M0300B: Stage 2 Pressure Ulcers

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

Enter Number ☐

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐

2. **Number of <u>these</u> 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

Item Rationale

Health-related Quality of Life

Stage 2 pressure ulcers may worsen without proper interventions.

These residents are at risk for further complications or skin injury.

Planning for Care

Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days).

If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.

Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.

Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.

The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

DEFINITION

STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising.

May also present as an intact

M0300B: Stage 2 Pressure Ulcers (cont.)

Steps for Assessment

Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).

For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

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

Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-8).

Coding Instructions for M0300B

M0300B1

Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.

Enter 0 if no Stage 2 pressure ulcers are present and skip to M0300C, Stage 3.

M0300B2

Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.

Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here.

When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.