Accurate and Consistent MDS Coding for Sections J & M

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Objectives

- Describe a strategy to improve MDS coding for pain
- Discuss the MDS items that trigger the quality measure for pain
- Discuss a strategy to improve MDS coding for pressure ulcers
- Discuss the effects of accurate MDS coding on care outcomes

Accurate MDS Coding and Care Outcomes

Accurate Coding Meaningful Care Plan Quality Care
Pain Coding
MDS Section J

Pain is what the resident says it is

- Unpleasant sensory and emotional experience
- Affects more than 33 million over 65
- Undertreated and under-diagnosed in the elderly who reside in nursing homes
- Barriers: cognition, culture, communication, medications, training, systems

Myths

- Part of aging
- Death is near
- Detection of a serious illness
- There are only 4 vital signs (BP, T, P, R)
- Pain is the 5th vital sign
**Pain Screening**
- Admission, readmission, change in condition, new pain, worsened pain, each MDS
- Comprehensive evaluation
  - Description of pain
  - Location, intensity, frequency
  - Pain at its worse and best
  - Aggravating and alleviating factors
  - Current treatment
  - Response to current treatment
  - Non pharmacological interventions

**Strategies to Improve Coding for Pain: Team Knowledge & Collaboration**
- Know the MDS RAI
- Educate those conducting the interview
- Know MDS sections which impact the outcome of an interview (hearing, communication, cognition, vision, language)
- Review the medical record, interview staff and caregivers.
- Know which scale to use
  - Verbal or visual

**MDS QM Triggers for Pain**
**Short Stay: Percent who Self Report Moderate to Severe Pain**
- **Numerator:** Condition #1 or #2
  - **Condition #1:** Reports daily pain with at least one episode of moderate/severe pain. **Both** of the following conditions must be met:
    1.1 Almost constant of frequent pain
    1.2 At least one episode of moderate to severe pain
    *(J0400 = 1 or 2) and (J0600B = 2 or 3)*
  - **Condition #2:** Reports very severe/horrible pain of any frequency *(J0600 = 4)*
- **Denominator:** All short stay except exclusions.
- **Exclusions:** Pain assessment not completed, presence item not completed, frequency not completed, intensity not completed.
MDS QM Triggers for Pain
Long Stay: Percent who Self Report Moderate to Severe Pain

• Numerator: Condition #1 or #2
  Condition #1: Reports daily pain with at least one episode of moderate/severe pain. Both of the following conditions must be met:
  1.1 Almost constant or frequent pain (J0400 = 1 or 2) and
  1.2 At least one episode of moderate to severe pain (J0600B = 2 or 3)
  Condition #2: Reports very severe/horrible pain of any frequency (J0600 = 4)

• Denominator: All long stay except exclusions.
• Exclusions: Assessment is an admission assessment, pain assessment not completed, presence item not completed, frequency not completed, intensity not completed.

MDS Section J

All medication by any route during 5 day look back. Does not include medication used for underlying conditions (chemotherapy or steroids).

Pain Management

• Consistent level of comfort
• Maintain as much function as possible
• Identify effectiveness of interventions
• Identify all sources of pain
• Moderate to severe: scheduled
• Intermittent or mild: as needed
• Non-pharmacological: as adjunct or alone
Strategies to Improve Coding for Pain:
Know the clues
- Sleep cycle
- Appearance
- Mood changes, resisting care, behaviors
- Functional decline
- Weight loss
- Non-verbal descriptors (see MDS)
- Social withdrawal/depression

Sections of the MDS we must know to conduct the Pain Interview

<table>
<thead>
<tr>
<th>Language</th>
<th>Cognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant language?</td>
<td>Resident or staff interview?</td>
</tr>
<tr>
<td>Is an interpreter needed?</td>
<td></td>
</tr>
</tbody>
</table>

Hearing, Speech, Vision
- Hearing aids
- Yours and theirs
- Glasses, where you sit

Documentation
- Interventions
- Goals consistent with resident’s goals
- Intervention received
- Effectiveness
- 5 day look-back, but is on-going
J0100 Pain Management

- 5-day look-back
- Scheduled: specific time interval (i.e., Q12H)
- PRN: as needed with time interval (i.e., Q4H as needed)
- Non-medication intervention: scheduled or PRN (massage, stretching, e-stim, acupuncture, chiropractor, etc.)
  - Herbal medicines are not included in this category

J0200 Should interview be conducted?

