PADONA
present
Demystifying F686: CMS Updates to Pressure Ulcer/Injury Tag

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Objectives

- At the end of this presentation participants will be able to:
- Verbalize regulatory language associated with F-Tag 686, including updated staging definitions;
- Identify other F-Tags surveyors are instructed to review when F686 (pressure ulcer/injury) has been given to a facility;
- Verbalize evidence-based clinical and best practices for pressure ulcer/injury prevention and care that meets regulatory mandates.

Critical Documents You and Your Staff MUST Read and Learn in Detail for PU/PI Regulatory & Clinical Success

1. CMS State Operations Manual. Transmittal 173, Rev 11-22-17. **F686 and associated tags**
2. CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16, October 2018. **Section M**
3. Pressure Ulcer/Injury Critical Element Pathway. **DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES. CMS Form 20078, 5/2017.**
4. Braden Protocols by Level of Risk
5. Braden Scale for Predicting Pressure Sore Risk

F686 Skin Integrity

Pressure Ulcers/Injuries

CMS SOM F686

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.

- *Based on the comprehensive assessment of a resident, the facility must ensure that—*
- *(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and*
- *(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.*

PRESSURE ULCER/INJURY PREVENTION ACCORDING TO REGULATORY AND BEST PRACTICES

This section of the SOM continues to evolve as better understanding of skin issues come to light within the health care community and is shared with CMS.

American Medical Technologies Education Division

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.
- **Ensure you or your consultants (visiting wound practitioners) are delivering the current standards of care for assessments and treatments of wounds**

F658

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).*

F658

KEY ELEMENTS OF NONCOMPLIANCE: Instructions to Surveyors

- ***To cite deficient practice at F658, the surveyor's investigation will generally show that the facility did one or more of the following:***
- *Provided or arranged for services or care* ***that did not adhere to accepted standards of quality;***
- *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).
- *Failed to provide or arrange for services or care that accepted standards of quality dictate should have been provided.*

F658

Questions the Surveyor Will Ask

- *Do the services provided or arranged by the facility, as outlined in the comprehensive care plan, reflect accepted standards of practice?*
- *Are the references for standards of practice, used by the facility, up to date, and accurate for the service being delivered?*

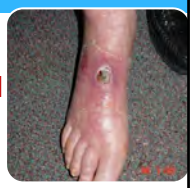
NOTE: Standards of practice change as we learn more. Who is keeping up with your wound prevention and care standards of care? How do you know the services provided by outside contractors are up-to-date and appropriate?

F684

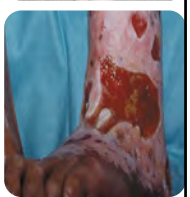
F684-Quality of Care

- Review of a Resident with Non Pressure-Related Skin Ulcer/Wound
- Residents may develop various types of skin ulceration.
- At the time of the assessment and diagnosis of a skin ulcer/wound, the clinician is expected to document the clinical basis (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.
- This section differentiates some of the different types of skin ulcers/wounds that are not considered to be pressure ulcers.
- Other types of wounds specifically mentioned are arterial, diabetic neuropathic, & venous ulcers, but includes ALL etiologies
- NOTE: ALL wound etiologies must have a wound assessment including measurements.

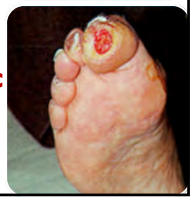
Arterial



Venous



Diabetic Neuropathic



Why Prevention?

- National priority
- Decrease PU/PI incidence
- Survey (F-Tags, monetary penalties)
- Quality Assurance and Performance Improvement (QAPI)
- Reimbursement affected in future (PDPM)
- Framework for identifying unavoidable pressure Injury
- Facility reputation (5 STAR Process)
- Litigation
- **IMPROVED QUALITY OF LIFE**

MDS Section-M

MDS and PU/PI Risk Determination and Reporting

NOTE: Literature mentions more than 100 risk factors for Pressure Ulcer/Injuries!!!

M0100: Determination of Pressure Ulcer/*Injury* Risk

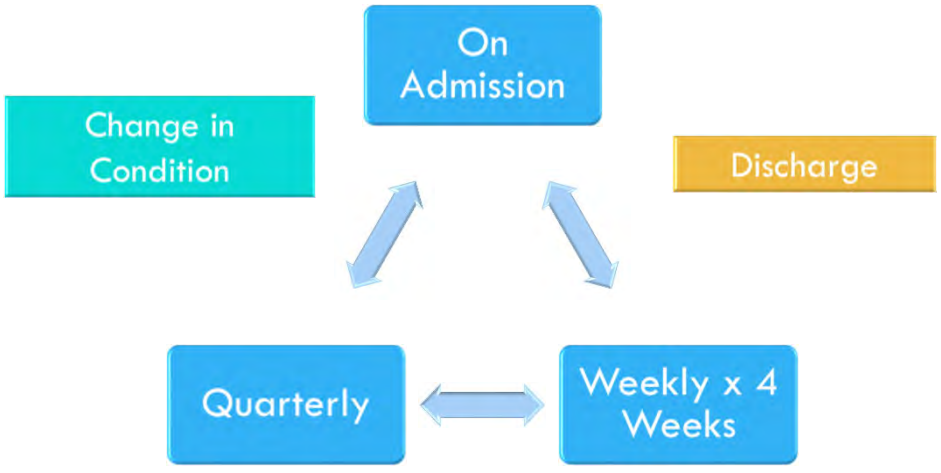
M0100. Determination of Pressure Ulcer/Injury Risk	
↓ Check all that apply	
☐	A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
☐	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
☐	C. Clinical assessment
☐	Z. None of the above

MDS Section-M

NOTE: Braden **NOT** comprehensive for all you need to recognize as risk for PU/PI!!!

