OASIS ITEM

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No **[*Go to M1322 at SOC/ROC/FU; Go to M1324 at DC*]** 1 Yes

ITEM INTENT

- Identifies the presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers/injuries only.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&A's, providers should rely on the CMS OASIS instructions.
- Pressure ulcers/injuries are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer/injury.
- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Enter Response 0 (No), if the only pressure ulcer/injury is one or more Stage 1 OR healed pressure ulcers/injuries (of any previous stage) AND the patient has no other pressure ulcers/injuries.
- Enter Response 1 (Yes), if the patient has an unhealed Stage 2, Stage 3, OR Stage 4 pressure ulcer OR if the patient has an Unstageable ulcer/injury, defined as:
  - Pressure ulcers/injuries that are known to be present but that are unobservable due to a dressing/device, such as a cast, that cannot be removed to assess the skin underneath. "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device.
  - Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.
    - Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1306)

- Deep tissue injury which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface, known as "re-epithelialization."
- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1307)	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ ☐☐ ☐☐☐☐ Month day year NA No Stage 2 pressure ulcers are present at discharge

ITEM INTENT

- The intent of this item is to a) identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed), b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage 2 pressure ulcers while under the care of the agency.

TIME POINTS ITEM(S) COMPLETED

- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called, “re-epithelialization.”
- Enter Response 1 only if the oldest Stage 2 pressure ulcer that is present at discharge was already present as a Stage 2 pressure ulcer at the first skin assessment completed at the SOC/ROC.
- Enter Response 2 if the oldest Stage 2 pressure ulcer that is present at discharge was NOT a Stage 2 pressure ulcer at the first skin assessment completed at the SOC/ROC.
- If Response 2 is entered, specify the date the Stage 2 pressure ulcer was first identified. Use two digits to indicate the month (for example, May is 05), single-digit dates should begin with 0, and use four digits to indicate the year (for example, May 4, 2019 would be 05/04/2019).
- If no pressure ulcer existed at the SOC, then a Stage 1 pressure injury developed, which progressed to a Stage 2 by discharge, enter Response 2, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.
- Enter “NA” if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
- An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the “oldest Stage 2 pressure ulcer” (See M1311 for definition of Unstageable due to non-removable dressing/device).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Clinical Record
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. 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. **Number of Stage 2 pressure ulcers**	☐
B1. 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. **Number of Stage 3 pressure ulcers**	☐
C1. 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. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Follow-up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. 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. **Number of Stage 2 pressure ulcers**	☐
B1. 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. **Number of Stage 3 pressure ulcers**	☐
C1. 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. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. 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. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. 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. **Number of Stage 3 pressure ulcers** [If 0 – Go to M1311C1, Stage 4]	☐
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. 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. **Number of Stage 4 pressure ulcers** [If 0 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

ITEM INTENT

- This item identifies the number of pressure ulcers/injuries at each stage (Stage 2, 3, and 4) and designated as Unstageable, that are observed on assessment.
- At discharge, this item also identifies if each pressure ulcer/injury present on the discharge assessment was observed at the same stage at the time of the most recent SOC/ROC.
- Stage 1 pressure injuries and all healed pressure ulcers/injuries are not reported in this item.

TIME POINTS ITEMS COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE SPECIFIC INSTRUCTIONS

- Terminology referring to “healed” vs. “unhealed” ulcers/injuries can refer to whether the ulcer/injury is “closed” vs. “open”. Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.