- Most can be interviewed
- Obtain directly from resident
- More reliable, accurate
- If cannot communicate verbally, with gestures, or written, conduct staff interview, code “0” at J0200.
- Staff interview if rarely/never understood or interpreter unavailable

J0300 – J0600 Resident Pain Interview

- J0300 Pain presence
- J0400 Pain frequency
- J0500 Pain effect on function
- J0600 Pain intensity
- Conduct interview as close to end of 5 day look-back
- Preferably day before or day of ARD
J0300 – J0600
Resident Pain Interview

- If no pain on first item, code 0 and skip to next MDS item (J1100 shortness of breath)
  - Code 0 if no pain even if due to pain mgmt
- If at any time the resident chooses not to answer, is unable to answer, does not respond, or gives nonsensical response, code 9 and go to staff interview

J0600 Resident Pain Interview Rating Scale

- Numeric, Verbal Descriptor
- One or the other
- Choose appropriate scale according to cognition, vision, etc.

Completed Interview

- Resident reports no pain at J0300
- Reported pain at J0300 and follow-up J0400 is answered
- J0700 closes the interview
  - Determines if resident interview was complete.
  - Complete staff interview if J0200-J0600 was not completed
Staff Interview

- Be specific
  - Non-verbal sounds (crying, whining, gasping, moaning, groaning)
  - Vocal complaints (that hurts, stop, ouch)
  - Facial expressions (grimacing, wincing, wrinkled forehead, clenched teeth, etc.)
  - Protective body movements (bracing, guarding, rubbing, massaging, clutching during movement, etc.)

Pain Treatment Goals & Care Plan

- Determined collaboratively
- Decrease occurrence
- Improve function, mood, sleep
- Address underlying cause
- Monitoring, change approaches as needed

Mrs. Jones received:

Hydrocodone 5/500, 1 tab PO every 6 hours.
Discontinued on day 1 of the look back.
Cold pack to the right knee BID, applied by PT.
Mr. Clark's interview:
When asked about pain, “No. I have been taking the pain medicine so I have no pain.

Mrs. Smith's interview:
When asked about pain, “No pain, but I have had a terrible throbbing and spasm sensation down my leg.

Mr. Carter's interview:
When asked about pain, “I was living in Utah in 1935.
Mrs. Knoll is unable to answer the questions. Staff interview is conducted:

When staff is asked “Does Mrs. Knoll exhibit any non-verbal signs of pain?” staff responds, “No. But sometimes she moans then yells ‘stop!’ when we move her.

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**Pressure Ulcer Coding**

MDS Section M

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**MDS QM Triggers for PUs**

Short Stay: Percent with Pressure Ulcers that are New or Worsened (Stage II, III, IV)

**Numerator: Condition #1 and #2**

- Condition #1: High risk for pressure ulcers
  - Bed mobility self performance G01100A1 = 3,4,7,8
  - Transfer self performance F0110B1 = 3,4,7,8
  - Comatose B0100 = 1
  - Malnutrition or at risk of malnutrition I5600 = 1

- Condition #2: M0300B1, or C1, or D1 = 1-9

**Denominator:**

- Bed mobility self performance G01100A1 = 3,4,7,8
- Transfer self performance F0110B1 = 3,4,7,8
- Comatose B0100 = 1
- Malnutrition or at risk of malnutrition I5600 = 1

**Exclusions:** Admission assessment, PPS 5-day, readmission/return assessment, no pressure ulcers, does not meet high risk criteria above
MDS Section 15600

Nutritional

15600: Malnutrition (protein or calorie) or at risk for malnutrition

- Documented by physician or registered dietician.
- Supplements, protein powder
- Lab work
- Has it or is at risk for it

MDS QM Triggers for PU’s

Long Stay: Percent of High Risk with Pressure Ulcers (Stage II, III, IV)