CMS SOM F686

Frequency of Risk Assessment



CMS SOM F686

When the Score Doesn't Match the Risk

- *"Regardless of any resident's total risk score on an assessment tool, clinicians are responsible for evaluating each existing and potential risk factor for developing a pressure injury and determining the resident's overall risk.*
- *It is acceptable if* ***the clinician's assessment places the resident at a higher risk level than the overall score of the assessment tool*** *based on assessment factors that are not captured by the tool. Documentation of the clinician's decision should be placed in the medical record."*

Critical Concept for PU/PI Prevention

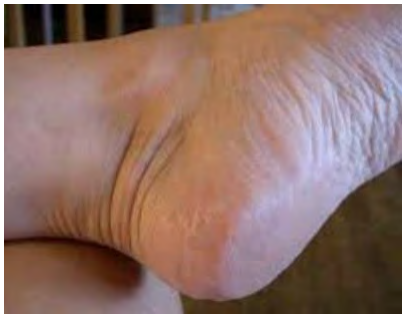
NOTE: You can do a PU/PI risk assessment without doing the Braden or any other formal tool. You can review the medical record and **extract each risk factor**, in addition to interviewing the resident and family for other risk factors.

Or you can **do the Braden AND review the medical record and interview the resident and family.**

You **CANNOT ONLY perform the Braden** and expect to pick up all the pressure ulcer/injury risk factors.

Blanch Test (Capillary Refill) of EVERY Heel

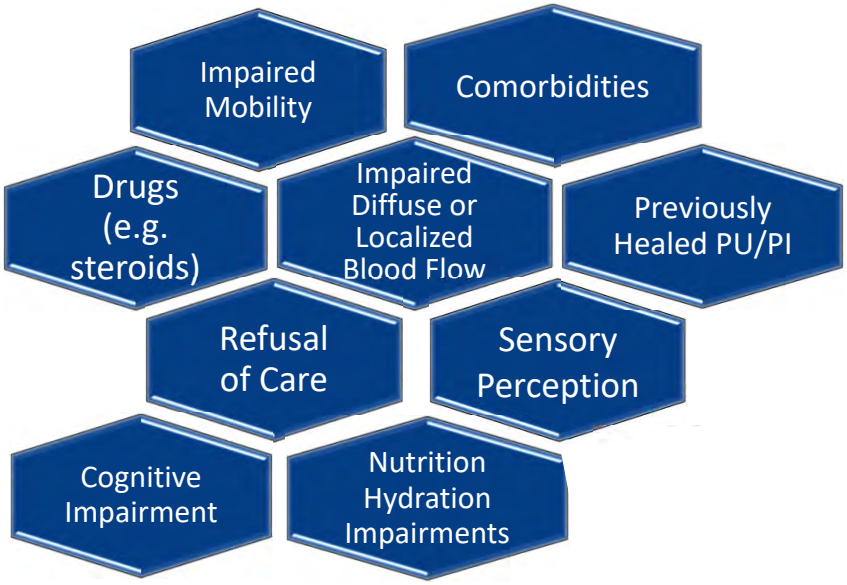
Consider capillary refill exam of most common areas for pressure injuries in those patients/residents with significantly impaired mobility,



- Sacrum
- Trochanter
- Malleolus
- Heels
- Other risk areas associated with bed positioning

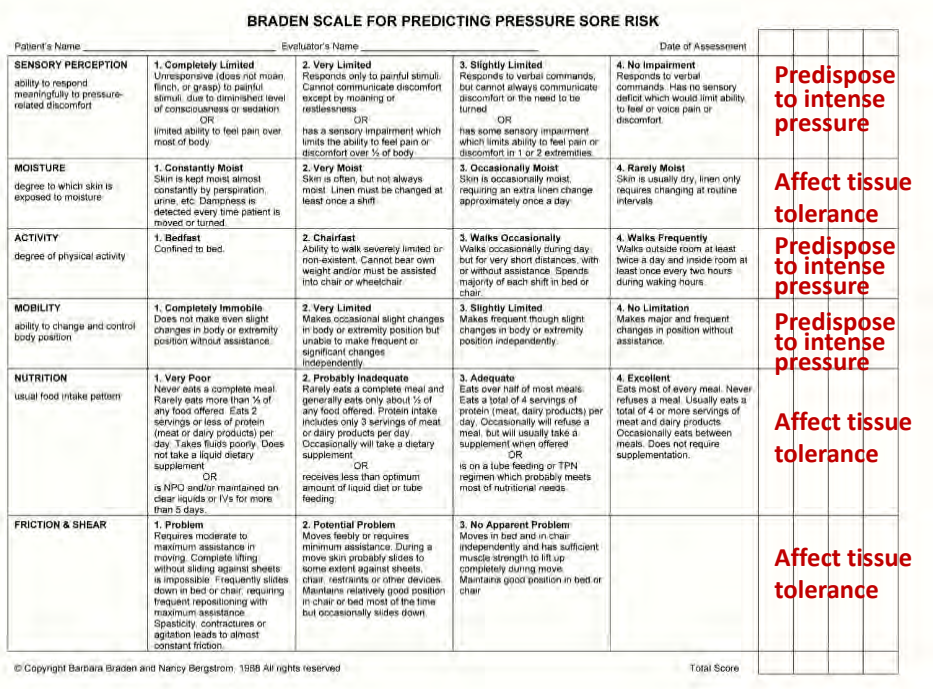
CMS SOM F686

Specific Considerations for PrU Risk



Braden Parameters

Sensory Perception	Moisture	Activity
1. Completely Limited	1. Constantly Moist	1. Bedfast
2. Very Limited	2. Very Moist	2. Chairfast
3. Slightly Limited	3. Occasionally Moist	3. Walks Occasionally
4. No Impairment	4. Rarely Moist	4. Walks Freq.
Mobility	**Nutrition**	**Friction & Shear**
1. Completely Immobile	1. Very Poor	1. Problem
2. Very Limited	2. Probably Inadequate	2. Potential Problem
3. Slightly Limited	3. Adequate	3. No Apparent Problem
4. No Limitations	4. Excellent	



BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name _____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	**Predispose to intense pressure**
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	**Affect tissue tolerance**
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.	**Predispose to intense pressure**
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	**Predispose to intense pressure**
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	**Affect tissue tolerance**
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		**Affect tissue tolerance**