Determining “Present at the most recent SOC/ROC” to answer M1311X2

- For each pressure ulcer/injury observed and coded in items M1311A1-F1 on Discharge, determine whether that pressure ulcer/injury was observed at the same stage at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If the pressure ulcer/injury was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its “Present at the most recent SOC/ROC” stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being “present at the most recent SOC/ROC” when completing the Discharge assessment.
- The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment time frame, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC.
- At SOC/ROC and FU, enter a response for the following rows of this item: A1, B1, C1, D1, E1, F1.
  - Example: At SOC, in B1, enter the number of Stage 3 pressure ulcers that are observed at the first skin assessment completed during the SOC assessment timeframe. Enter 0 if no Stage 3 pressure ulcers are observed.
- At Discharge, enter a response for each row of this item: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, F2, unless directed to skip.
  - Example: At Discharge, in A1 enter the number of Stage 2 pressure ulcers that are observed at the discharge assessment.
    - If no Stage 2 pressure ulcers are observed, enter 0 in A1 and skip A2.
    - If at least one Stage 2 pressure ulcer is observed, and reported in A1, enter in A2 the number of these Stage 2 pressure ulcers that were observed at the same stage at the most recent SOC/ROC.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1311)

Stage 2 Ulcers

- Report in M1311A1 the number of Stage 2 pressure ulcers that are observed on the current day of assessment.
- Definition: Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.

- 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 3 and 4 Ulcers

- Definition: Stage 3 pressure ulcers are characterized by 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 or tunneling.
- Definition: Stage 4 pressure ulcers are characterized by 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.
- If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
- A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer. A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer.
- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including patient's physician) to determine the highest numerical stage of the pressure ulcer.
- Any type of flap procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311.
- A pressure ulcer treated with any type of graft is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340.

Unstageable Ulcers

- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.

  - Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.

- Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at discharge, should be considered new, and not coded as present at the most recent SOC/ROC for M1311X2.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1311)

- Pressure ulcers/injuries that are known to be present but that are Unstageable due to a non-removable dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported in M1311D1, Unstageable. "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device. Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT], an orthopedic device, or a cast).
- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as present at the most recent SOC/ROC for M1311X2.

DEFINITIONS

SLOUGH TISSUE
Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

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

- Response F1 refers to deep tissue injury, which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure injuries meeting this definition should be counted to determine the response to F1. Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered present at the most recent SOC/ROC at the stage at which it first becomes numerically stageable.

EXAMPLES – Identify "Present at the most recent SOC/ROC" to answer M1311 at Discharge

1. Deep Tissue Injury (DTI) with intact skin at a SOC assessment becomes numerically stageable

The RN assesses Mr. J's skin at the SOC and identifies a DTI with intact skin on his left heel. This DTI remains unchanged until the RN skin assessment 10 days later, which reveals open skin presenting as a Stage 3 pressure ulcer. The pressure ulcer does not change for the remainder of the episode. At the discharge (DC) skin assessment, the ulcer remains a Stage 3. (In this example, there are no other pressure ulcers/injuries at the SOC assessment, during the episode or at DC).

Coding: On the DC assessment, M1311B1, Number of Stage 3 pressure ulcers, would be coded "1". M1311B2, Number of these Stage 3 pressure ulcers that were present at the most recent SOC/ROC would be coded "1". M1311F1, Number of unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).

Rationale: At the DC assessment, Mr. J had one Stage 3 pressure ulcer, and zero unstageable pressure injuries presenting as DTI. The Stage 3 pressure ulcer observed on the DC skin assessment is reported "present at the most recent SOC/ROC" because that is the stage at which the DTI observed at the SOC assessment first became numerically stageable.

2. Deep tissue injury (DTI) with intact skin at SOC, becomes numerically stageable and increases in numerical stage by discharge (DC)

The RN completes a skin assessment during the SOC visit for Mrs. K, and identifies a right hip DTI with intact skin. This DTI is first numerically stageable 10 days later as a Stage 3 pressure ulcer and increases in numerical stage five days after that, to a Stage 4 pressure ulcer. The pressure ulcer remains a Stage 4 at DC.

Coding: On the DC assessment M1311C1, Number of Stage 4 pressure ulcers, would be coded "1". M1311C2, Number of these Stage 4 pressure ulcers that were present at the most recent SOC/ROC, would be coded "0". M1311F1, unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).