- Numerator: New or worsened pressure ulcer
- Denominator: All residents except those with exclusions
- Exclusions:
  - M0800A less than or equal to M0300B1
  - M0800B less than or equal to M0300C1
  - M0800C less than or equal to M0300D1

M0100 & M0150 Determination of Risk

- Sensory perception
- Mobility
- Communication
- Nutrition
- Moisture
- Friction/shear
- Activity
M0100 & M0150 Determination of Risk

- Admission, readmission, change in condition, new or worsened pressure ulcer, new risk factor
- Healed vs. Unhealed, Open vs. Closed
  - Unstageable and deep tissue injury is considered “open”
- Closed = 80% original tensile strength

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M0100 & M0150 Determination of Risk

- Review formal risk score, previous pressure sites, non-removable dressings, scars over bony prominences, etc.
- But beware of “risk scores”.
- Still must stabilize, reduce, or remove underlying risk factors.

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Determining Present on Admission

- As close to the actual time of admission as possible
- Higher stage on admission/readmission is not “present on admission”
- Unstageable on admission/readmission and stageable later is “present on admission”
+ Determining Present on Admission

- Has pressure ulcer in facility, goes to hospital, returns at same stage not coded as “present on admission”
- Current pressure ulcer increased in stage during hospitalization is coded as “present on admission”

+ Steps to assess

- Head to toe, focus on bony prominences and other pressure bearing areas
- If pressure is not the primary cause, do not code as a pressure ulcer
- Do not rely on only one descriptor
  - i.e., the descriptors for stage I and deep tissue injury are similar (temperature is cold or warm, tissue consistency is firm or boggy)
- Non-blanchable = no loss of skin color when compressed
- Compare area to surrounding areas.

+ Evaluating Pressure Ulcers

**Stage I: M0300A**

Observable pressure related alteration of skin, when compared to adjacent or opposite areas include changes in either temperature, consistency, sensation, or persistent redness.
**Stage II: M0300B**
Partial thickness loss of dermis presenting as shallow open ulcer with red-pink wound bed, without.
May also present as intact or open/ruptured blister.

**Stage III: M0300C**
Full thickness tissue loss. Subcutaneous fat may be visible, but not bone, tendon, or muscle.
Slough may be present but does not obscure the depth of tissue loss.
May have undermining or tunneling.

**Stage IV: M0300D**
Full thickness tissue loss with exposed bone, tendon, or muscle.
Slough or eschar may be present on some parts of the wound bed.
Often includes undermining or tunneling.
Evaluating Pressure Ulcers

Unstageable due to non-removable dressing or device: M0300E

Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.
The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent skin.

Unstageable due to slough or eschar: M0300F

Slough – Non-viable yellow, tan, gray, green, or brown tissue. Usually moist, can be soft, stringy, and mucinous. May adhere to the base of the wound or appear in clumps throughout the wound bed.

Eschar - Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan. May appear scab-like. Necrotic tissue and eschar are usually adherent to the base of the wound and often the sides and edges of the wound.

Unstageable due to suspected deep tissue injury: M0300G

Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.
The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent skin.
Measuring Wounds: Dementions of stage III, IV, or unstageable: M0610

- Consistency
- Looking for largest surface area to code
- Linear clock method
- Longest length, head to toe
- Greatest width, left to right
- Depth
- Undermining
- Tunneling

Evaluating Pressure Ulcers for M0700 Most Severe Tissue Type

**Epithelial tissue**
New skin that is light pink and shiny. In stage II pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In stage III and IV ulcers, it advances from the edges of the wound.

**Granulation tissue**
Red tissue with “cobblestone” or bumpy appearance. Bleeds easily when injured.

- Slough
- Eschar

M0800 Worsening in pressure ulcer

- Progressed to a deeper level of tissue damage
- Higher stage
- Compared to prior assessment
- OBRA, PPS, last admission/entry, re-entry
M0900 Healed pressure ulcer

- Completely closed
- Fully epithelialized, fully covered
  - Stage III and IV fill with granulation tissue before they re-epithelialize, the previous layers of tissue are not replaced
- Resurfaced with new skin
- Even if area continues to have discoloration

Strategies to Improve Coding for PUs: Team Knowledge and Collaboration

- Know the types of ulcers
  - Arterial, Venous, Diabetic, Pressure
- Train staff on consistent measurements
- Keep quality documentation
- Monitor skin daily by nursing assistants
- Monitor skin weekly by nurses
- Know the difference between ulcers
  - F309, F314

A stage II pressure ulcer was documented on admission. On a later assessment, the wound is full thickness stage III without exposed bone, tendon, or muscle.
A stage II pressure ulcer was acquired at the nursing facility. The resident is then hospitalized and returns 8 days later with a stage III pressure ulcer in the same location.