 Total Score

Number 1 Reason for Acquiring Pressure Ulcer/Injuries

Create a **Culture of Mobility** in your building

Mobility

- Assessing **accurately** for mobility impairments and implementing a mobility plan of care is probably **the most important component** of a pressure Injury prevention program
- Bed mobility
  - Roll side to side
  - Hold side lying position
  - Scooting up in bed
  - Lying to sitting
  - Sit to stand

Braden Scale Scores

At Risk = 15 - 18
Moderate Risk = 13 - 14
High Risk = 10 - 12
Very High Risk = 9 or below

Advance Level of Risk-Original Braden Documents

- **If other major risk factors are present**
  - **Advance age**
  - **Fever**
  - **Poor dietary intake of protein**
  - **Diastolic pressure <60**
  - Hemodynamic instability…
- **ADVANCE TO THE NEXT LEVEL OF RISK!!!**

AT RISK (15-18)* FREQUENT TURNING MAXIMAL REMOBILIZATION PROTECT HEELS MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR PRESSURE-REDUCTION SUPPORT SURFACE IF BED OR CHAIR BOUND *** If other major risk factors are present** *(advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability)* **advance to next level of risk**	**MANAGE MOISTURE** USE COMMERCIAL MOISTURE BARRIER USE ABSORBANT PADS OR DIAPERS THAT WICK & HOLD MOISTURE ADDRESS CAUSE IF POSIBLE OFFER BEDPAN/URINAL AND GLASS OF WATER IN CONJUNCTION WITH TURNING SCHEDULES
MODERATE RISK (13-14)* TURNING SCHEDULE USE FOAM WEDGES FOR 30! LATERAL POSITIONING PRESSURE-REDUCTION SUPPORT SURFACE MAXIMAL REMOBILIZATION PROTECT HEELS MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR *** If other major risk factors present, advance to next level of risk**	**MANAGE NUTRITION** INCREASE PROTEIN INTAKE INCREASE CALORIE INTAKE TO SPARE PROTEINS SUPPLEMENT WITH MULTI-VITAMIN (SHOULD HAVE VIT A, C & E) ACT QUICKLY TO ALLEVIATE DEFICITS CONSULT DIETITIAN
HIGH RISK (10-12) INCREASE FREQUENCY OF TURNING SUPPLEMENT WITH SMALL SHIFTS PRESSURE REDUCTION SUPPORT SURFACE USE FOAM WEDGES FOR 30! LATERAL POSITIONIING MAXIMAL REMOBILIZATION PROTECT HEELS MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR	**MANAGE FRICTION & SHEAR** ELEVATE HOB NO MORE THAN 30! USE TRAPEZE WHEN INDICATED USE LIFT SHEET TO MOVE PATIENT PROTECT ELBOWS & HEELS IF BEING EXPOSED TO FRICTION
VERY HIGH RISK (9 or below) ALL OF THE ABOVE + USE PRESSURE-RELIEVING SURFACE IF PATIENT HAS INTRACTABLE PAIN OR SEVERE PAIN EXACERBATED BY TURNING OR ADDITIONAL RISK FACTORS *low air loss beds do not substitute for turning schedules	**OTHER GENERAL CARE ISSUES** NO MASSAGE OF REDDENED BONY PROMINENCES NO DO-NUT TYPE DEVICES MAINTAIN GOOD HYDRATION AVOID DRYING THE SKIN

Braden Document For Assigning PU/PI Risks

Training in the Braden

- Clinicians performing the Braden should review methods for scoring correctly
- Surveyors may check medical records and MDS for use & accuracy of the risk assessment with corresponding subscales
- In-services on how to perform and use the risk assessment scale are **important components of the pressure Injury prevention program** and should be required for all nurse managers and other individuals delegated the task of completing the risk assessment
- In addition, a quality assurance (QA) review is recommended to ensure accurate determination of the subscales of the risk assessment tool being used

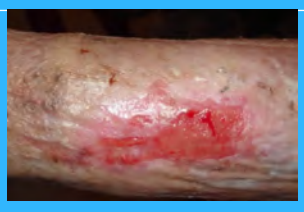
Describing Tissue Destruction in Your Documentation

Partial vs Full Thickness

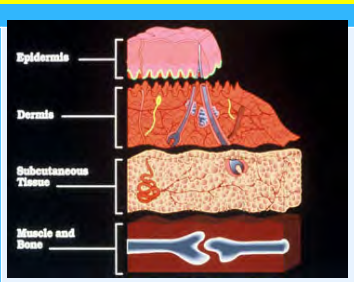
Pressure Ulcer Staging

All wounds, regardless of etiology, can be assessed as either partial or full-thickness wounds.

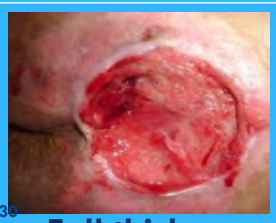
Classification of Wound by Tissue Destruction



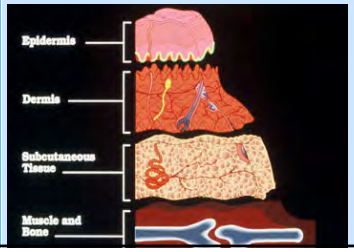
Partial thickness



Extends through the epidermis (first layer of skin), but not through dermis (second layer)
STAGE 2 PU/PI



Full thickness



Extends through epidermis and dermis; may involve subcutaneous tissue, muscles, joint capsule, bone
STAGE 3 and 4 PU/PI

30

CMS SOM F686

Comparisons of Definitions

NPUAP

31

F-686/Formerly F314	NPUAP - 2016
"Pressure Ulcer/Injury (PU/PI)" 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 skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue.	Pressure Injury: 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. **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.**

F686 , MDS & NPUAP Staging Definitions

1. Centers for Medicare and Medicaid Services (CMS) - State Operations Manual: Guidance to Surveyors
2. CMS - MDS 3.0, Section - M
3. National Pressure Ulcer Advisory Panel: Prevention and Treatment Clinical Practice Guidelines

MDS 3.0

What is the Purpose of Staging?

