

**FMDA – The Florida Society for  
Post-Acute & Long-Term Care Medicine**

**Regulations Affecting Wound Care in  
the Post Acute Setting**

FACULTY:  
**PAMELA SCARBOROUGH**  
PT, DPT, MS, CWS, CEEAA  
DIRECTOR OF PUBLIC POLICY & EDUCATION  
AMERICAN MEDICAL TECHNOLOGIES

AMT Education Division

Copyright © 2019 Gordian Medical, Inc. dba American Medical Technologies.

1

---

---

---

---

---

---

---

---

**Disclaimer**

*"This information is provided for informational purposes only. Patient management decisions should be based on a number of factors, including (but not limited to) professional society guidelines and published clinical literature relevant to a patient's condition. Providers are encouraged to rely on their training and expertise, as well as any and all available information, prior to making management or treatment decisions for any individual patient."*

2

---

---

---

---

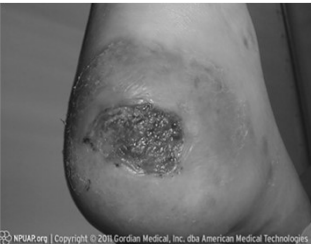
---

---

---

---

**What Stage?**



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- DTPI

NPQAR.org | Copyright © 2019 Gordian Medical, Inc. dba American Medical Technologies.

3

---

---

---

---

---

---

---

---

**Please Remember: A Chronic Wound is  
EVIDENCE of Failing Physiology!!!**

Pressure Injuries	Peripheral Arterial Disease	Venous Insufficiency	Diabetic Neuropathic Foot Ulcers	Lymphedema

☐ **1. What caused the wound initially?**  
☐ **2. What's causing the wound to NOT close and heal?**  
☐ **Two CRITICALLY important questions.**

4

---

---

---

---

---

---

---

---

**What are the Expectations from a  
Regulatory Perspective**

---

**State Operations Manual**  
**Appendix PP - Guidance to Surveyors for**  
**Long Term Care Facilities**  
 Table of Contents  
 (Rev. 11-22-17)

Transmittals for Appendix PP

*INDEX*

**Read and Study F686  
and Associated Tags**

5

---

---

---

---

---

---

---

---

MDS  
Section M

**What are the Expectations from a  
Regulatory Reporting Perspective**

---

CMS's RAI Version 3.0 Manual CH 3: MDS Items [M]

**READ SECTION M!!!**

**SECTION M: SKIN CONDITIONS**

**Intent:** The items in this section document the risk, presence, appearance, and change of pressure ulcers/*injuries*. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

6

---

---

---

---

---

---

---

---

### F658 Comprehensive Care Plans

- ☐ **INTENT §483.21(b)(3)(i)**
- ☐ *The intent of this regulation is to assure that services being provided meet professional standards of quality.*
- ☐ **GUIDANCE §483.21(b)(3)(i)**
- ☐ *"Professional standards of quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature.*
- ☐ **IMPORTANT** when you are negotiating with a surveyor regarding an F tag.
- ☐ Visiting practitioners and consultants should be providing the current standards of care for assessments and treatments of all wound etiologies

7

---

---

---

---

---

---

---

---

### F658 Ties to All Care Including F686

- ☐ *If a negative or potentially negative resident outcome is determined to be related to the facility's failure to meet professional standards and the team determines a deficiency has occurred, it should also be cited under the appropriate quality of care or other relevant requirement.*
- ☐ *For example, if a resident develops a pressure injury because the facility's nursing staff failed to provide care in accordance with professional standards of quality, the team should cite the deficiency at both F658 and F686 (Skin Integrity).*

8

---

---

---

---

---

---

---

---

Other Tags Surveyors Instructed to Review When <b>F686</b> Deficiency Given			
Surveyors Instructed to Review <b>EACH</b> of These Tags			
F710	Physician Services	F641	Accuracy of Assessment
F880	Infection Control	F656	Comprehensive Care Plan What must be included
F655	Comprehensive Person-Centered Care Planning	F657	Comprehensive Care Plan Effectiveness of CP and who must be included
F636	Resident Assessment	Other Tags to be considered	• F552 Right to be Informed
F637	Significant Change		• F580 Notification of Change
			• F635 Admission Orders

