Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 1.0

PATIENT ASSESSMENT FORM - UNPLANNED DISCHARGE

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

A0055. Correction Number

Enter Number ☐☐

Enter the number of correction requests to modify/inactivate the existing record, including the present one.
Enter 0 (zero) for new record

A0100. Facility Provider Numbers. Enter Code in boxes provided.

A. National Provider Identifier (NPI):

☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN):

☐☐☐☐☐☐☐☐☐☐☐☐

C. State Provider Number:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐

3. **Long-term Care Hospital**

A0210. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0220. Admission Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0250. Reason for Assessment

Enter Code ☐☐

01. **Admission**
02. **Reentry**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

Section A Administrative Information

A0270. Discharge Date

	Month – Day – Year

Patient Demographic Information

A0500. Legal Name of Patient

	A. First name:
	B. Middle initial:
	C. Last name:
	D. Suffix:

A0600. Social Security and Medicare Numbers

	A. Social Security Number: – –
	B. Medicare number (or comparable railroad insurance number)**:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code	
	1. **Male** 2. **Female**

A0900. Birth Date

	Month – Day – Year

A1000. Race/Ethnicity

↓ **Check all that apply**	
	A. American Indian or Alaska Native
	B. Asian
	C. Black or African American
	D. Hispanic or Latino
	E. Native Hawaiian or Other Pacific Islander
	F. White

Section A Administrative Information

A1400. Payer Information

Check all that apply

☐	**A. Medicare** (traditional fee-for-service)
☐	**B. Medicare** (managed care/Part C/Medicare Advantage)
☐	**C. Medicaid** (traditional fee-for-service)
☐	**D. Medicaid** (managed care)
☐	**E. Workers' compensation**
☐	**F. Title programs** (e.g., Title III, V, or XX)
☐	**G. Other government** (e.g., TRICARE, VA, etc.)
☐	**H. Private insurance/Medigap**
☐	**I. Private managed care**
☐	**J. Self-pay**
☐	**K. No payor source**
☐	**X. Unknown**
☐	**Y. Other**

A1970. Discharge Return Status

Enter Code ☐

1. **Anticipated**
2. **Not Anticipated**

A2100. Discharge Location

Enter Code ☐☐

01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. **Long-term care facility**
03. **Skilled nursing facility** (SNF)
04. **Hospital emergency department**
05. **Short-stay acute hospital** (IPPS)
06. **Long-term care hospital** (LTCH)
07. **Inpatient rehabilitation facility or unit** (IRF)
08. **Psychiatric hospital or unit**
09. **MR/DD facility**
10. **Hospice**
12. **Discharged Against Medical Advice**
98. **Other**

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness at time of assessment.

0. **No**
1. **Yes**

Section GG Functional Status: Usual Performance

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. **Patient refused**
09. **Not applicable**

If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

↓ Enter Codes in Boxes	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

Section H Bladder and Bowel

H0400. Bowel Continence
(Complete during the 3-day assessment period.)

Enter Code ☐

Bowel continence - Select the one category that best describes the patient.

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

Section I Active Diagnoses

For this section, indicate the presence of the following conditions, based on a review of the patient's clinical records at the time of assessment.

↓	Check all that apply
	Heart/Circulation
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Section K Swallowing/Nutritional Status

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches	**A. Height** (in inches). Record most recent height measure since admission
☐☐☐ pounds	**B. Weight** (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

Section M Skin Conditions

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

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

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

0. **No** → *Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting*
1. **Yes** → *Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage*

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers

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

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐

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

Enter Number ☐

2. **Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Number ☐

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 Stage 3 pressure ulcers** - If 0 → *Skip to M0300D, Stage 4*

Enter Number ☐

2. **Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

Enter Number ☐

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*

Enter Number ☐

2. **Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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

Enter Number ☐

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

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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

Enter Number ☐

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*

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued

Enter Number ☐

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*

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the patient 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 ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm — **A. Pressure ulcer length:** Longest length in any direction

☐☐.☐ 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)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed, consider all pressure ulcers

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. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment.
If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

		–			–				
Month			Day			Year			

PRA Disclosure Statement

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