

RAI/MDS Pressure Ulcers

Resident Assessment Instrument Manual
Differences Between the RAI Manual of 1995 and 2002 for
Skin Conditions and Restraints: MDS Sections M and P4
This is an excerpt, courtesy of Keane Care:
www.keanecare.com/html/news/mds20/RAI-sects-M-P4.pdf
Differences between 1995 and 2002 RAI Manual
Keane Care

Coding skin ulcers and restraints on the MDS is so important that those sections were released as final when CMS published its otherwise draft Resident Assessment Instrument (RAI) manual in August 2002. The complete RAI manual was released as final in December 2002, and is effective January 1, 2003. The 2002 version incorporates the questions and answers CMS published since the RAI manual was first released in 1995.

This paper highlights differences between the 1995 and 2002 RAI manuals on the instructions for coding pressure ulcers and restraints. It is provided by Keane Care, Inc. for educational and informational purposes only. It is not intended and should not be construed as legal advice.

Accurate MDS coding of both pressure ulcers and restraints is especially important since those items trigger Quality Measures (results posted publicly on the Nursing Home Compare Website) and Quality Indicators (used by surveyors).

Download the RAI manual from either Website:
<http://cms.hhs.gov/medicaid/mds20/man-form.asp>
www.keanecare.com/html/news/mds20.asp

Resident Assessment Instrument
Chapter 3, Item-by-item Guide to the MDS
Revised Section M instructions
M1. Ulcers (7-day look back)

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Expanded definition of skin ulcer, including Stage 1, open lesions/sores, and types of conditions coded in M4.

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Added All skin ulcers should be coded in this item (M1). to the Coding instructions section

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Added a Clarifications section that addresses four points

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All problems and lesions should be documented on the MDS

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Healing ulcers should be coded in the MDS using a reverse-staging protocol

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Debridement

*

Coding skin shear or tear on a pressure point as a Stage 2 ulcer

*

An Example was added for a resident with open wounds as a result of frostbite
M2. Type of Ulcer (7-day look back)

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Information from the AHCPR Guidelines for Pressure Ulcers in Adults was added to the Clarifications section (What are Pressure Ulcers, Where Pressure Ulcers Form)

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In the Examples of Mr. C with diabetes and poor circulation to his lower extremities and Mrs. B with blockage in the arteries of her right leg, the coding examples were modified.

M4. Other Skin Problems or Lesions Present (7-day look back)

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M4a definition. Revised for Abrasions, Bruises to add skin shears and skin tears not penetrating to subcutaneous layer

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M4c definition. Added definition for Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions): A local loss of epidermis and variable levels of dermis and subcutaneous tissue. May develop due to injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Do not code skin tears or cuts in M4c (see also M4a or M4f).

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M4f definition. Added skin shears as an example. Also added direction to code skin tears or cuts that do not penetrate to subcutaneous tissue in M4a.

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M4g definition: Added to last sentence of Surgical Wounds: This category does not include lacerations that require suturing or butterfly closure as surgical wounds.

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Added to Coding section: Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in M4a or M4 if not both. Ulcers coded in M2 should not be coded in M4.

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Added new Clarifications section: It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code.

M5. Skin Treatments (7-day look back)

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M5d definition: added that vitamins and minerals used to manage a potential or active skin problem, such as Vitamin C and Zinc, should be coded here.

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Added a Clarifications section:

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Good clinical practice dictates that staff should document treatment listed in MDS Item M5 and M6.

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Dressing applied even once during the 7-day period can be checked.

M6. Foot Problems, Care (7-day look back)

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Definition added for M6a. Resident has one or more Foot Problems includes ulcerated areas over plantar warts on the foot.

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Clarification was added: For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in M5.

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SECTION M.

SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. Ulcers (due to any cause) (7-day look back)

Intent: To record the number of ulcers/open lesions, of any type at each ulcer stage, on any part of the body.