9

---

---

---

---

---

---

---

---

F658	<b>KEY ELEMENTS OF NONCOMPLIANCE:</b> <b>Instructions to Surveyors</b>
<input type="checkbox"/>	<p><b>To cite deficient practice at F658, the surveyor's investigation will generally show that the facility did one or more of the following:</b></p> <p><input type="checkbox"/> Provided or arranged for services or care that did not adhere to accepted standards of quality;</p> <p><input type="checkbox"/> Provided a service or care when the accepted standards of quality dictate that the service or care should not have been provided; (e.g. debridement of heel PU/PI with arterial insufficiency without objective blood flow studies (ABI).</p> <p><input type="checkbox"/> Failed to provide or arrange for services or care that accepted standards of quality dictate should have been provided.</p>

10

---

---

---

---

---

---

---

---

F658	<b>Questions the Surveyor Will Ask</b>
<input type="checkbox"/>	<p><input type="checkbox"/> Do the services provided or arranged by the facility, as outlined in the comprehensive care plan, reflect accepted standards of practice?</p> <p><input type="checkbox"/> Are the references for standards of practice, used by the facility, up to date, and accurate for the service being delivered?</p>

11

---

---

---

---

---

---

---

---

<input type="checkbox"/>		<b>Pressure Ulcers/Injuries</b>

12

---

---

---

---

---

---

---

---

Old SOM F686	Comparisons of Definitions	NPUAP
F-686/Formerly F314	NPUAP - 2016	
<input type="checkbox"/> "Pressure Ulcer/Injury (PU/PI)" <input type="checkbox"/> Refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by <b>skin temperature and moisture</b> , nutrition, perfusion, co-morbidities and condition of the soft tissue.	<input type="checkbox"/> Pressure Injury: <input type="checkbox"/> A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. <b>The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.</b>	

13

---

---

---

---

---

---

---

---

F686 Staging Definitions
<p>Centers for Medicare and Medicaid Services SOM Pressure Ulcer Staging Descriptions</p> <p>Adapted from</p> <p>National Pressure Ulcer Advisory Panel (NPUAP) Staging System</p>

14

---

---

---

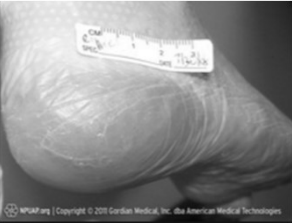
---

---

---

---

---

What Stage?	
 <p>Non-blanchable erythema</p>	<ul style="list-style-type: none"> <li>• Stage 1</li> <li>• Stage 2</li> <li>• Stage 3</li> <li>• Stage 4</li> <li>• Unstageable</li> <li>• DTPI</li> </ul>

15

---

---

---

---

---

---

---

---

MDS 3.0

### What is the Purpose of Staging?

- To indicate the **depth** of tissue damage
- RAI language:
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be **visible or palpable** in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.
- **NOTE: More mistakes on Staging than any other section of the MDS!**

16

---

---

---

---

---

---

---

---

### Stage 1 Pressure Injury

17

---

---

---

---

---

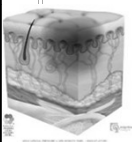
---

---

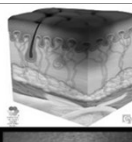
---


MDS 3.0  
RAI  
Pain

### Stage 1 Pressure Injury: Slide 1



Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues.





**Stage 1 Pressure Injury with Edema**

18

---

---

---

---

---

---

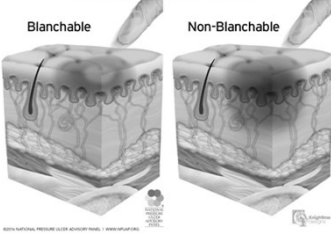
---

---

**Stage 1 Pressure Injury – Slide 2**

Blanchable vs Non-Blanchable

Blanchable Non-Blanchable



- The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.
- Color changes of intact skin may also indicate a deep tissue PI.

