



ADMINISTRATIVE RULES OF MONTANA



37.106.2880 PREVENTION AND CARE OF PRESSURE SORES: CATEGORY B

- (1) A resident shall receive skin care that meets the following standards:
 - (a) the facility shall practice preventive measures to identify those at risk and maintain a resident's skin integrity; and
 - (b) an area of broken or damaged skin must be reported within 24 hours to the resident's practitioner. Treatment must be as ordered by the resident's practitioner.
- (2) A person with an open wound or having a pressure or stasis ulcer requiring treatment by a health care professional may not be admitted or permitted to remain in the facility unless:
 - (a) the wound is in the process of healing, as determined by a licensed health care professional, and is either:
 - (i) under the care of a licensed health care professional; or
 - (ii) can be cared for by the resident without assistance.
- (3) The facility shall ensure records of observations, treatments and progress notes are entered in the resident record and that services are in accordance with the resident health care plan.
- (4) No over the counter products such as creams, lotions, ointments, soaps, iodine or alcohol shall be put on an open pressure or stasis wound unless ordered by the resident's practitioner after an appropriate evaluation of the wound.
- (5) Evidence the facility is meeting those resident's identified as a greater risk for skin care needs include the following outcomes for residents:
 - (a) the facility has identified those residents who are at greater risk of developing a pressure or stasis ulcer. Primary risk factors include but are not limited to:
 - (i) continuous urinary incontinence or chronic voiding dysfunction;
 - (ii) severe peripheral vascular disease (poor circulation to the legs) ;
 - (iii) diabetes;
 - (iv) chronic bowel incontinence;
 - (v) sepsis;
 - (vi) terminal cancer;
 - (vii) decreased mobility or confined to bed or chair;

- (viii) edema or swelling of the legs;
 - (ix) chronic or end stage renal, liver or heart disease;
 - (x) CVA (stroke) ;
 - (xi) recent surgery or hospitalization;
 - (xii) any resident with skin redness lasting more than 30 minutes after pressure is relieved from a bony prominence, such as hips, heels, elbows or coccyx, is at extremely high risk in that area; and
 - (xiii) malnutrition/dehydration whether secondary to poor appetite or another disease process.
- (b) direct care staff have received training related to maintenance of skin integrity and the prevention and care of pressure sores from a licensed health care professional who is trained to care for that condition;
 - (c) the resident's practitioner has diagnosed the condition and ordered treatment;
 - (d) the resident is kept clean and dry;
 - (e) the resident is provided clean and dry bed linens;
 - (f) the resident is kept hydrated;
 - (g) the resident is turned and repositioned;
 - (h) the wound is getting smaller;
 - (i) there is no evidence of infection;
 - (j) wound bed is moist, not dried out or scabbed over;
 - (k) the resident has less restriction of movement; and
 - (l) the resident's pain level has diminished.

Authorizing statute(s): Sec. 50-5-103, 50-5-226 and 50-5-227, MCA

Implementing statute(s): Sec. 50-5-225, 50-5-226 and 50-5-227, MCA

History: NEW, 2002 MAR p. 3638, Eff. 12/27/02.