Section M
Skin Conditions

Intent

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions.
To document if pressure ulcers were developed since admission to the facility.
To document prevention, treatment, and management of skin problems.
To document the healing progress of pressure ulcers.

Significant Changes

M0300B, M0300C, M0300D – Emergence of new pressure ulcer Stage 2 or higher, when no previous ulcer of Stage 2 or higher was present – Sentinel Event if low risk resident

Care Area Triggers

M1040A – Dehydration / Fluid Maintenance
M0150, M0210, M0300, M0800 – Pressure Ulcer
M0300 – Nutritional Status

Quality Indicators

M0210 – Stage 1 to 4 Pressure Ulcer

Enhanced Quality Measures

M0210 – Percent of residents with pressure ulcers

RUG IV Categories

M0300, M1030, M1040A, M1040B, M1040C, M1200I – Special Care Low
M1040E – Clinically Complex

Skilled Charting Wound Care

Care Plans

Peripheral Vascular Disease
Skin Breakdown

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M0100. Determination of Pressure Ulcer Risk	
Check all that apply.	
	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing, device
	B. Formal Assessment Instrument/Tool (e.g., Braden, Norton, or other)
	C. Clinical Assessment
	Z. None of the above

M0100. Determination of Pressure Ulcer Risk

Check all that apply. This item is judging the **risk only of** pressure sore development.

A. Resident has stage 1 or greater, a scar over bony prominence, or a non-removable dressing, device

B. Formal Assessment Instrument/Tool (Braden, Norton, or other)

The Braden Scale evaluates pressure ulcer risk by examining: level of sensory perception, exposure of the skin to moisture, degree of physical activity, ability to change and control body position, usual food intake pattern, and friction and shear.

The Norton Scale examines physical condition, mental condition, activity, mobility, and incontinence, and is not as comprehensive or detailed as the Braden Scale.

Each facility will have an assessment form that is approved by its director of Nursing.
If a formal assessment is not used, the evaluating nurse should carefully document why she has drawn her conclusions.

C. Clinical Assessment

A clinical assessment could include a head-to-toe physical examination of the skin and/or observation or medical record review of pressure ulcer risk factors.

Examples of risk factors include the following:
Impaired/decreased mobility and decreased functional ability
Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus
Drugs, such as steroids, that may affect wound healing
Impaired diffuse or localized blood flow (atherosclerosis or lower extremity arterial insufficiency)
Resident refusal of some aspects of care and treatment
Cognitive impairment
Urinary and fecal incontinence
Under nutrition, malnutrition, and hydration deficits
Healed Stage 3 or 4 pressure ulcers, which are more likely to have recurrent breakdown

Z. None of the above

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M0150. Risk of Pressure Ulcers
Is this resident at risk of developing pressure ulcers? **0. No** **1. Yes**

M0150. Risk of Pressure Ulcers **CAT- Pressure Ulcer**

Is this resident at risk of developing pressure ulcers?
0. No 1. Yes

Documents the conclusion drawn from M0100. Determination of Pressure Ulcer Risk.

M0210. Unhealed Pressure Ulcers
Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? **0. No** → Skip to M0900, Healed Pressure Ulcers **1. Yes**→ Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0210. Unhealed Pressure Ulcers

CAT- Pressure Ulcer

QI – Stage 1 to 4 Pressure Ulcer **EQM – Percent of residents with pressure ulcers**

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. No → Skip to M0900, Healed Pressure Ulcers

1. Yes→ Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage Skip Item

Sentinel Event – if low risk resident

Significant Change – Emergence of new pressure ulcer Stage 2 or higher, when no previous ulcer of Stage 2 or higher was present

RUG – Special Care Low **CAT- Pressure Ulcer** **CAT – Nutritional Status**

QI – Stage 1 to 4 Pressure Ulcer **EQM – Percent of residents with pressure ulcers**

Skin ulcers related to diseases such as syphilis and cancer are not coded here, but are included in Item M1020. If an ulcer met the definition for more than one stage during the observation period, code the ulcer as it appeared in the time frame closest to the ARD. Do not code the debrided skin ulcer as a surgical wound. If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

Report based on highest stage of existing ulcer(s) at its worst; do not reverse stage.