19

---

---

---

---

---

---

---

---

**Coding Tips:**

**Steps for Assessment of a Stage 1 Pressure Ulcer/Injury**

- Perform head-to-toe assessment
- For the purpose of coding, determine the lesion being assessed is primarily related to pressure
- Reliance on only one descriptor is inadequate to determine the staging of a pressure injury between Stage 1 and deep tissue injury
- Check any reddened areas for ability to blanch
- Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft warmer or cooler than adjacent tissue

20

---

---

---

---

---

---

---

---

**Stage 2 Pressure Ulcer**

21

---

---

---

---

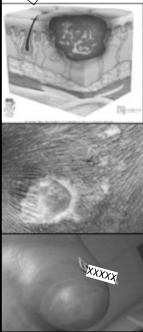
---

---

---

---

**Stage 2 Pressure Ulcer – Slide 1**



- Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer.
- The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister.
- Adipose (fat) is not visible and deeper tissues are not visible.
- Granulation tissue, slough and eschar are not present.

22

---

---

---

---

---

---

---

---

**Stage 2 Pressure Ulcer – Slide 2**

☐ *This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).*

23

---

---

---

---

---

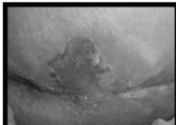
---

---

---

**M0300B: Coding Tips for Stage 2 Pressure Ulcers**

- ☐ Partial thickness loss of dermis
- ☐ **Granulation tissue, slough and eschar are NOT present**
- ☐ Do NOT code skin tears, tape burns, MASD or excoriation here
- ☐ When PU presents as intact blister, examine surrounding area for signs of **deep tissue injury (DTPI)**.
- ☐ When DTI is determined do NOT code as Stage 2



Stage 2  
With dermal tissue  
exposed  
NOT Granulation tissue

24

---

---

---

---

---

---

---

---



### Stage 3 Pressure Ulcer

25

---

---

---

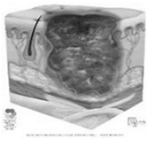
---

---

---

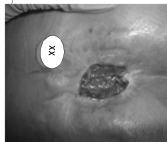
---

### Stage 3 Pressure Ulcer – Slide 1



**Stage 3 Pressure Ulcer with light slough**

- Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.
- Slough and/or eschar may be visible but does not obscure the depth of tissue loss.



**Stage 3 Sacral Pressure Ulcer**

26

---

---

---

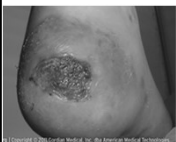
---

---

---

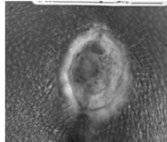
---

### Stage 3 Pressure Ulcer – Slide 2



**Shallow Stage 3**

- The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.
- Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.
- If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.



**Deep Stage 3**

27

---

---

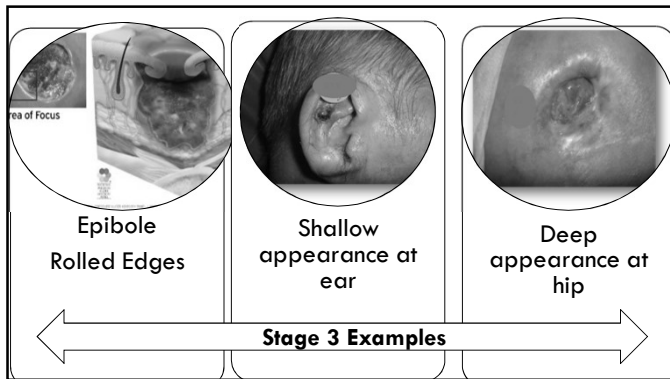
---

---

---

---

---



28

---

---

---

---

---

---

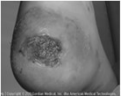
---

---

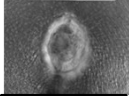
M03  
Severity: III

### Coding Tips: M0300C

- ☐ Depth of a Stage 3 pressure ulcer varies by anatomical location
- ☐ Can be shallow
- Areas of significant adiposity can develop deep Stage 3 pressure ulcers
- Observation and assessment of skin folds should be part of overall skin assessment.
- Do **not** code moisture-associated skin damage or excoriation here.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.



