MDS 3.0 Section M – Skin Conditions

Quick Reference & Documentation Tips for Wound Care Nurses

Purpose of Section M

Section M captures the resident's **skin condition and presence of wounds**.
It identifies **pressure injuries**, **surgical wounds**, **skin tears**, and other lesions that influence care planning, quality measures, and reimbursement under PDPM.

Key Coding Areas

Item	Description	What the Nurse Provides
M0100	Was a skin assessment performed?	Confirm a head-to-toe skin check was done within the look-back period.
M0210	Does the resident have one or more unhealed pressure ulcers/injuries?	Yes/No — based on current wound evaluation.
M0300A–G	Pressure ulcer/injury stage (1–4, unstageable, deep tissue)	Document **stage**, **location**, **size**, **onset date**, and **wound characteristics**.
M0610A–B	Status of pressure ulcers — whether healed or unhealed	Supply measurement trends and healing progression.
M0700	Most severe pressure ulcer since the prior assessment	Identify worsening or new ulcers.
M0800	Other ulcers (e.g., venous, arterial, diabetic)	Record ulcer type, cause, and treatment.
M0900	Healed pressure ulcers that reopened	Provide documentation of healing and re-opening date.
M1040	Other skin problems (e.g., burns, rashes, skin tears)	Describe location, appearance, and treatment.
M1200	Skin and ulcer treatments	List interventions such as pressure-relieving devices, dressings, ointments, or debridement.

Documentation Essentials

✅ **Perform and record a full-body skin assessment** within 24 hours of admission and weekly thereafter.
✅ **Use objective measurements** (length × width × depth) and consistent terminology for all

wounds.
✅ **Include wound type, stage, drainage, periwound condition, odor, and pain** in progress notes.
✅ **Document every dressing change**, including product used and resident tolerance.
✅ **Photograph wounds** per facility policy to validate changes and support MDS coding.
✅ **Update the care plan** for each wound with a measurable goal (e.g., "reduce wound size by 20% in 4 weeks").
✅ **Notify the MDS coordinator** immediately of new, worsened, or healed wounds.
✅ **Track treatment changes** (e.g., new orders for offloading, nutritional supplements, or specialty dressings).

Working with the MDS Coordinator

- Review **Section M coding** together before each assessment submission.
- Confirm wound **onset dates**, **healing status**, and **type** (pressure vs. non-pressure).
- Cross-check data from **wound logs**, **treatment sheets**, and **nursing notes** for consistency.
- Participate in **Quality Assurance (QA)** or **QAPI** meetings to review wound trends.
- Support **timely completion** of admission, quarterly, and significant change assessments.

Common Documentation Errors to Avoid

🚫 Labeling moisture-associated skin damage as a pressure ulcer.
🚫 Omitting healed wounds or re-opened sites.
🚫 Failing to document wound measurements or drainage changes.
🚫 Using vague descriptions like "small sore" instead of stage-specific terms.
🚫 Missing communication with the MDS coordinator after wound status changes.

Quick Reference: Best Practice Flow

1. **Admission:** Complete head-to-toe assessment → Document all wounds → Notify MDS coordinator.
2. **Ongoing:** Weekly wound rounds → Measure, stage, and record → Update care plan as needed.
3. **Change in Status:** Report new/worsened wounds → MDS coordinator updates Section M.
4. **Healed Wound:** Record healing date → Track for M0900 coding.
5. **Quarterly Review:** Verify all wounds accurately reflected in the MDS and care plan.

Key Takeaway

Accurate wound documentation = Accurate MDS coding = Better resident outcomes and facility compliance.
Collaboration between the **Wound Care Nurse** and **MDS Coordinator** ensures that every wound is recognized, tracked, and healed under the highest standards of clinical and regulatory practice.