WHCA
Presents

Demystifying F686:
CMS Updates to the Pressure Ulcer/Injury Tag

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Objectives

- At the end of this presentation participants will be able to:
  - Verbalize new regulatory language associated with F-Tag 686, including new 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.

Pressure Ulcers/Injuries
CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer and bed sore. Clinicians may use and the medical record may reflect any of these terms, as long as the primary cause of the skin alteration is related to pressure. For example, the medical record could reflect the presence of a Stage 2 pressure injury, while the same area would be coded as a Stage 2 pressure ulcer on the MDS.

CMS often refers to the National Pressure Ulcer Advisory Panel’s (NPUAP) terms and definitions, which it has adapted, within its patient and resident assessment instruments and corresponding assessment manuals, which includes the Minimum Data Set (MDS). We intend to continue our adaptation of NPUAP terminology for coding the resident assessment instrument while retaining current holistic assessment instructions definitions and terminology. The adapted terminology was used in the development of this guidance.
**Comparisons of Definitions**

<table>
<thead>
<tr>
<th>F-686/Formerly F314</th>
<th>NPUAP - 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ “Pressure Ulcer/Injury (PU/PI)”</td>
<td></td>
</tr>
<tr>
<td>□ 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 <strong>pressure injury</strong> will present as intact skin and may be painful. A <strong>pressure ulcer</strong> 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.</td>
<td></td>
</tr>
<tr>
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<td></td>
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**Top-Down / Bottom-Up Skin Injuries**
Top-Down Injuries

- Newer concept to describe superficial cutaneous injuries
  - Versus “bottom-up” injuries such as pressure ulcers/injury
- Injuries resulting from
  - Mechanical forces
  - Moisture and/or the effects of inflammation
  - Friction
- Three most common
  - Moisture associated skin damage (MASD) (moisture + friction)
  - Medical adhesive related skin injury (MARSI) (stripping of skin’s top layer)
  - Skin tears


Top-Down Skin Injuries

- Top-down skin injuries – **Nonischemic wounds**
- Usually develop due to super-hydrated skin (incontinence, perspiration, maceration) in combination with friction
- Affect exposed surface of skin
  - Other example of top-down skin damage
    - Tape injuries (denuding)
    - Excoriation (scratches)
**Ischemic wounds** – caused by pressure or pressure in combination with shear

- Evidence indicates most ischemic wounds develop from “bottom up”

- **Muscle layer more vulnerable to ischemia** than the epidermis, dermis or subcutaneous tissue
  - i.e. muscles requires most oxygen to survive of any tissue in body

- Therefore *decreased perfusion from pressure* will have greatest effect at muscle layer

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**Bottom-Up Skin Injuries**

- **Muscle layer more vulnerable to ischemia**
- Most pressure/shear wounds are **full-thickness injuries**

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**Deep Tissue Pressure Injury**

**Stage 4 Pressure Ulcer/Injury**
Important Questions to Ask Oneself When Differentiating the Wound’s Origin

- Is there evidence of ischemic damage, or significant tissue loss?
- Or
- Does wound appear to have mechanical damage that disrupted superficial skin layers?

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.
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 are delivering the current standards of care for assessments and treatments.

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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).
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.

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-Quality of Care-Previously F309

- **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.

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New State Operations Manual Released November 22, 2017

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F686
(Rev. 7/3, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(b) Skin Integrity

Based on the comprehensive assessment of a resident, the facility must ensure that—

1. 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

2. 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.

**INTENT**

The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PUs/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- Promote the prevention of pressure ulcer/injury development;
- Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcer/injury.

**NOTE:** CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer and bed sore. Clinicians may use and the medical record may reflect any of these terms, as long as the primary cause of the skin alteration is related to pressure. For example, the medical record could reflect the presence of a Stage 2 pressure injury, while the same area would be coded as a Stage 2 pressure ulcer on the MDS.
Why Prevention?

- National priority
- Decrease PU/PI incidence
- Survey (F-Tags, monetary penalties)
- Reimbursement may be affected in future (P4P)
- Framework for identifying unavoidable pressure Injury
- Facility reputation (5 STAR Process)
- Litigation
- IMPROVED QUALITY OF LIFE

Why Use a Risk Assessment Tool

- “Although the requirements do not mandate the use of any specific assessment tool (other than the RAI), many validated instruments are available to aid in assessing the risk for developing PU/PIs.”