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	A. **Number of Stage 1 pressure ulcers** **Stage 1: –** Intact skin with non-blancheable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

A. Number of Stage 1 pressure ulcers
Stage 1: – Intact skin with non-blancheable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Intact skin with non-blancheable 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.
Do not code in this item: rashes without open areas, burns, skin tears/shears, desensitized skin surgical wounds, ulcers related to diseases such as syphilis and cancer, or skin ulcer repaired with a flap graft (code as a surgical wound until healed)

	B. Stage 2: 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. **1. Number of pressure ulcers at Stage 2 → If** 0, skip to M0300C, Stage 3
	2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry Enter how many were noted at the time of admission/entry or reentry
	3. Date of oldest Stage 2 pressure ulcer: Enter dashes if date is unknown. __ __ - __ __ - __ __ __ __ month day year

B. Stage 2: 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.

Significant Change – Emergence of New Pressure Ulcer

1. **Number of pressure ulcers at Stage 2** → If 0, skip to M0300C, Stage 3

2. **Number of these Stage 2 pressure ulcersthat were present upon admission**/entry or reentry – enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer: MM / DD / YYYY**

	C. 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. **1. Number of pressure ulcers at Stage 3 → If** 0, skip to M0300D, Stage 4
	2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

C. 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.

Significant Change – Emergence of New Pressure Ulcer

1. **Number of pressure ulcers at Stage 3** → If 0, skip to M0300D, Stage 4

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry**

Enter how many were noted at the time of admission/entry or reentry

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	D. 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. **1. Number of Stage 4 pressure ulcers →** If 0, skip to M0300E, Unstageable: Non-removable dressing
	2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

D. 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.

Significant Change – Emergence of New Pressure Ulcer

1. Number of Stage 4pressure ulcers → If 0, skip to M0300E, Unstageable: Non-removable dressing

2. Number of these Stage 4 that were present upon admission/entry or reentry
Enter how many were noted at the time of admission/entry or reentry

	E. Unstageable – **Non-removable dressing** Known but not stageable due to non-removable dressing / device **1. Number of unstageable pressure ulcers due to non-removable dressing / device →** If 0, skip to M0300F, Unstageable: Slough and/or eschar
	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

E. Unstageable - Non-removable dressing
Known but not stageable due to non-removable dressing / device

1. Number of unstageable pressure ulcers due to non-removable dressing/device → If 0, skip to M0300F, Unstageable: Slough and/or eschar

2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry
Enter how many were noted at the time of admission/entry or reentry

	F. Unstageable - Slough and/or eschar Known but not stageable due to coverage of wound bed by slough and/or eschar **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar →** If 0, skip to M0300G, Unstageable: Deep tissue injury
	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

F. Unstageable- Slough and/or eschar
Known but not stageable due to coverage of wound bed by slough and/or eschar

1. Number of unstageable pressure ulcers due to coverage **of wound bed by slough and/or eschar** → If 0, skip to M0300G, Unstageable: Deep tissue injury

2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry
Enter how many were noted at the time of admission/entry or reentry

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	G. **Unstageable** – **Deep tissue** injury Suspected deep tissue injury in evolution. **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** → If 0, skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

G. Unstageable

Deep tissue injury
Suspected deep tissue injury in evolution.

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 than adjacent tissue.

Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution →
If 0, skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

2. Number of these unstageable pressure ulcers that were present upon admission/reentry
Enter the number of unstageable pressure ulcers due to suspected deep tissue injury that were first noted at the time of admission AND—for residents who are being readmitted after a hospital stay—that were acquired during the hospitalization. Enter 0 if no unstageable pressure ulcers were first noted at the time of admission.

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M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar Complete only is M0300C1, M0300D1, or M0300F1 is greater than 0			
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcers with the largest surface area (length x width) and record in centimeters.			
	.	cm	**A. Pressure Ulcer Length:** Longest length from head to toe
	.	cm	**B. Pressure Ulcer Width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
	.	cm	**C. Pressure Ulcer Depth:** Depth of the same pressure ulcer, from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only is M0300C1, M0300D1, or M0300F1 is greater than 0 - if there is actually at least on Stage 3, Stage 4, or Unstageable Ulcer due to coverage of wound bed by slough and/or eschar.
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcers with the largest surface area (length x width) and record in centimeters.
Of the number of pressure ulcers, identify the ulcer with the largest surface area, and use that one pressure ulcer's data to fill in M0610 A, B, and C.