Definition: A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are NOT coded here, but are included in Item M4.

- a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer/open lesion. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer/open lesion can be missed. Assessing a Stage 1 ulcer/open lesion requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers/open lesions in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a CMS's RAI Version 2.0 Manual CH 3: MDS Items [M] Revised--December 2002 Page 3-160 subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: All skin ulcers/open lesions should be coded in this item. Record the number of ulcers/open lesions at each stage on the resident's body, in the last 7 days, regardless of the ulcer/open lesion cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer/open lesion as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers/open lesions at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers/open lesions at any one stage, enter a "9" in the appropriate box.

Clarifications:

- All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.
- Staff should code healing ulcers in the MDS using a reverse-staging protocol. For the MDS assessment, Item M2a, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a “2”. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.
- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments). If, as the result of pressure, a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on her sacrum while being pulled up in bed), it should be coded as a Stage 2 ulcer (M1). However, the determination that an ulcer is the result of pressure cannot be made based merely on its location over a pressure point. Instead, a clinician’s assessment may be required to determine the ulcer’s cause. Using this example, if the resident cannot reposition herself while on her back in bed, it is logical to determine that pressure on the sacrum contributed to the formation of the ulcer, i.e., the resident cannot move independently to relieve the pressure. On the other hand, if the shear or tear occurred over a pressure point, but on a resident who is able to reposition herself, the determination is less likely that pressure on that point was the cause of the ulcer. In either case, Item M1 would be completed, but Item M2a would be completed only if pressure caused the lesion.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	2
	b. 2	0
	c. 3	1
	d. 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: Four ulcers are consistent with Stage 2 ulcer staging and one ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	0
	b. 2	4
	c. 3	1
	d. 4	0

Items M2, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4, Other Skin Problems or Lesions Present:

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 and M6, (Foot Problems and Care) as appropriate.

M2. Type of Ulcer (7-day look back)

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the last 7 days.

Definition: a. Pressure Ulcer - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

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b. Stasis Ulcer - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1 may not necessarily be recorded in Item M2 (see last example below).

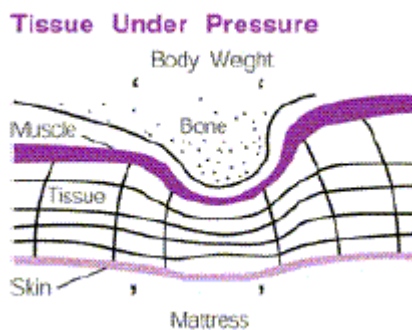
More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: <http://www.ahrq.gov/consumer/bodysys/edbody6.htm>.

What are Pressure Ulcers?

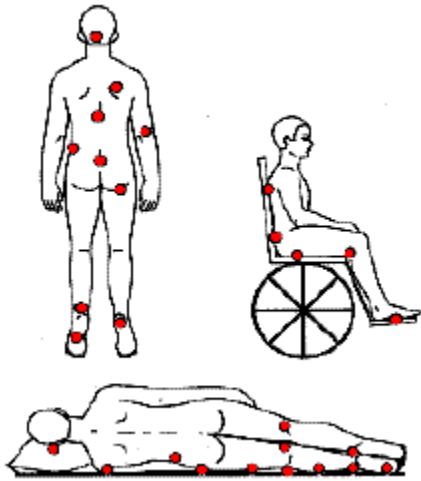
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



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Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

NOTE: It is also common for pressure ulcers to form on the ears and scrotum.

The full AHCPR guideline for clinicians can be found at: <http://www.ahcpr.gov/clinic/cpgonline.htm>.

Clarifications:

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. *Journal of Gerontological Nursing* 23 (12), 5-10.
- If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer. Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1, Ulcers (due to any cause)	Code (# at stage)
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure Ulcer	2
b. Stasis Ulcer	0

Rationale for coding: Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1, Ulcer (due to any cause)	Code (# at Stage)
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure ulcer	0
b. Stasis ulcer	0

Items M4, Other Skin Problems or Lesions Present
 c. Open lesions other than pressure or stasis ulcers, rashes, cuts (e.g., cancer lesions)

Rationale for coding: Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

M3. History of Resolved/Cured Ulcers (90 days ago)

Intent: To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers.