Shallow Stage 3



Deep Stage 3

29

---

---

---

---

---

---

---

---

	Stage 4 Pressure Ulcer

30

---

---

---

---

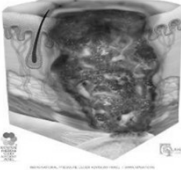
---

---

---

---

**Stage 4 Pressure Ulcer: Full-thickness Skin & Tissue Loss**



Stage 4 pressure injury with light slough in wound base.

- Full-thickness skin and tissue loss with exposed or **directly palpable** fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.
- Slough and/or eschar may be visible.
- Epibole (rolled edges), undermining and/or tunneling often occur.
- Depth varies by anatomical location.
- If slough or eschar **obscures** the extent of tissue loss this is an Unstageable Pressure Injury.

31

---

---

---

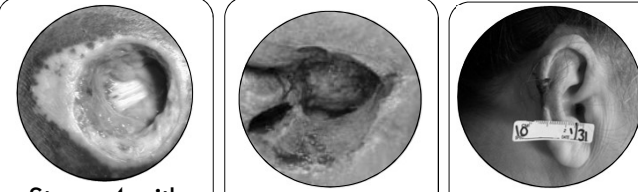
---

---

---

---

---



Stage 4 with tendon exposed      Deep Stage 4      Stage 4 into ear cartilage

← Stage 4 Examples →

Attribution: Dot Weir, RN, CWON, CWS

32

---

---

---

---

---

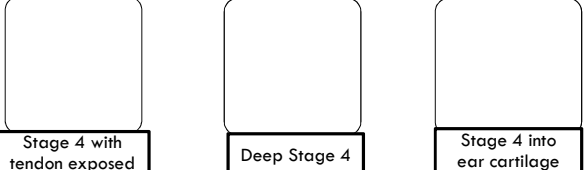
---

---

---

**Coding Tips: M0300D: Stage 4 Pressure Ulcers**

- ☐ Depth varies by anatomical location
- ☐ Stage 4 PU can extend into muscle and supporting structures (fascia, tendon, or joint capsule) making osteomyelitis possible
- ☐ Exposed bone/tendon/muscle IS visible or directly palpable
- ☐ PU with exposed cartilage = Stage 4 PU



Stage 4 with tendon exposed      Deep Stage 4      Stage 4 into ear cartilage

33

---

---

---

---

---

---

---

---

## Unstageable Pressure Ulcer

34

---

---

---

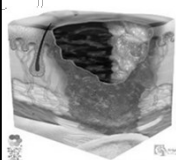
---

---

---

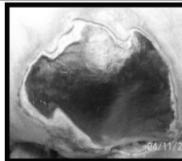
---

### Unstageable Pressure Ulcer – Slide 1



**Unstageable Pressure Ulcer due to Eschar & Slough**

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar.



**Unstageable Pressure Ulcer due to Eschar**

35

---

---

---

---

---

---

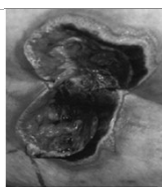
---

### Unstageable Pressure Ulcer – Slide 2



**Stable Eschar On Great Toe With PAD**

□ Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.



**Unstable Eschar In Pressure Ulcer**

36

---

---

---

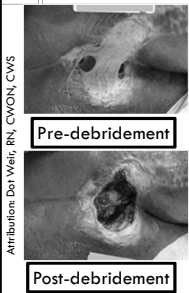
---

---

---

---

### Unstageable Pressure Ulcer – Slide 3



- If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed.
- If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned.
- **The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.**

