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MDS Alert

Compliance: Steer Clear of Noncompliance Citations for F314 Pressure Sores

Make sure you are following the SOM requirements at §483.25(c).

The Medicare State Operations Manual (SOM) states that facilities must ensure that:

"(1) a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."

Key definitions

A pressure ulcer is defined as "any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers."

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

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

Non-compliance for F314

According to the SOM, a facility can be cited for non-compliance for F314 for any of the following reasons:

- Failure to accurately or consistently assess a resident's skin integrity on admission and as indicated thereafter;
- Failure to identify a resident at risk of developing a pressure ulcer(s);
- Failure to identify and address risk factors for developing a pressure ulcer, or explain adequately why they could not or should not do so;
- Failure to implement preventive interventions in accord with the resident's need and current standards of practice;
- Failure to provide clinical justification for the unavoidable development or non-healing/delayed healing or deterioration of a pressure ulcer;
- Failure to provide appropriate interventions, care and treatment to an existing pressure ulcer to minimize infections and to promote healing;
- Failure to implement interventions for existing wounds;
- Failure to notify the physician of the resident's condition or changes in the resident's wound(s);
- Failure to adequately implement pertinent infection management practices in relation to wound care; and
- Failure to identify or know how to apply relevant policies and procedures for pressure ulcer prevention and treatment.

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Source: State Operations Manual, Appendix PP--Guidance to Surveyors for Long Term Care Facilities, pgs. 195-231.

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