Process: Review clinical records, including the last Quarterly or Medicare PPS assessment.

Coding: Code "0" for No or "1" for Yes.

M4. Other Skin Problems or Lesions Present (7-day look back)

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

Definition:

a. Abrasions, Bruises - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

b. Burns (Second or Third Degree) - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include firstdegree burns (changes in skin color only).

c. Open Lesions/Sores Other Than Pressure or Stasis Ulcers, Rashes, Cuts (e.g. cancer lesions) - A local loss of epidermis and variable levels of dermis and subcutaneous tissue. This open sore may develop because of injury or in association with other diseases such as syphilis. Do NOT code skin tears or cuts here (see also M4a or M4f).

d. Rashes (e.g., intertrigo, exzema, drug rash, heat rash, herpes zoster) - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

e. Skin Desensitized to Pain or Pressure - The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and CMS's RAI Version 2.0 Manual CH 3: MDS Items [M]

neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."
- Compare the sensations in symmetrical areas on both sides of the body.
- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.
- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

f. Skin Tears or Cuts (Other Than Surgery) - Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.

g. Surgical Wounds - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds.

h. NONE OF ABOVE

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.

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Coding: Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should NOT be coded here. If there is no evidence of such problems in the last seven days, check NONE OF ABOVE.

Clarification: It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

M5. Skin Treatments (7-day look back)

Intent: To document any specific or generic skin treatments the resident has received in the past seven days.

Definition:

a. Pressure Relieving Device(s) for Chair - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

b. Pressure Relieving Device(s) for Bed - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

c. Turning/Repositioning Program - Includes a continuous, consistent program for changing the resident's position and realigning the body.

d. Nutrition or Hydration Intervention to Manage Skin Problems - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., 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.

e. Ulcer Care - Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. Surgical Wound Care - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

g. Application of Dressings (With or Without Topical Medications) Other Than to Feet - Includes dry gauze dressings, dressings moistened with saline

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or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

h. Application of Ointments/Medications (Other Than to Feet) - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. Other Preventative or Protective Skin Care (Other Than to Feet) - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).

j. NONE OF ABOVE

Process: Review the resident's records. Ask the resident and nurse assistant.

Coding: Check all that apply. If none apply in the past seven days, check NONE OF ABOVE.

Clarifications:

Good clinical practice dictates that staff should document treatments listed in MDS Item M5, Skin Treatments (e.g., turning and repositioning program; application of ointments) and MDS Item M6, Foot Problems and Care (e.g., trimming of nails/calluses; application of dressings). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

Dressings do not have to be applied daily in order to be coded on the MDS. If any dressing meeting the MDS definitions provided for MDS Items M5e-h was applied even once during the 7-day period, the assessor would check the appropriate MDS item.

M6. Foot Problems and Care (7-day look back)

Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition:

a. Resident Has One or More Foot Problems (e.g., Corns, Callouses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems – includes ulcerated areas over plantar's warts on the foot.

b. Infection of the Foot – e.g., Cellulitis, Purulent Drainage

c. Open Lesions On the Foot - Includes cuts, ulcers, fissures. CMS's RAI Version 2.0 Manual CH 3: MDS Items [M/N]

d. Nails or Callouses Trimmed During the Last 90 Days - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

e. Received Preventative or Protective Foot Care - Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

f. Application of Dressings (With or Without Topical Medications) - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. NONE OF ABOVE

Process: Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding: Check all that apply. If none apply in the past seven days, check NONE OF ABOVE.

Clarification: For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in Item M5.

For more detailed information, see <http://www.cms.hhs.gov/medicaid/mds20/man-form.asp>