- “Research has shown that in a skilled nursing facility, 80 percent of PU/PIs develop within two weeks of admission and 96 percent develop within three weeks of admission.”
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.”
Essential Components

- Skin Inspection
- Risk Assessment
- Pressure redistribution and offloading
- Maintaining skin health
- Nutrition & hydration
- Patient & family education

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
Specific Considerations for PrU Risk

- Impaired Mobility
- Comorbidities
- Drugs (e.g. steroids)
- Impaired Diffuse or Localized Blood Flow
- Previously Healed PU/PI
- Refusal of Care
- Sensory Perception
- Cognitive Impairment
- Nutrition Hydration Impairments

Braden Parameters

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Friction &amp; Shear</th>
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<table>
<thead>
<tr>
<th>Mobility</th>
<th>Nutrition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely Immobile</td>
<td>1. Very Poor</td>
<td>1. Problem</td>
</tr>
<tr>
<td>4. No Limitations</td>
<td>4. Excellent</td>
<td>4. Problem</td>
</tr>
</tbody>
</table>
# BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

## SENSORY PERCEPTION
- Completely Limited
  - Unable to feel pain or pressure
- Impaired Sensation
  - Sensation impaired but able to feel pain or pressure
- Normal Sensation
  - No sensory impairment

## MOISTURE
- Completely Wound
  - Skin is clear, moist, and intact
- Impaired Moisture or Ulcerated
  - Slight amount of drainage, skin is covered by a small amount of crust
- Occasional Ulceration
  - Ulceration or drainage is present

## ACTIVITY
- Bed Rest
  - Limited mobility
- Dressed/Partially Dressed
  - Capable of limited mobility
- Completely Activated
  - Capable of unrestricted mobility

## MOBILITY
- Completely Immobile
  - Patient is immobile
- Limited Mobility
  - Patient is able to move from supine position
- Normal Mobility
  - Patient is able to move independently

## NUTRITION
- Poor
  - Unable to eat
- Fair
  - Poor appetite
- Good
  - Adequate intake

## EXTRUSION & SHEAR
- No Pressure
  - No evidence of pressure sore
- Potential Pressure
  - Pressure sore imminent
- Ulcerated Pressure
  - Pressure sore present

<table>
<thead>
<tr>
<th>Number 1 Reason for Acquiring Pressure Ulcer/Injuries</th>
<th>Create a Culture of Mobility in your building</th>
</tr>
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### Patient’s Name:

<table>
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<tr>
<th>Date of Assessment</th>
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<table>
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<tr>
<th><strong>Predispose to intense pressure</strong></th>
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</thead>
<tbody>
<tr>
<td>Affect tissue tolerance</td>
</tr>
<tr>
<td><strong>Predispose to intense pressure</strong></td>
</tr>
<tr>
<td>Affect tissue tolerance</td>
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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

### Assessment for Mobility - F688 - Lots of NEW Language

- The resident’s comprehensive assessment should include and measure:
  - Resident’s current mobility status
  - Identification of limitations, if any and opportunities for improvement.
- The MDS tool provides an assessment of the resident’s ability for movement including:
  - To and from the lying position,
  - Turning and side to side movement in bed,
  - Positioning of the body,
  - Transfers between surfaces such as to and from bed or chair, standing, and walking
- The resident’s comprehensive assessment should also address whether the resident had previously received treatment and services for mobility and whether he/she maintained his/her mobility, whether there was a decline, and why the treatment/services were stopped.
- For resident with limited mobility assessment should address, if he/she is not receiving services, the reason for the services to not be provided.
- See Range of Motion section
Rehab Can Help—Make Sure Rehab Read F688

- Ensure your rehab team involved with residents who have mobility & activity issues
- OT & PT can assist in evaluating & treating residents with mobility issues by improving:
  - Strength
  - Body movement strategies in bed & chair
  - Sitting & standing balance
  - Teaching residents, staff, & family members how to use adaptive equipment (i.e., transfer/gait belts, walkers, canes)
- Restorative program
- Therapists also provide assessments & make suggestions or create proper seating interventions when sitting mobility issues

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!!!
Pressure Points and Tissue Tolerance

- Assessment of a resident’s skin condition helps define prevention strategies. The skin assessment should include an evaluation of the skin integrity and tissue tolerance (ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed.

- The measurement of tissue tolerance can be done in a variety of ways and the method chosen for use in the facility should be identified.

