F314- Pressure Ulcers

**KNOWING THE REGULATORY REQUIREMENTS**

Study Guide for VOHRA Educational module
Introduction to F314 Regulatory Requirements

For a skilled nursing facility every process and system created must, at a minimum, follow the federal regulatory guidance for that specific area of care. Many states have state specific regulatory processes in addition to federal. A general rule is the most stringent regulatory guidance triumphs. In most aspects of care this would be the federal guidance.

For pressure ulcers the federal tag of F314 dictates the guidance for which a skilled facility cares and evaluates pressure ulcers. This is broken down into two areas of focus:

§483.25(c) Pressure Sores

Based on the comprehensive Assessment of a resident, the facility must ensure that--

1. A resident who enters the facility without pressure sores does not develop pressure sores 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.

We will be reviewing each of these individually to break down each component of guidance under F314. First, let us review the very first item under the F314 guidance for its specific intent:

A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable.

This item seems straightforward in regards to prevention. A skilled nursing facility has the responsibility to prevent pressure sores and to appropriately identify risk of a resident including identification of a pressure sore that may be unavoidable.

Let’s take the first step in assessment and that would be to identify risk. Many facilities utilize a tool upon admission to identify skin risk. The most commonly used tool in the long term care industry is the Braden scale. Regardless of what tool you decide to utilize, the key to a risk assessment is to act upon the risk identified. For example, if you have a new admission and you identify that resident to be at a low risk for skin breakdown, do you implement an intervention? The answer is yes! Regardless of the level of risk identified on the assessment you must implement an intervention. A risk is still a risk regardless of how minimal it may be. As a clinician you have a responsibility to implement an intervention that is appropriate for the risk identified on the assessment. Many nurses may be uncomfortable with this as at times they may identify a person with a very low risk and think it is alright to omit implementing an intervention. This is incorrect, the regulatory guidance interprets that any and all risk need to be addressed. A nurse manager may develop an algorithm or decision tree that will assist the nursing staff in implementing an appropriate intervention based on the risk assessment. This is the first step in pressure ulcer prevention.
Let’s look at an example:

Mrs. Smith, 71 years old, is admitted to the facility and upon admission her Braden risk scores her at a low risk for pressure ulcers. She is very independent, cognitively intact and is continent of bowel and bladder. She is independent with dressing but has some difficulty bending to tie her shoes. She ambulates well but has a slight gait abnormality due to a car accident when she was in her 30’s. The nurse does not feel there is any reason to implement an intervention.

Three weeks after admission she develops a blister on her ankle due to her abnormal gait and her shoe not being tied securely. Is this avoidable?

The definition of “avoidable” pressure ulcer under the CMS F314 regulatory guidance is:

“Avoidable” 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.

So yes, this should have been identified as a risk. Due to her gait and the possibility of friction causing a wound on her foot should have been identified during the assessment process. This is an avoidable stage II pressure ulcer that could have easily been prevented if the nursing staff would have properly assessed the residents low risk score. The importance of identifying risk and implementing an appropriate intervention is where it all starts when caring for a resident. Risk assessments should be completed upon admission and every week for four weeks, then quarterly thereafter at a minimum. Assessments should also be completed with an identified significant change and also upon readmission.

Now let us review the rest of item number one under the federal regulation. “unavoidable pressure ulcers”.

“Unavoidable” 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.

Many times a facility will make the mistake of assuming the pressure is unavoidable due to the resident meeting the CMS requirement of “unavoidable”. Under the F314 guidance it does list the many criteria for an unavoidable, but the one component of implementing interventions is that they are **consistently implemented**. This is a common cause of why a facility may get a citation on pressure ulcers.
Mr. Jones is admitted to the facility with lung cancer. His prognosis is very poor and he is placed on hospice. He is also incontinent of bowel and bladder and is also anemic. He has a history of transfusions since his diagnosis and also had received chemotherapy prior to admission. Mr. Jones can still ambulate with assistance and needs assistance to reposition himself in his bed. He develops stage II ulcers on his heels and another on his ankle that has slough present, determined to be stage III. The facility determines them all unavoidable due to his many comorbidities. The facility has a survey and Mr. Jones is picked for observation of his dressing change by the surveyor. The paperwork for his unavoidable ulcers is in the chart and signed by the physician. The surveyor continues to monitor Mr. Jones after the dressing change and walks by his room daily during the survey. Daily the surveyor observes his heels not being floated per his intervention on his care plan. At exit the surveyor cites F314 at a G- actual harm level for failure to prevent numerous pressure ulcers for a high risk resident. Can you determine why?