37

---

---

---

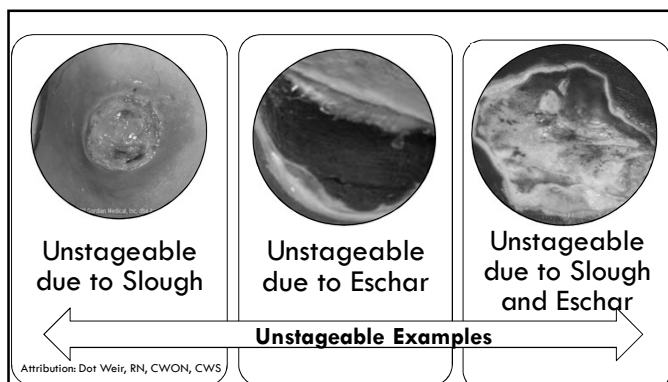
---

---

---

---

---



38

---

---

---

---

---

---

---

---

**M0300F: Coding Tips**

- ❑ PUs covered with slough and/or eschar, wound bed cannot be visualized, coded as unstageable
- ❑ Stage once enough slough and/or eschar removed to expose anatomic depth of soft tissue damage

Mixed Slough/eschar  
**Unstageable**

**Tendon visible**

NOTE: Even though slough and eschar present, this wound is a stageable stage 4 due to visibility of tendon.

Mixed Slough/eschar  
**Stageable**

39

---

---

---

---

---

---


---

---


**MDS Section VII**

### M0300F: Coding Tips

- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover"
- Removed after careful clinical consideration, including ruling out ischemia



**Stable Eschar**



**Unstable Eschar**

- Code PU at reclassified stage once debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined
- **PU does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.**

40

---

---

---

---

---

---


---


---

**MDS-3.0**

### M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device

- Only on RAI/MDS - Not part of NPUAP staging definitions





Courtesy: Dot Weir

- **DEFINITION**
- **NON-REMOVABLE DRESSING/ DEVICE**
- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

41

---

---

---

---


---

---


---

---

### What Stage?



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- DTPI



Copyright © 2019 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com

42

---

---

---

---

---

---

---

---

## Deep Tissue Pressure Injury

43

---

---

---

---

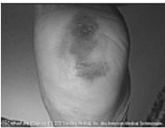
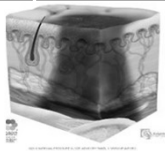
---

---

---



## Deep Tissue Pressure Injury (DTPI)



- Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue.
- This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin.

44

---

---

---

---

---

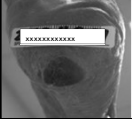
---

---

## Deep Tissue Pressure Injury – Slide 2



DTPI on Admission



DTPI 30 days later

- This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.
- The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.
- If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer.

45

---

---

---

---

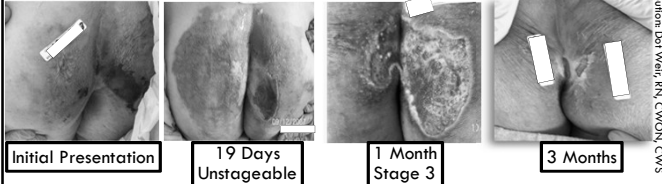
---

---

---

### Deep Tissue Pressure Injury – Slide 3

- Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage.
- Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.



46

---

---

---

---

---

---

---

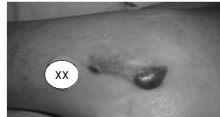
---

### What Does the MDS Say About Blood-Filled Blisters

- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage.
- If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.



Stage 2  
Serum filled blister



Blood-filled blister with evidence of surrounding tissue damage

Code and Report  
as Unstageable

47

---

---

---

---

---

---

---

---

### New Ulcer/Injury Definitions in the SOM

48

---

---

---

---

---

---


---

---

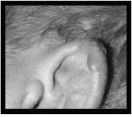


**New Definition**  
**Medical Devices Related Pressure Injury**


• Medical device related PU/PIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. **The injury should be staged using the staging system.**



Bed pan medical device related pressure injury Stage 2  
**MUST be staged.**  
Courtesy: Dot Weir



Oxygen tubing medical device related pressure injury Stage 2  
**MUST be staged.**



• TED hose not removed for several days  
 • Caused full-thickness Stage 4 Medical Device Related PU/PI

49

---

---

---

---

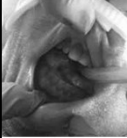
---

---

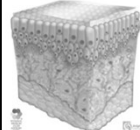
---

---

**News Definition**  
**Mucosal Membrane Pressure Ulcer/Injury**



Mucous Membrane



- Mucosal membrane PU/PIs are found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged.
- **RAI Coding Tip:** "Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made."