33

- 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!**

Staging per the SOM

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- Deep Tissue Pressure Injury (DTPI)
- Medical Devices Related Pressure Injury

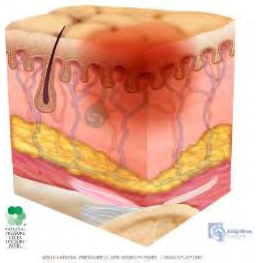
For Pressure Ulcer/Injuries ONLY

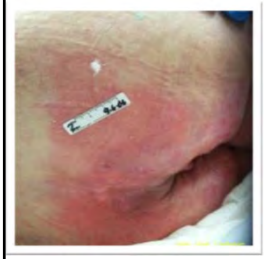
34

Stage 1 Pressure Injury

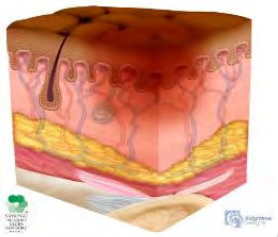
CMS SOM F686

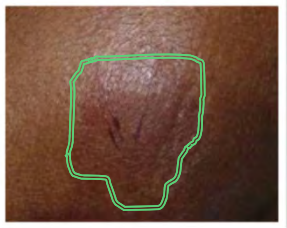
Stage 1 Pressure Injury: Slide 1





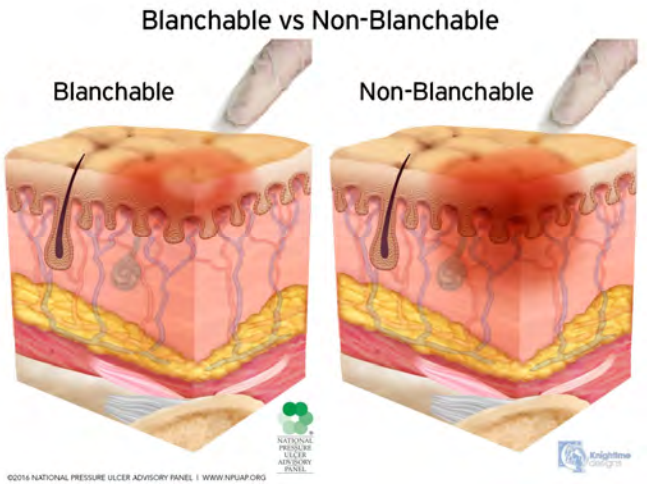
Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues.





Stage 1 Pressure Injury with Edema

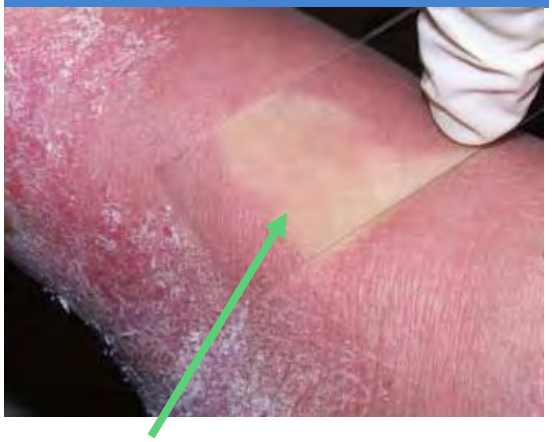
Stage 1 Pressure Injury – Slide 2



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

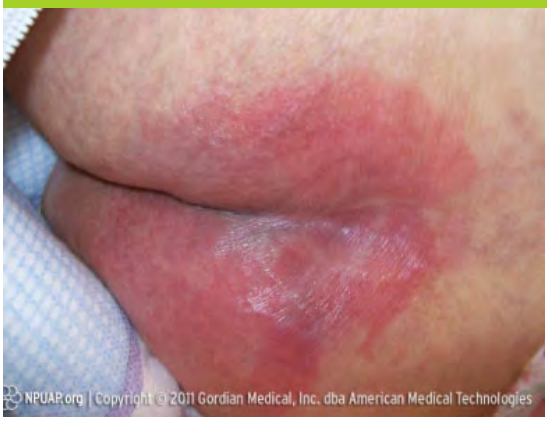
Blanchable vs. Non Blanchable Erythema

Blanchable Erythema



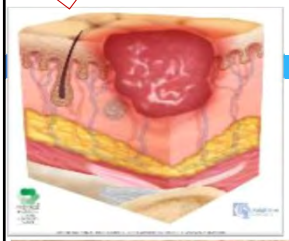
Using clear plastic sheet to blanch

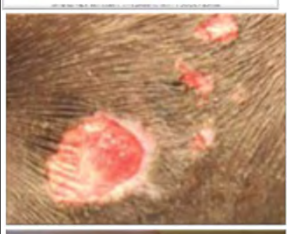
Non-Blanchable

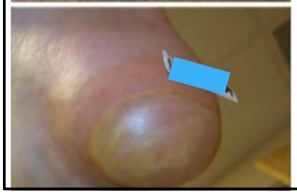


Stage 2 Pressure Ulcer

CMS SOM F686







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.

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).*

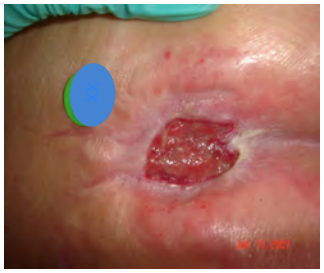
Stage 3 Pressure Ulcer

CMS SOM F686

Stage 3 Pressure Ulcer – Slide 1

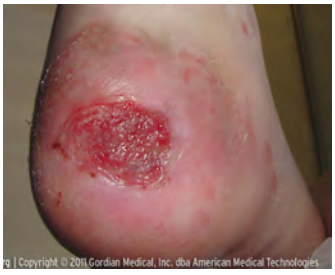
Stage 3 Pressure Ulcer with light slough

- 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.