It appears in the above scenario that everything is perfect, so why the citation? The fact that the intervention on his care plan was observed not to be in place daily was the issue. The interpretive guidance for determining a citation under F314 clearly summarizes:

**Determination of unavoidable is made only when routine preventative and daily care were provided continually.**

Although he was terminal and had been assessed the development of his pressure ulcers may have been prevented if the floating of the heels had been consistent daily.

Let’s look at the second component of this regulation:

**A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**

This is the second item under the F314 regulation guidance. This is a straightforward statement and stresses the importance of the facility maintaining and healing wounds that are admitted to their facility and also for acquired pressure ulcers. It also states that if a resident has a pressure ulcer, they will not develop additional ones.

A facility must consider their ability to treat and care for wounds. If the facility admits a patient with a complex stage III, it must not progress to a stage IV. In addition interventions identified must be regularly reviewed, modified, communicated to staff and implemented. Healing and managing wounds is not just a nurse assigned duty. The whole interdisciplinary team must be involved. Below are a few examples of various considerations for each department.

- Nursing- clinical interventions, positioning, treatment changes and considerations of appropriate types of dressings, patient teaching, evaluation of lab results, risk
assessments, monitoring for worsening of the wound and recognizing signs and symptoms of infection.

- **Dietary** - Nutritional interventions, appetite, consumption and eating habits, evaluation of lab results, identify nutritional risk and needs.
- **Therapy** - Positioning, assistance devices, cognitive needs, treatment modalities
- **Social Services** - Psychosocial needs, communication with family and resident regarding interdisciplinary care planning and individual needs.
- **Physician** - Wound assessment, treatment plan, patient and staff teaching, clinical interventions, evaluation and orders.

As you can see most of the disciplines do have items that are cross referenced in each area. The collaboration between the team is an important part of the interdisciplinary decision and care process. The monitoring of the progress of healing is crucial as a part of this regulatory guidance as well as the partnership of each individual on this interdisciplinary team. Documentation of the collaboration and teamwork must be indicated in the medical record to include but not be limited to the nursing notes, dietary notes, physician progress notes, care plan, risk assessment, therapy assessment and notes, MDS assessment, treatment records and current orders.

**If a pressure ulcer fails to show some evidence of progress toward healing within 2-4 weeks, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify the current interventions is also indicated.**

Daily assessments should be completed during the dressing change and any changes noted and documented in the medical record. A weekly in-depth assessment of the wound should be completed with measurements and description of the wound noted in the medical record. Any interdisciplinary team discussion or evaluation should also be noted. The F314 guidance indicates the following:

**The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment (for example, why some, or all, of the plan’s interventions remain relevant despite little or no apparent healing).**

Pressure ulcers may progress or may be associated with complications such as infection of the soft tissues around the wound (cellulitis), infection of the bone (osteomyelitis), infection of a joint (septic arthritis), abscess, spread of bacteria into the bloodstream (bacteremia/septicemia), chronic infection, or development of a sinus tract. Sometimes these complications may occur despite apparent improvement in the pressure ulcer itself. **The physician’s involvement is integral whenever significant changes in the nature of the wound or overall resident condition are identified.**
Pain is also an issue that must be addressed daily and especially prior to a treatment, dressing change or therapy. A cross referenced citation can be cited for F309, Quality of Care for pain and also F309 may be cited for any wounds that are non-pressure related.

