State and Federal regulations. Therefore, the IRF-PAI Admission assessment's sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present **at the time of admission** are based on the skin assessment that is in conjunction with the admission). So, if a patient that is clinically assessed upon admission has a pressure ulcer/injury identified and staged, that initial clinical assessment is what should be used to assist in coding the IRF-PAI Admission assessment pressure ulcer/injury items. If the pressure ulcer/injury that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day IRF assessment period, the **initial** stage of the pressure ulcer/injury would be documented on the IRF-PAI Admission assessment. This pressure ulcer/injury would be captured on the IRF-PAI Discharge assessment as worsened (unless it heals) and would not be coded as present on admission.

6. If a patient is discharged to another facility/hospital for longer than 3 calendar days and subsequently returns to the IRF, and a current pressure ulcer increases in numerical stage, it **is coded at the higher stage** on the patient's new admission assessment for the second IRF stay.
7. ~~**If a pressure ulcer/injury is documented as healed during the stay, but prior to discharge a pressure ulcer/injury is identified at the same anatomical location as the previously documented healed ulcer/injury, the facility staff, including the physician, should determine if the previous ulcer/injury reopened, or if it is a new pressure ulcer/injury. If it is determined that the previous ulcer/injury has reopened, it should not be considered as healed and should be staged at its previously identified highest numerical stage until it is fully healed. If the reopened pressure ulcer/injury was originally observed at the time of admission and has not worsened, it would still be considered present on admission when coding the discharge assessment. However, if the reopened pressure ulcer/injury has worsened (that is, the current stage of the reopened pressure ulcer/injury is a higher numerical stage than it was before it was considered healed), it must be at its new higher stage, and would no longer be considered present on admission when coding the discharge assessment. If the reopened pressure ulcer/injury does not heal before discharge, the facility must code the status of the pressure ulcer/injury on the Discharge assessment according to the instructions in Section M. If it is determined that the pressure ulcer/injury is a new pressure ulcer, and does not heal before discharge, it should be staged and coded on the Discharge assessment according to the instructions in Section M as would be done for any new pressure ulcer/injury that develops during the stay.~~ **If a patient is admitted to an IRF with a healed pressure ulcer/injury, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and would not be coded as present on admission on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new, or facility acquired.**