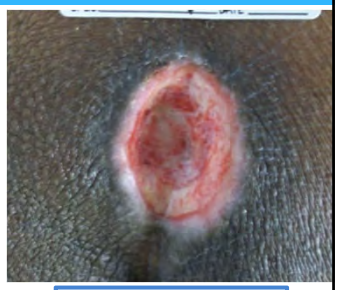
Stage 3 Sacral Pressure Ulcer

Stage 3 Pressure Ulcer – Slide 2

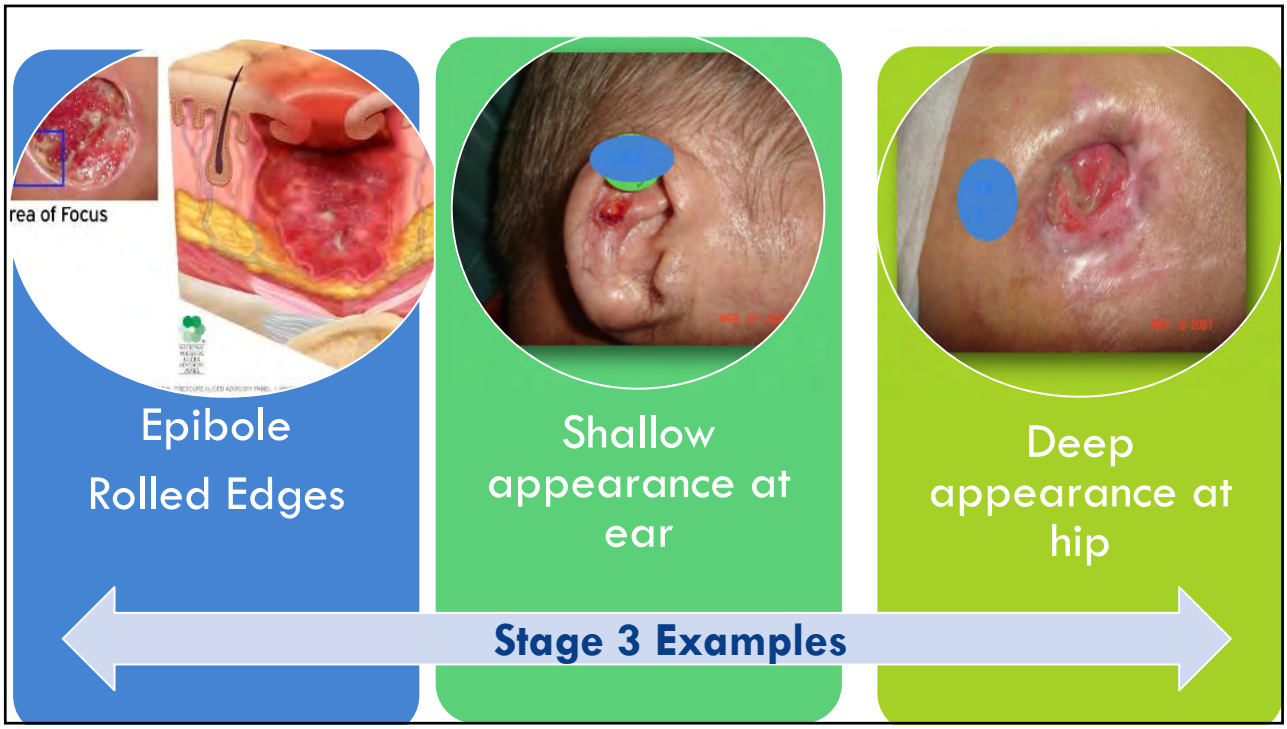


Shallow Stage 3

- 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.



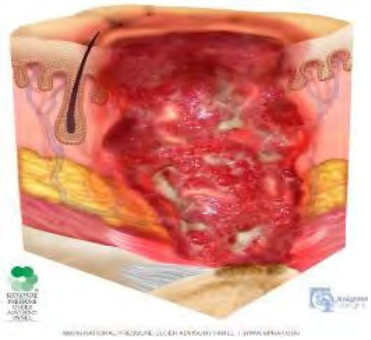
Deep Stage 3



Stage 4 Pressure Ulcer

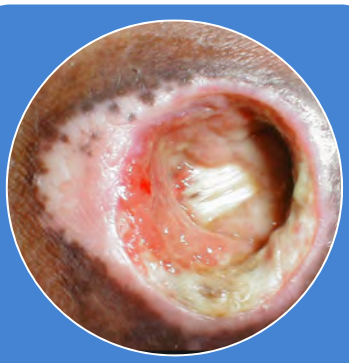
CMS SOM F686

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

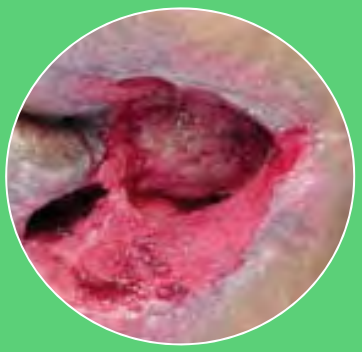


Stage 4 pressure injury with light slough in wound base.

- 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.



Stage 4 with tendon exposed



Deep Stage 4

Stage 4 into ear cartilage

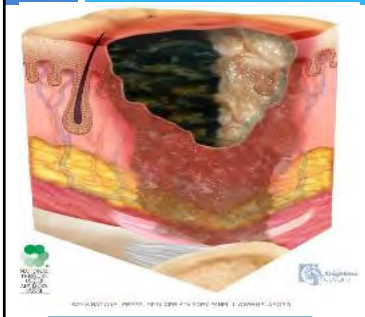
Stage 4 Examples

Attribution: Dot Weir, RN, CWON, CWS

Unstageable Pressure Ulcer

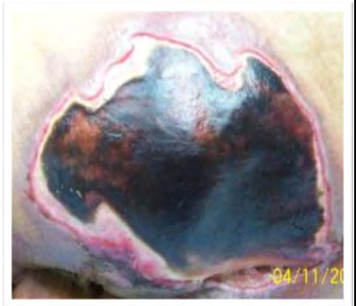
CMS SOM F686

Unstageable Pressure Ulcer – Slide 1



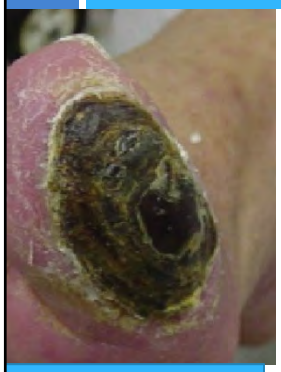
Unstageable Pressure Ulcer due to Eschar & Slough

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.