**NOTE:** Strike through language removed from 11/22/17 SOM version…latest version to date.

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Case Study

- Previously active independent 68 y/o female with L-partial hip replacement 5 days ago due to femoral neck fracture after fall in home
- Admitted to skilled services for nursing and rehab with goal of returning to daughter’s home for continued recovery rehab with home health.
- Vitals: T=99.6, R=17, BP=92/58, P=100bpm
- Goal: return to highest level of functionality as an independent community ambulator and return to her personal home to live alone
- Let’s do the Braden together
## Braden Parameters

<table>
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<th>Sensory Perception</th>
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<th>Friction &amp; Shear</th>
</tr>
</thead>
</table>

### Mobility
1. Completely Immobile
2. Very Limited
3. Slightly Limited
4. No Limitations

### Nutrition
1. Very Poor
2. Probably Inadequate
3. Adequate
4. Excellent

### Friction & Shear
1. Problem
2. Potential Problem
3. No Apparent Problem

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**Braden Score**

- Sensory Perception
- Moisture
- Activity
- Friction & Shear

**Diastolic BP < 60 mmHg**

**LGF=99**

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**18**

Moderate Risk!!!
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.

F686 & NPUAP Staging Definitions

Centers for Medicare and Medicaid Services
And
National Pressure Ulcer Advisory Panel (NPUAP)
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!

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**Stage 1 Pressure Injury:**
**Nonblanchable Erythema of Intact Skin**

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. 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 (see below).
**Stage 2 Pressure Ulcer:**
Partial-thickness Skin Loss with Exposed Dermis

- 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.
- *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:**
Pressure Injury: Full-thickness Skin Loss

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

- 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.

**NOTE:** Wound base does **NOT** need to be completely free of necrotic tissue. If you can see the wound base you should be able to stage.

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

- 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*
Unstageable Pressure Ulcer - Obscured Full-thickness Skin & Tissue Loss

• 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.
• 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.
• 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.

Deep Tissue Pressure Injury (DTPI): Persistent Non-blanchable Deep Red, Maroon or Purple Discoloration

• 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.
• 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.
• 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.
New Definition
Medical Devices Related Pressure Injury

This definition describes an etiology.

- 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 MUST be staged.**

Courtesy: Dot Weir
**Mucosal Membrane Pressure Ulcer/Injury**

- 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

What We **Do Not** Stage

- **Skin Tears** - International Skin Tear Advisory Panel

<table>
<thead>
<tr>
<th><strong>Type 1:</strong> No skin loss</th>
<th><strong>Type 2:</strong> Partial flap loss</th>
<th><strong>Type 3:</strong> Total flap loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear or flap tear that can be repositioned to cover the wound</td>
<td>Partial flap loss that can't be repositioned to cover wound bed</td>
<td>Total flap loss exposing the entire wound bed</td>
</tr>
</tbody>
</table>
What We **DO NOT** Stage

- 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**

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**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.”
Kennedy’s Terminal Ulcer: Pressure Ulcer

- Kennedy Terminal Ulcers are considered PRESSURE ULCER/INJURY per CMS
- 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.

**NOTE:** Next statement not CMS approved, but reality.
- These skin changes are not pressure ulcers...they are the result of skin failure due to the dying process or acute or chronic multi-organ failure.
- The resident is in the dying process and the skin...largest organ of the body begins to also fail.
- If you recognize this situation and your MDs/NPs documents accordingly, then you can at least document them as unavoidable pressure ulcer/injuries.

Pressure Ulcer/Injuries at End of Life

**F686 Page 267 – 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.**”
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.

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.
### Other Tags Reviewed when F686 Deficiency Given

<table>
<thead>
<tr>
<th>Surveyors Instructed to Review EACH of These Tags</th>
<th></th>
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<tbody>
<tr>
<td>F710 Physician Services</td>
<td>F641</td>
<td>Accuracy of Assessment</td>
</tr>
<tr>
<td>F880 Infection Control</td>
<td>F656</td>
<td>Comprehensive Care Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What must be included</td>
</tr>
<tr>
<td>F655 Comprehensive Person-Centered Care Planning</td>
<td>F657</td>
<td>Comprehensive Care Plan</td>
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<td>Effectiveness of CP and</td>
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<td>who must be included</td>
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<tr>
<td>F636 Resident Assessment</td>
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<td>Other Tags to be</td>
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### Summary

- F686, formerly F314, has a significant number of updates that should be read in detail by all managers and treatment nurses involved 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 perform 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.
State Operations Manual
Appendix PP - Guidance to Surveyors for Long-Term Care Facilities

Recognized Standards of Practice
Association for the Advancement of wound Care (AAWC)
Wound Ostomy Continence Nurses Association
Wound Journals
Wound Books

Framing Your Wound Prevention and Care Program

Resident Assessment Instrument (RAI)
Minimum Data Set (MDS) 3.0

NPUAP
Prevention & Treatment of Pressure Ulcers: Clinical Practice Guidelines

References

- Braden Protocols by Level of Risk
- Braden Scale for Predicting Pressure Sore Risk