A. Pressure Ulcer Length: Longest length from head to toe

B. Pressure Ulcer Width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

C. Pressure Ulcer Depth: Depth of same pressure ulcer, from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
	Select the best description of the most severe type of tissue present in any ulcer bed. **1. Epithelial Tissue –** new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin. **2. Granulation Tissue –** pink or red tissue with shiny, moist, granular appearance **3. Slough –** yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous **4. Eschar –** black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any ulcer bed.

1. Epithelial Tissue New skin growing in superficial ulcer
It can be light pink and shiny, even in persons with darkly pigmented skin.

2. Granulation Tissue Pink or red tissue with shiny, moist, granular appearance

3. Slough Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous

4. Eschar Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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M0800. Worsening in Pressure Ulcer Status Since Last Assessment (OBRA, PPS, or Discharge) Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage on prior Assessment (OBRA or Scheduled PPS) or last Admission/Entry or Reentry** If no current pressure ulcer at a given stage, enter 0.	
Enter number of pressure ulcers in boxes.	
	A. Stage 2
	B. Stage 3
	C. Stage 4

M0800. Worsening in Pressure Ulcer Status Since Last Assessment (OBRA, PPS, or Discharge)

New Item Skip Item **CAT- Pressure Ulcer**

Complete only is A0130E = 0

If an ulcer was unstageable on admission, do not consider it to be worse on the first assessment in which it can be staged after being debrided. However, if it worsens after that assessment, it should be included in counts.

If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable. If its stage has worsened, code it as such in this item.

If a pressure ulcer is acquired during a hospital admission, it is coded as "present on admission" and not included in a count of worsening pressure ulcers.

If a pressure ulcer worsens to a more severe stage during a hospital admission, it should also be coded as "present on admission" and not included in counts of worsening pressure ulcers.

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage on prior Assessment (OBRA or Scheduled PPS) or last Admission/Entry or Reentry**

If no current pressure ulcer at a given stage, enter 0.

A. Stage 2

B. Stage 3

C. Stage 4

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M0900. Healed Pressure Ulcers Complete only is A0130E = 0	
	A. Were pressure ulcers present on the prior assessment (OBRA or Sheduled PPS)? **0. No** → If A0310F=1 → Skip to M1030, Number of Venous and Arterial Ulcers **1. Yes** → Continue to M0900B, Stage 2
Indicate the number of current pressure ulcers that were noted on the prior assessment (OBRA or Scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment, (OBRA or Scheduled PPS) enter 0.	
	B. Stage 2
	C. Stage 3
	D. Stage 4

M0900. Healed Pressure Ulcers Skip Item Complete only is A0130E = 0

A pressure ulcer that is completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration. Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.

Most Stage 2 pressure ulcers should heal very quickly (typically within 60 days), even in substantially ill people. Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.

Current clinical standards do not support reverse staging or backstaging. For example, over time, a Stage 4 pressure ulcer has been healing such that it is less deep, wide, and long. Previous standards using reverse (or back) staging would have permitted identification of the pressure ulcer as a Stage 2 pressure ulcer when it reached a depth consistent with Stage 2 pressure ulcers.

Current standards require that it continue to be documented as a Stage 4 pressure ulcer until it has completely healed. For care planning purposes, a healed Stage 4 pressure ulcer will remain at increased risk for future breakdown or injury and will require continued monitoring.

A. Were pressure ulcers present on the prior assessment (OBRA or Sheduled PPS)?

0. No → If A0310F=1 → Skip to M1030, Number of Venous and Arterial Ulcers

1. Yes → Continue to M0900B, Stage 2

Indicate the number of current pressure ulcers that were noted on the prior assessment (OBRA or Scheduled PPS) that have completely closed (resurfaced with epithelium).

If no healed pressure ulcer at a given stage since the prior assessment, (OBRA or Scheduled PPS) enter 0.

B. Stage 2

C. Stage 3

D. Stage 4

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M1030. Number of Venous and Arterial Ulcers	
	Enter the total number of venous and arterial ulcers present.

M1030. Number of Venous and Arterial ulcers **RUG – Special Care Low**

Enter the total number of venous and arterial ulcers present.

Venous Ulcers
Ulcers caused by peripheral venous disease and most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle or on the lower calf area of the leg.

Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate.

The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.

The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair.

The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer.

Arterial Ulcers
Ulcers caused by peripheral arterial disease and commonly occur on the tips of toes, tops of the foot, or distal to the medial malleolus.

Arterial ulcers are often painful and have a pale pink wound bed, minimal exudate, minimal bleeding, and necrotic tissue.

Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present.

The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair.

The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer.

Lower extremity and foot pulses may be diminished or absent.

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M1040. Other Ulcers, Wounds, and Skin Problems	
Check all that apply.	
	Foot Problems
	A. Infection of the foot (e.g. cellulitis, purulent drainage)
	B. Diabetic foot ulcer(s)
	C. Other open lesions on the foot
	Other Problems
	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
	E. Surgical wound(s)
	F. Burn(s) (second or third degree)
	G. Skin Tear(s)
	H. Moisture Associated Skin Damage (MASD) (incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
	Z. None of the above were present

M1040. Other Ulcers, Wounds, and Skin Problems   Check all that apply.

Intent: To document the presence of skin problems or lesions, (other than pressure or circulatory skin ulcers) and conditions that are risk factors for more serious problems.

Pressure and circulatory ulcers are addressed in sections M0210 – M0900.

Foot Problems

A. Infection of the foot (e.g. cellulitis, purulent drainage)   **RUG – Special Care Low**

B. Diabetic foot ulcer(s)   RUG – Special Care Low

Ulcers caused by the neuropathic and small blood vessel complications of diabetes. These neuropathic changes combined with the small blood vessel changes in diabetes puts the diabetic at high risk for foot ulcers.

Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot.

Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance.

These wounds are typically not painful.

Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.

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Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure.

Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his/her feet.

Do NOT include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

C. Other open lesions on the foot **RUG – Special Care Low**

Other Problems

D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
Code in this category any skin lesions that are not coded elsewhere in section M.
Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer.
Do NOT code skin tears or cuts here. **RUG – Clinically Complex**

E. Surgical wound(s) **RUG – Special Care**
This category does not include healed surgical sites and stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers.
This coding is appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.

F. Burn(s) (second or third degree) **RUG – Clinically Complex**
Includes burns from any cause (heat, chemicals), in any stage of healing.
This category does not include first degree burns (changes in skin color only).

G. Skin Tear(s)

H. Moisture Associated Skin Damage (MASD) (incontinence-associated dermatitis [IAD], perspiration, drainage)

None of the Above **Z. None of the above** were present

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M1200. Skin and UlcerTreatments	
Check all that apply.	
	A. Pressure reducing device for chair
	B. Pressure reducing device for bed
	C. Turning/repositioning program
	D. Nutrition or hydration intervention to manage skin problems
	E. Pressure Ulcer care
	F. Surgical wound care
	G. Application of non-surgical dressings (with or without topical medications) other than to feet
	H. Application of ointments/medications other than to feet
	I. Application of dressings to feet (with or without topical medications)
	Z. None of the above were provided

M1200. Skin and UlcerTreatments **RUG – Special Care**

A. Pressure reducing device(s) for chair **CAT- Dehydration**
Includes gel, air (e.g. Roho), or other cushioning placed on a chair or wheelchair.
Include pressure relieving, pressure reducing, and pressure redistributing devices.
Do not include egg crate cushions in this category.

B. Pressure reducing device(s) for bed
Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.
Do not include egg crate cushions in this category.

C. Turning/repositioning program
The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (every 2 hours).
Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

D. Nutrition or hydration intervention to manage skin problems
Dietary measures received by resident to prevent and treat a specific skin condition
Ex) Wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing
Vitamins and minerals, such as vitamin C and zinc, which are used to manage a potential or active skin problem, should be coded here

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E. Pressure Ulcer care
Ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300). Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure (VAC), and/or hydrotherapy.

F. Surgical wound care
Do not include post-operative care following eye or oral surgery.
Surgical debridement of a pressure ulcer continues to be coded as a pressure ulcer.
Surgical would care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.

G. Application of non-surgical dressings (with or without topical medications) other than to feet
Do not code dressing for pressure ulcer on the foot in this item; use Ulcer Care item (M1200E).
Do not code application of dressings to the ankle. The ankle is not part of the foot.
Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
This category may include dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

H. Application of ointment/medications (other than to feet)
This category may include ointments or medications used to treat a skin condition (cortisone, antifungal preparations, chemotherapeutic agents).
Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
This definition does not include ointments used to treat non-skin conditions (nitropaste for chest pain).
Includes interventions to treat any foot wound or ulcer other than a pressure ulcer. For pressure ulcers on the foot, use Ulcer Care item (M1200E).

I. Application of dressings (with or without topical medications)
RUG - Special Care Low

Z. None of the above were provided

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