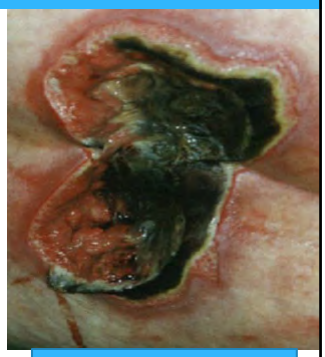
Unstageable Pressure Ulcer due to Eschar

Unstageable Pressure Ulcer – Slide 2



Stable Eschar On Great Toe

- 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

Unstageable Pressure Ulcer – Slide 3

Attribution: Dot Weir, RN, CWON, CWS

Pre-debridement

Post-debridement

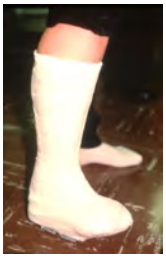
- If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed.
- If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned.
- **The pressure ulcer does not have to be completely debrided or free of all slough or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

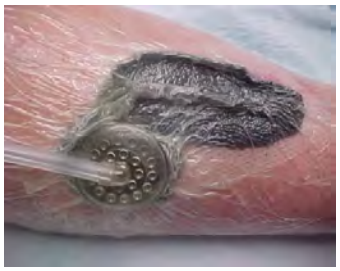
MDS 3.0

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

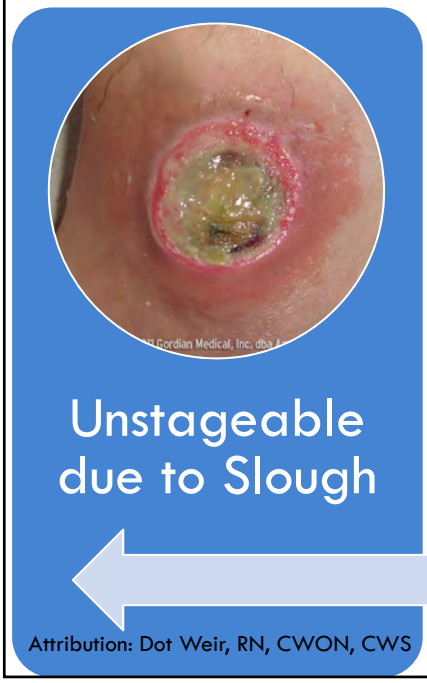
53

- Only on RAI/MDS - Not part of NPUAP staging definitions
- **DEFINITION**
- **NON-REMOVABLE DRESSING/ DEVICE**
- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.





Courtesy: Dot Weir



Deep Tissue Pressure Injury

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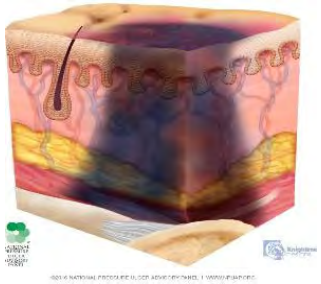
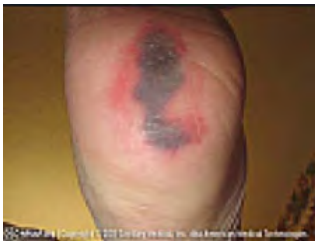
Deep Tissue Pressure Injury (DTPI)





- 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.

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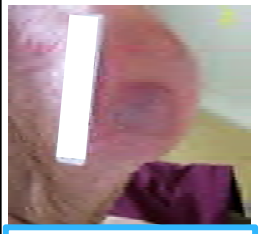
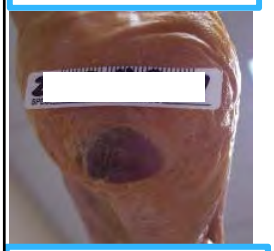
Deep Tissue Pressure Injury – Slide 2



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.

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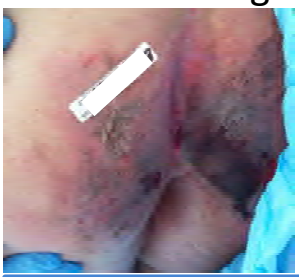
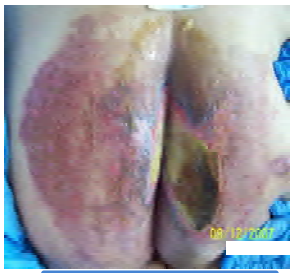
Deep Tissue Pressure Injury – Slide 3

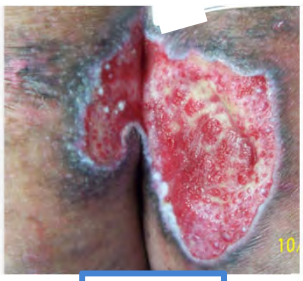
- Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage.
- Do not use DTI to describe vascular, traumatic, neuropathic, or dermatologic conditions.



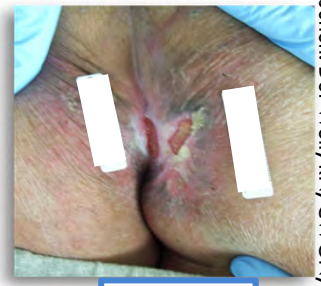
Initial Presentation
DTI



19 Days
Unstageable



1 Month
Stage 3



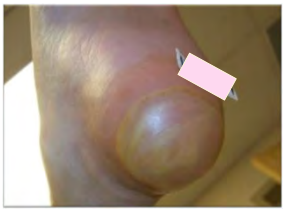
3 Months
Stage 3

Attribution: Dot Weir, RN, CWON, CWS

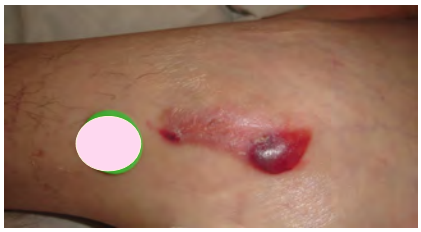
MDS M-Section

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 suspected deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.*