Rationale: The DTI with intact skin observed on the SOC skin assessment first became numerically stageable as a Stage 3. Because the Stage 3 pressure ulcer increased in numerical stage to a Stage 4 by the DC assessment, the Stage 4 pressure ulcer at DC is considered new, and not coded as present at the most recent SOC/ROC.

3. **Deep Tissue Injury (DTI) with intact skin at SOC, becomes numerically stageable, then is unstageable due to slough and/or eschar at DC**

The RN assesses Mr. L's skin during the assessment timeframe for the SOC, and identifies a DTI with intact skin on his right heel. This DTI first becomes numerically stageable at the third home visit, as a Stage 3 pressure ulcer. At the DC skin assessment, this pressure ulcer is unstageable due to slough and eschar.

Coding: On the DC assessment, M1311E1, number of unstageable pressure ulcers due to slough and/or eschar, would be coded "1". M1311E2, number of these unstageable pressure ulcers that were present at the most recent SOC/ROC, would be coded "0". M1311F1, unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).

Rationale: The DTI with intact skin observed on the SOC skin assessment first became stageable as a Stage 3 pressure ulcer. This ulcer did not remain a Stage 3, however. At the DC skin assessment the ulcer was observed to be unstageable due to slough and eschar. Any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar, but was previously numerically stageable, is considered new, and not coded as present at the most recent SOC/ROC.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1322)	**Current Number of Stage 1 Pressure Injuries:** 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.
Enter Code ☐	0 1 2 3 4 or more

ITEM INTENT

- Identifies the presence and number of Stage 1 pressure injuries.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- NPUAP defines a Stage 1 pressure injury as follows: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage 1 injuries may be difficult to detect in individuals with dark skin tones and may indicate "at risk" persons (a heralding sign of risk).”
- Recognize that although Stage 1 pressure injuries are closed (intact skin), they would not be considered healed.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

ITEM INTENT

- Identifies the stage of the most problematic stageable pressure ulcer/injury.
- Please note; pressure ulcers/injuries that have healed are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Terminology referring to “healed” vs. “unhealed” ulcers can refer to whether the ulcer is “closed” vs. “open”. Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Determine which pressure ulcer(s)/injur(ies) are stageable or Unstageable. A pressure ulcer/injury is considered Unstageable if:
  - it is covered with a non-removable dressing/device, such as a cast, that cannot be removed.
  - it presents as a deep tissue injury, or
  - the wound bed is obscured by some degree of necrotic tissue AND no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible. Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4 even if slough or eschar is present.
- Determine which stageable pressure ulcer is the most problematic.
  - “Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
  - If the patient has only one stageable pressure ulcer, then that ulcer is the most problematic.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1324)

- Enter the response that most accurately describes the stage of the most problematic stageable pressure ulcer/injury using the definitions of Stage in M1311. Enter "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.
  - Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Unless it becomes unstageable, clinical standards require that a Stage 4 pressure ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
  - If a pressure ulcer is Stage 4 at SOC and is granulating at the Follow-up Assessment, the ulcer remains a Stage 4 ulcer.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral documentation
- Review of health history
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1330)	Does this patient have a **Stasis Ulcer**?	
Enter Code ☐	0	No **[*Go to M1340*]**
	1	Yes, patient has BOTH observable and unobservable stasis ulcers
	2	Yes, patient has observable stasis ulcers ONLY
	3	Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**

ITEM INTENT

- Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.
- Stasis ulcers DO NOT include arterial lesions or arterial ulcers.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- A response of “Yes” identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs).
- It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.
- Enter Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot) that cannot be removed. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
- Enter Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot that cannot be removed, and has no observable stasis ulcers. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician’s orders
- Referral information
- Review of health history
- Observation
- Physical assessment
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1332)	Current Number of Stasis Ulcer(s) that are Observable:
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more

ITEM INTENT

- Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- All stasis ulcers except those that are covered by a non-removable dressing/device, such as a cast or Unna boot, are considered observable.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- Physician
- Referral information
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1334)	Status of Most Problematic Stasis Ulcer that is Observable:
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing

