on both her bed and chair, and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance.
- On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/10.
- Upon reentry the 5-day PPS ARD was set at 11/19/2010.
- In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx; however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth.
- It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.