Stage 2
Serum filled blister



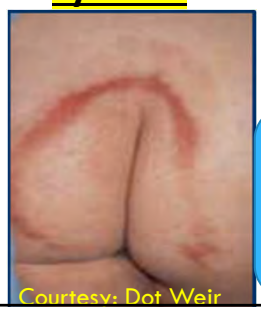
DTI
Blood-filled blister with evidence of surrounding tissue damage

New Ulcer/Injury Definitions in the SOM

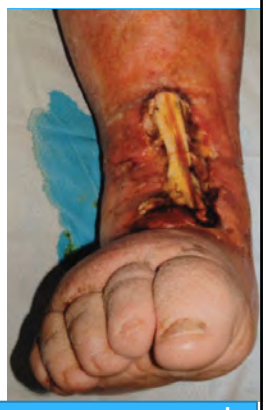
CMS SOM F686

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.**



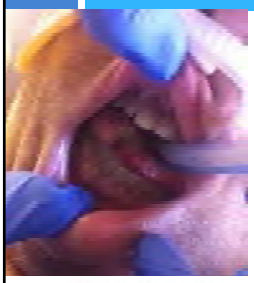
Bed pan medical device related pressure injury Stage 2
MUST be staged.



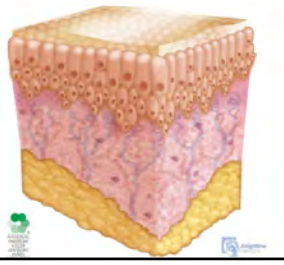
•TED hose not removed for several days
•Caused full-thickness Stage 4 Medical Device Related PU/PI
•MUST be staged

CMS SOM F686

News Definition
Mucosal Membrane Pressure Ulcer/Injury



Mucous Membrane

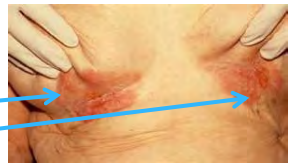


- Mucosal membrane PU/PIs are found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged.

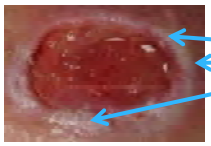
- RAI Coding Tip: *"Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made."*

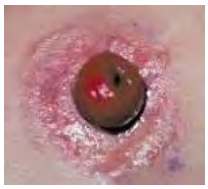
What We **DO NOT** Stage

- **Top-down injuries**
- **Moisture associated skin damage (MASD)**
  - **Intertriginous dermatitis** - Inflammation in skin folds

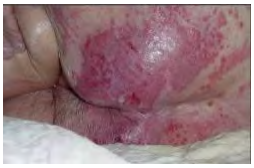


- **Periwound MASD**





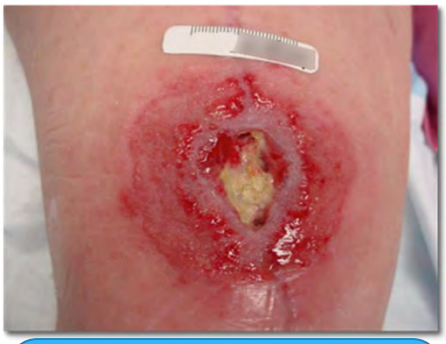
- **Peristomal MASD**



- **Incontinence Associated Dermatitis (IAD)**

What We **DO NOT** Stage

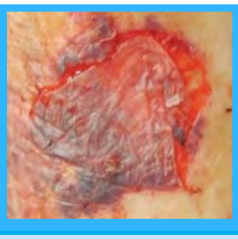
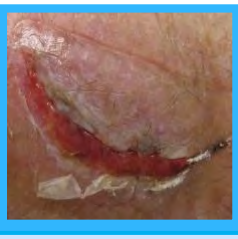
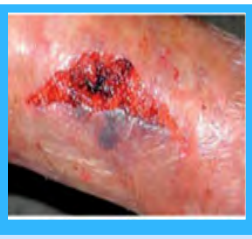
- **Medical adhesive related skin injury (MARSI)**- term brought forward in 2012
  - Defined as an occurrence in which erythema and/or other manifestation of cutaneous abnormality including, but not limited to, vesicle, bulla, erosion or tear
  - Common skin damage due to use of adhesive products particularly (but not exclusively) in institutional healthcare



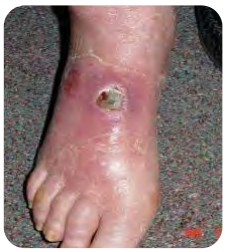
Denuding (adhesive removal over MASD)

What We **Do Not** Stage

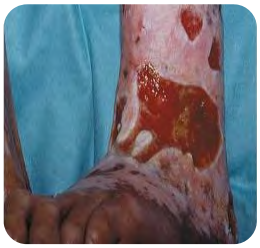
- Skin Tears -International Skin Tear Advisory Panel

		
Type 1: No skin loss Linear or flap tear that can be repositioned to cover the wound	**Type 2: Partial flap loss** Partial flap loss that can't be repositioned to cover wound bed	**Type 3: Total flap loss** Total flap loss exposing the entire wound bed

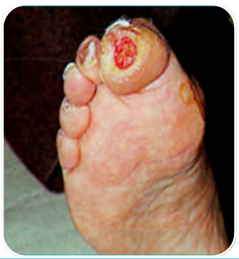
What We **DO NOT** Stage



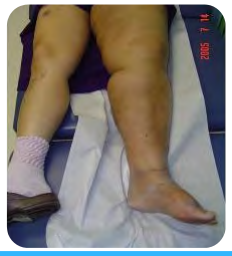
Peripheral Arterial Disease (PAD)



Venous Insufficiency



Diabetic Neuropathic Foot Ulcer



Lymphedema

- Chronic wound etiologies other than pressure – must have good **wound differentiation skills** to determine wound etiologies;
- **All etiologies should be validated by the practitioner in the medical record**