Two stage II merged pressure ulcers:  
M0300B1  
M0300B2

Stage III pressure ulcer:  
M0300C1  
M0300C2

On admission, the resident has three small stage II pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed to find two of the ulcers have merged and the third is now a stage III.

Coccyx stage II pressure ulcer:  
M0300B1  
M0300B2

Hip stage III pressure ulcer:  
M0300C1  
M0300C2

A resident acquired two stage II pressure ulcers at the facility, one on the coccyx and one on the ankle. She is transferred to the hospital and returns with the coccyx ulcer unchanged, the ankle ulcer closed, and a new pressure ulcer on her left hip.
Decrease the opportunity for something to go wrong.

Continue to identify your MDS system vulnerabilities.

- Develop a process to train those involved in completing the MDS.
- Train staff on identifying potential problems.
- QM statistics should not be a surprise.
- MDS coding should not be a surprise.
- The MDS RAI should not look new.

Dr. W. Edwards Deming
Father of Quality Improvement

It is not enough to do your best; you must know what to do, and then do your best.

Help people do better so you can build quality into the product.

It's in the soil not the seed

- Adapt to changes in the industry
- Train and teach (how and why)
- Keep improving
- Drive out fear, create trust
- Collaborate
- PDSA Deming Cycle
James T. Reason
Model of Organizational Errors

Swiss Cheese Model of Accident Medical Errors

Change systems.
Blame free environment.
Identify the holes.
Collaborate.
Catch errors before they occur.
Organizational commitment.

Latent errors = the blunt end
- Organizational, policies, allocation of resources, leadership, management, transfer of knowledge
- Errors waiting to happen
- Must revise system, create a culture of safety
- Freedom to report errors without punishment

Active errors = the sharp end
- Direct contact with patients, front line staff
- Slips = lapses in concentration, most common
- Mistakes = lack of experience, insufficient training, outright negligence
- Culture of on-going learning and advocacy

Accurate MDS Coding and Care Outcomes

Right Time
Right Communication
Right Environment
Right Relationship
Right Outcomes
# Section J  
## Health Conditions

### J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last 5 days, has the resident:

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Received scheduled pain medication regimen?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Received PRN pain medications OR was offered and declined?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Received non-medication intervention for pain?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Yes</td>
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</tbody>
</table>

### J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. No (resident is rarely/never understood) ➔ Skip to and complete J0800, Indicators of Pain or Possible Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Yes ➔ Continue to J0300, Pain Presence</td>
</tr>
</tbody>
</table>

## Pain Assessment Interview

### J0300. Pain Presence

Ask resident: "**Have you had pain or hurting at any time in the last 5 days?**"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. No ➔ Skip to J1100, Shortness of Breath</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Yes ➔ Continue to J0400, Pain Frequency</td>
</tr>
<tr>
<td></td>
<td>9. Unable to answer ➔ Skip to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

### J0400. Pain Frequency

Ask resident: "**How much of the time have you experienced pain or hurting over the last 5 days?**"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Almost constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Frequently</td>
</tr>
<tr>
<td></td>
<td>3. Occasionally</td>
</tr>
<tr>
<td></td>
<td>4. Rarely</td>
</tr>
<tr>
<td></td>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

### J0500. Pain Effect on Function

#### A. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

#### B. Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

### J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)

#### A. Numeric Rating Scale (00-10)

Ask resident: "**Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.**" (Show resident 00 -10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

#### B. Verbal Descriptor Scale

Ask resident: "**Please rate the intensity of your worst pain over the last 5 days.**" (Show resident verbal scale)