50

---

---

---

---

---

---

---

---

	<b>Coding Tips</b>  <b>M0210</b>

51

---

---

---

---

---

---



---

---

**M0210: Coding Tip**

☐ If an ulcer/injury arises from a combination of factors *that* are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.

Clinical Pearl: Moisture Associated Skin Damage (MASD) only will **NOT** have necrotic tissue

DM Pressure Neuropathy Arterial		Moisture Associate Skin Damage (MASD) and Pressure	
--	---	---	---

52

---

---

---

---

---

---

---


---

**M0210 - Coding Tip**

☐ PU surgically closed with a flap or graft

☐ Coded as a surgical wound

☐ If the flap or graft fails, continue to code it as a surgical wound until healed.



Journal of Plastic, Reconstructive & Aesthetic Surgery  
Volume 67, Issue 3, March 2014, Pages 377-382

Note: Surgical debridement does **NOT** convert a pressure ulcer to a surgical wound.

53

---

---

---

---

---

---

---

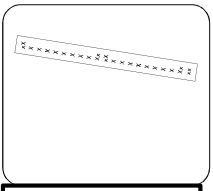
---

**M0210 - Coding Tip**

☐ Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer.

☐ The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

☐ Number 1 Question: Is the resident immobile...in most cases this is a pressure ulcer



**Pressure & Arterial**

54

---

---

---

---

---

---

---

---

**M0300: Step 1**  
**Determine Deepest Anatomical Stage**

- ☐ Observe and palpate base of PU/PI
- ☐ Stage based on deepest soft tissue damage visible or palpable
- ☐ If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below).
- ☐ Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.

55

---

---

---

---

---

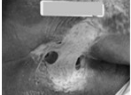
---

---

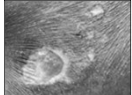
---

**M0300: Step 3**  
**Determine "Present on Admission"**

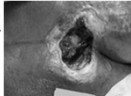
- ☐ PU/PI was unstageable on admission/entry or reentry,
- ☐ Becomes numerically stageable later
- ☐ Consider **"present on admission" stage at which it first becomes numerically stageable.** (Stage 3 or 4)
- ☐ If subsequently **increases** in numerical stage, that higher stage **should not be coded as "present on admission."**



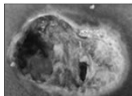
Unstageable on Admission PoA



Stage 2 on Admission PoA



Debrided: Stage 4 PoA



Stage 4 on Admission NOT PoA

Courtesy: Dot Weir, RN, CWDN, CWS

56

---

---

---

---

---


---

---

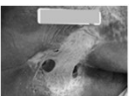
---

**M0300: Step 3**  
**Determine "Present on Admission"**

- ☐ PU/PI was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, the pressure ulcer/injury is coded at M0300F and **should not be coded as "present on admission."**



Stage 4 POA



Unstageable

57

---

---

---

---

---

---

---

---

MDS Section M	<b>M0300: Step 3</b>
	<b>Determine "Present on Admission"</b>
<input type="checkbox"/> Two PUs merge <input type="checkbox"/> Both "present on admission," continue to code the merged pressure ulcer as "present on admission." <input type="checkbox"/> Although two merged pressure ulcers might increase the overall surface area of the ulcer, <b><u>there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."</u></b> <input type="checkbox"/> NOTE: this means if the PU deteriorates on your watch, becoming deeper or acquiring necrotic tissue when there was none on admission, the PU is now facility acquired.	

58

---

---

---

---

---

---

---

---

<b>You MUST Code and Report Pressure Ulcer/Injuries According to the RAI Instructions for Staging</b>	
<input type="checkbox"/> For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. <input type="checkbox"/> Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. <input type="checkbox"/> However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you must code the MDS according to the instructions in this manual.	

59

---

---

---

---

---

---

---

---

<b>References</b>	
<input type="checkbox"/> CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17, October 2019, Section M. <input type="checkbox"/> CMS State Operations Manual. Transmittal 173, Rev 11-22-17. <input type="checkbox"/> National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.	

60

---

---

---

---

---

---

---

---