Once the survey team determines a deficient practice occurred they follow the F314 investigative protocol to determine the severity of the deficiency. They utilize the following to determine the noncompliance and then severity of the citation:

- Observation
- Resident and staff interviews
- Record review- includes assessment, documentation and care plan
- Interviews with Healthcare practitioners and professionals

The clinical management team should familiarize themselves with the investigative protocol under F314 as it list examples of the different levels of severity. Of course F314 at a G, H or I level is considered actual harm while a F314 at a J, K or L level is considered immediate jeopardy level. Of course at any scope and severity the survey team may choose to cross reference other deficient practices. Below are some examples of what other tags may be cited in conjunction with F314 Pressure Ulcers.

F157 Notification of Changes- An example of this would be a failure of the facility to notify the physician when a change in the wound is noted, a failure to notify the physician that a current treatment plan is ineffective or notification upon development of a new pressure ulcer.

F272 Comprehensive Assessments- An example of this would be a failure of the facility to appropriately identify a worsening pressure ulcer or a new pressure ulcer timely.

F279 Comprehensive Care Plan and F280 Comprehensive Care Plan Revision- an example of this would be a failure of the facility to develop and implement a care plan that identified the risk and interventions to prevent pressure ulcers or to heal and change treatment plan of existing ulcers.

F281 Services Provided Meet Professional Standards- an example of this would be if the facility failed to provide pressure ulcer care in accordance with accepted professional standards.

F353 Sufficient Staff- an example of this would be a low staffing ratio that could be related to poor care and the result of the development of a pressure ulcer.

F385 Physician Supervision- an example of this would be to ensure that physician has assessed and developed a treatment regimen relevant to preventing or healing a pressure ulcer and responded appropriately to the notice of changes in condition.

These are just a few of the main F-tags that could be cross references with F314 pressure ulcer deficiency. Of course the main goal is to heal current pressure ulcers and prevent any
negative outcomes. The F314 tag is not cited at level one scope and severity but starts at a level two. So a severity at an A, B or C is not possible. In addition, F314 defines examples of negative outcomes at the actual harm and Immediate Jeopardy level as:

- The development of avoidable Stage III pressure ulcer(s): As a result of the facility’s non-compliance, Stage III pressure ulcers occurred, which are open wounds in which damage has occurred into the subcutaneous level and may be painful.

- The development of recurrent or multiple avoidable Stage II pressure ulcer(s): As a result of the facility’s non-compliance, the resident developed multiple and/or recurrent avoidable Stage II ulcers.

- Failure to implement the comprehensive care plan for a resident who has a pressure ulcer: As a result of a facility’s failure to implement a portion of an existing plan related to pressure ulcer care, such as failure to provide for pressure redistribution, or inappropriate treatment/dressing changes, a wound increased in size or failed to progress towards healing as anticipated, or the resident experienced untreated pain.

- Development of avoidable Stage IV pressure ulcer(s): As a result of the facility’s non-compliance, permanent tissue damage (whether or not healing occurs) has compromised the resident, increasing the potential for serious complications including osteomyelitis and sepsis.

- Admitted with a Stage IV pressure ulcer(s) that has shown no signs of healing or shows signs of deterioration: As a result of the facility’s non-compliance, a Stage IV pressure ulcer has shown signs of deterioration or a failure to progress towards healing with an increased potential for serious complications including osteomyelitis and sepsis.

- Stage III or IV pressure ulcers with associated soft tissue or systemic infection: As a result of the facility’s failure to assess or treat a resident with an infectious complication of a pressure ulcer. (See discussion in guidelines and definitions that distinguishes colonization from infection.)

- Extensive failure in multiple areas of pressure ulcer care: As a result of the facility’s extensive noncompliance in multiple areas of pressure ulcer care, the resident developed recurrent and/or multiple, avoidable Stage III or Stage IV

Understanding the F314 regulatory requirements may seem cumbersome but it is having a process and system that includes identifying risk, assessment, interventions, treatment, communication and on-going assessment by every member of the interdisciplinary team.