ITEM INTENT

- Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Determine which stasis ulcers are observable. Includes all stasis ulcers that are not covered with a non-removable dressing/device, such as a cast or Unna boot.
- Determine which observable stasis ulcer is the most problematic.
  - "Most problematic" may be based on healing status, size, difficulty in accessing for treatment, etc., depending on clinical judgment and the specific situation.
  - If the patient has only one observable stasis ulcer, that ulcer is the most problematic.
- Determine status of the most problematic stasis ulcer that is observable using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society:
  - Response 1 – Fully Granulating: Enter Response 1 when a stasis ulcer has a wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.
  - Response 2 – Early/Partial Granulation: Enter Response 2 when ≥ 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.
  - Response 3 – Not Healing: Enter Response 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.
- Once a stasis ulcer has completely epithelialized and is without signs/symptoms of infection, it is considered healed and should not be reported as a current stasis ulcer.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1340)	Does this patient have a **Surgical Wound?**
Enter Code ☐	0 No **[*Go to M1400*]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[*Go to M1400]***

ITEM INTENT

- Identifies the presence of a wound resulting from a surgical procedure.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one observable surgical wound.
- Enter Response 2 if the only surgical wound(s) is/are not observable. A wound is considered not observable if it is covered by a dressing/device, such as a cast, which is not to be removed per physician order.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item. The incision line would be considered the surgical wound. The staple or suture sites are not considered as surgical wounds for M1340.
- If a pressure ulcer is surgically closed with a flap or graft it is no longer reported as a pressure ulcer. It should be reported as a surgical wound until healed. If the flap or graft fails, it should continue to be considered a surgical wound until healed.
- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.
- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc.
- Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- A PICC line (peripherally-inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, when it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for the purpose of this item.
- For additional guidance on questions related to surgical wounds, please see Q & As for M1340.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Physical Assessment.
- Referral documentation.
- Review of health history.
- Physician.
- CMS OASIS Q & As can be accessed through the CMS OASIS web page.
- See references/resources in Chapter 5 of the OASIS Guidance Manual.

OASIS ITEM

(M1342)	Status of Most Problematic Surgical Wound that is Observable
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

ITEM INTENT

- Identifies the degree of healing present in the most problematic, observable surgical wound.

TIME POINTS ITEM(S) COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Determine which surgical wounds are observable.
  - Includes all surgical wounds (as defined in M1340 guidance) that are not covered with a non-removable dressing/device, such as a cast.
  - For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and no longer a surgical wound.
  - Openings in the skin adjacent to the incision line caused by the removal of staples or sutures are not to be considered as part of the surgical wound for M1342.
- Identify the most problematic observable surgical wound.
  - The “most problematic” surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on clinical judgment and the specific situation.
  - If the patient has only one observable surgical wound, that wound is the most problematic.
- Determine status of the most problematic surgical wound using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society. The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).
  - Surgical wounds healing by primary intention (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 – “Newly epithelialized” or Response 3 – “Not healing”. If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention. A surgical incision would not automatically be considered 3 – Not healing solely due to the presence of staples.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1342)

- Secondary Intention: If it is determined that there is incisional separation, healing will be by secondary intention. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."
- Response "0 – Newly epithelialized": Enter Response 0 when the wound bed has completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms or infection. Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized" until approximately 30 days of complete epidermal resurfacing have passed without complication, at which time it is no longer a reportable surgical wound.
- Enter Response 0 – Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.
- Response 1 – Fully granulating: Enter Response 1 when a surgical wound has a wound bed filled with granulation tissue to the level of the surrounding skin; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.
- Response 2 – Early/partial granulation: Enter Response 2 when ≥25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); no signs or symptoms of infection; wound edges open.
- Response 3 – Not healing: Enter Response 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- CMS OASIS Q & As can be accessed through the CMS OASIS web page
- See references/resources in Chapter 5 of the OASIS Guidance Manual