CMS SOM F686

Pressure Ulcer/Injuries at End of Life Guidance to Surveyors

- "It is important for surveyors to understand that when a facility has implemented individualized approaches for end-of-life care in accordance with the resident's wishes, the development, continuation, or worsening of a PU/PI may be considered **unavoidable**.
- **If the facility has implemented appropriate efforts** to stabilize the resident's condition (or indicated **why the condition cannot or should not be stabilized**) and has **provided care to prevent or treat existing PU/PIs** (including pertinent, routine, lesser aggressive approaches, such as, cleaning, turning, repositioning), the PU/PI may be considered **unavoidable and consistent with regulatory requirements."**

F684 Quality of Life

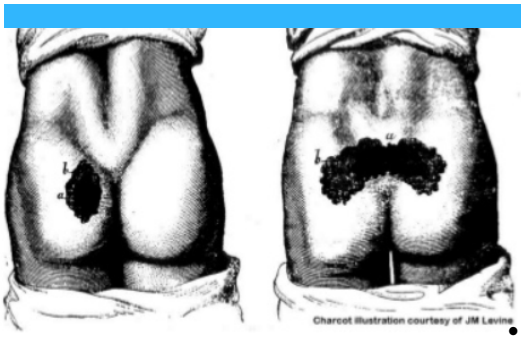
- " the clinician is expected to document the clinical basis which permit differentiating ulcer type, especially if the ulcer has characteristics consistent with pressure; but is deemed not to be one"
- This statement refers to ALL the different wound etiologies.
- And goes on to say: "Kennedy Terminal Ulcers are considered to be pressure ulcers that generally occur at the end of life. For concerns related to Kennedy Terminal Ulcers, refer to F686, §483.25(b) Pressure Ulcers.
- Medically unavoidable
- Example of unavoidable PU/PI due to CHF HoB up to facilitate breathing
- Get ORDER for HoB elevated to e.g. 70-80 degree elevation

CMS SOM F686

The Kennedy Terminal Ulcer (KTU) per SOM

- The facility is responsible for accurately assessing and classifying an ulcer as a KTU or other type of PU/PI and demonstrate that appropriate preventative measures were in place to prevent non-KTU pressure ulcers.

Decubitus Ominousus



//www.jeffreymlevinmd.com/charcot-on-pressure-ulcers/

Courtesy of Jeffrey M Levine MD

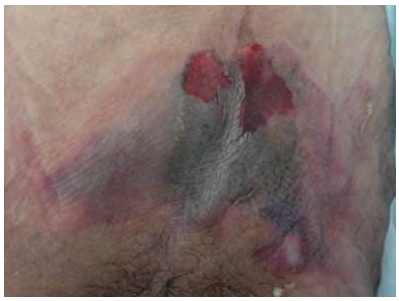
Jean-Martin Charcot

1825-1893

- Skin breakdown heralding impending death of the patient decubitus ominosus.
- This nomenclature (name) was forgotten until the late 20th century when Karen Kennedy recognized and published information on the what became known as the Kennedy Terminal Ulcer in 1980s.

Characteristic of Kennedy Terminal Ulcers - **F686**
Know When to Use This Designation!!!

- "KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:
  - KTUs appear suddenly and within hours;
  - Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms and elbows;



  - Edges are usually irregular and are red, yellow, and black as the ulcer progresses, often described as pear, butterfly or horseshoe shaped; and
  - Often appear as an abrasion, blister, or darkened area and may develop rapidly to a Stage 2, Stage 3, or Stage 4 injury."

KEY ELEMENTS OF NONCOMPLIANCE
To Cite Deficient Practice at F686

- Surveyor's investigation will generally show that the facility failed to do one or more of the following:
  - Provide preventive care, consistent with **professional standards of practice**, to residents who may be at risk for development of pressure injuries; or
  - Provide treatment, consistent with professional standards of practice, to an existing pressure injury; or
  - Ensure that a resident did not develop an avoidable PU/PI.

CMS SOM F686

Review the **Investigative Protocols** in the SOM

- Surveyors directed to use the **Pressure Ulcer Critical Element (CE) Pathway** in addition to the F686 guidelines when determining if a facility meets requirements of care for a resident. (Provided as handout)

- NOTE in SOM: To cite F686, it is not necessary to prove that a PU/PI developed. F686 can be cited when it has been determined that the provider failed to implement interventions to prevent the development of a PU/PI for a resident identified at risk.

CMS SOM F686

Avoidable Pressure Ulcer/Injury per CMS pg 261-11/22/17 SOM

- *"Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following:*
  - *evaluate the resident's clinical condition and risk factors;*
  - *define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice;*
  - *monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.*

CMS SOM F686

Unavoidable Pressure Ulcer/Injury per CMS

- *"Unavoidable" means that the resident developed a pressure ulcer/injury even though the facility had:*
  - *evaluated the resident's clinical condition and risk factors;*
  - *defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice;*
  - *monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.*

Other Tags Reviewed when F686 Deficiency Given

Surveyors Instructed to Review EACH 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 F580 Notification of Change F635 Admission Orders
F637	Significant Change		

Summary

- F686 has a significant number of updates that should be read in detail by all managers and treatment nurses involve in wound prevention and care.
- It has GREAT clinical advice and guidance
- Read F686 in its entirety and the corresponding F-tags
- Asking a treatment nurse to preform wound prevention and care without current evidence-based education on this mammoth topic sets that person, and the building, up for failure related to PU/PIs.

THANK YOU!!!

References

- CMS State Operations Manual. Transmittal 173, Rev 11-22-17.
- Pressure Ulcer/Injury Critical Element Pathway. **DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES. CMS Form 20078, 5/2017.**
- Braden Protocols by Level of Risk
- Braden Scale for Predicting Pressure Sore Risk
- CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16, October 2018.
- European Wound Management Association (EWMA). Position Document: *Wound Bed Preparation in Practice*. London: MEP Ltd, 2004. www.ewma.org
- Thayer DM, Rozenboom B, Baranoski S. Top-down Injuries, Prevention and Management of Moisture-Associated Skin Damage (MASD), Medical Adhesive-Related Skin Injury (MARSI) and Skin Tears. In: Doughty D, McNichol L. WOCN Core Curriculum, Wound Management. Chapter 17, Wolters Kluwer, 2016.