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Mild</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Moderate</td>
</tr>
<tr>
<td></td>
<td>3. Severe</td>
</tr>
<tr>
<td></td>
<td>4. Very severe, horrible</td>
</tr>
<tr>
<td></td>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>
### Section J  Health Conditions

#### J0700. Should the Staff Assessment for Pain be Conducted?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. <strong>No</strong> (J0400 = 1 thru 4)</th>
<th>Skip to J1100, Shortness of Breath (dyspnea)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. <strong>Yes</strong> (J0400 = 9)</td>
<td>Continue to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

#### Staff Assessment for Pain

**J0800. Indicators of Pain or Possible Pain** in the last 5 days

Check all that apply

- **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- **Z. None of these signs observed or documented**  
  If checked, skip to J1100, Shortness of Breath (dyspnea)

**J0850. Frequency of Indicator of Pain or Possible Pain** in the last 5 days

Frequency with which resident complains or shows evidence of pain or possible pain
### M0100. Determination of Pressure Ulcer Risk

Check all that apply:

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
- B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- C. Clinical assessment
- Z. None of the above

### M0150. Risk of Pressure Ulcers

Enter Code

Is this resident at risk of developing pressure ulcers?

1. No
2. Yes

### M0210. Unhealed Pressure Ulcer(s)

Enter Code

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

1. No ➔ Skip to M0900, Healed Pressure Ulcers
2. Yes ➔ Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

### M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number

**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

1. **Number of Stage 1 pressure ulcers** - If 0 ➔ Skip to M0300C, Stage 3
2. **Number of these Stage 1 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
3. **Date of oldest Stage 1 pressure ulcer** - Enter dashes if date is unknown: 
   ```
   [ ] [ ] [ ] [ ]
   ```
   Month Day Year

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

1. **Number of Stage 2 pressure ulcers** - If 0 ➔ Skip to M0300C, Stage 3
2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown: 
   ```
   [ ] [ ] [ ] [ ]
   ```
   Month Day Year

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

1. **Number of Stage 3 pressure ulcers** - If 0 ➔ Skip to M0300D, Stage 4
2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

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

1. **Number of Stage 4 pressure ulcers** - If 0 ➔ Skip to M0300E, Unstageable: Non-removable dressing
2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page
### M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued

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

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of unstageable pressure ulcers due to non-removable dressing/device</td>
<td>If 0 → Skip to M0300F, Unstageable: Slough and/or eschar</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</td>
<td>enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
<td>If 0 → Skip to M0300G, Unstageable: Deep tissue</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</td>
<td>enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</td>
<td>If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</td>
<td>enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

### M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

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

<table>
<thead>
<tr>
<th>cm</th>
<th>cm</th>
<th>cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Pressure ulcer length: Longet length from head to toe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

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

### M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry

Complete only if A0310E = 0

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

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>Enter Number</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Stage 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Stage 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Stage 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**M0900. Healed Pressure Ulcers**
Complete only if A0310E = 0

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No ➡️ Skip to M1030, Number of Venous and Arterial Ulcers</td>
</tr>
<tr>
<td></td>
<td>2. Yes ➡️ Continue to M0900B, Stage 2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>B. Stage 2</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>C. Stage 3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>D. Stage 4</th>
</tr>
</thead>
</table>

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

**M1040. Other Ulcers, Wounds and Skin Problems**
Check all that apply

### Foot Problems
- A. Infection of the foot *(e.g., cellulitis, purulent drainage)*
- B. Diabetic foot ulcer(s)
- C. Other open lesion(s) on the foot

### Other Problems
- D. Open lesion(s) other than ulcers, rashes, cuts *(e.g., cancer lesion)*
- E. Surgical wound(s)
- F. Burn(s) *(second or third degree)*
- G. Skin tear(s)
- H. Moisture Associated Skin Damage (MASD) *(i.e. incontinence (IAD), perspiration, drainage)*

None of the Above

Z. None of the above were present

**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. Pressure ulcer care
- F. Surgical wound care
- G. Application of nonsurgical dressings *(with or without topical medications)* other than to feet
- H. Applications of ointments/medications other than to feet
- I. Application of dressings to feet *(with or without topical medications)*
- Z. None of the above were provided