Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 4.00

PATIENT ASSESSMENT FORM - ADMISSION

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

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

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

A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐

C. State Medicaid 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**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

Section A Administrative Information

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

A1100. Language

Enter Code ☐

A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → *Skip to A1200, Marital Status*
1. **Yes** → *Specify in A1100B, Preferred language*
9. **Unable to determine** → *Skip to A1200, Marital Status*

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

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**

Pre-Admission Service Use

A1802. Admitted From. Immediately preceding this admission, where was the patient?

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. **ID/DD Facility**
10. **Hospice**
99. **None of the above**

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → *Continue to B0200, Hearing*
1. **Yes** → *Skip to GG0100, Prior Functioning: Everyday Activities*

B0200. Hearing (3-day assessment period)

Enter Code ☐

Ability to Hear (with hearing aid or hearing appliances if normally used)

0. **Adequate:** No difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty:** Difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty:** Speaker has to increase volume and speak distinctly
3. **Highly impaired:** Absence of useful hearing

B1000. Vision (3-day assessment period)

Enter Code ☐

Ability to See in Adequate Light (with glasses or other visual appliances)

0. **Adequate:** Sees fine detail, such as regular print in newspapers/books
1. **Impaired:** Sees large print, but not regular print in newspapers/books
2. **Moderately impaired:** Limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired:** Object identification in question, but eyes appear to follow objects
4. **Severely impaired:** No vision or sees only light, colors or shapes; eyes do not appear to follow objects

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code ☐

Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)

Enter Code ☐

Understanding Verbal and Non-Verbal Content (with hearing aid or device, if used, and excluding language barriers)

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all patients.

Enter Code ☐

0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM©)*
1. **Yes** → *Continue to C0200, Repetition of Three Words*

Brief Interview for Mental Status (BIMS) (3-day assessment period)

C0200. Repetition of Three Words

Enter Code ☐

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the patient's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code ☐

Ask patient: *"Please tell me what year it is right now."*

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code ☐

Ask patient: *"What month are we in right now?"*

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code ☐

Ask patient: *"What day of the week is today?"*

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

Section C Cognitive Patterns

C0400. Recall

Enter Code ☐

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)

Code after completing Brief Interview for Mental Status and reviewing medical record (3-day assessment period).

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the patient's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Code in Boxes**

☐ **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ **C. Disorganized Thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered Level of Consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Section D Mood

D0150. Patient Health Questionnaire 2 (PHQ-2©)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

	1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
			↓ **Enter Scores in Boxes** ↓	
A.	*Little interest or pleasure in doing things?*		☐	☐
B.	*Feeling down, depressed, or hopeless?*		☐	☐

Section E Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency
Note presence of symptoms and their frequency.

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Code in Boxes	
☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Section GG Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. **Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ **Enter Codes in Boxes**

☐ **B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ **Check all that apply**

- ☐ **A. Manual wheelchair**
- ☐ **B. Motorized wheelchair and/or scooter**
- ☐ **C. Mechanical lift**
- ☐ **Z. None of the above**

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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 and/or touching/steadying and/or contact guard 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 activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	1. Admission Performance	2. Discharge Goal
	↓ Enter Codes in Boxes ↓	
A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.	☐☐	☐☐
B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.	☐☐	☐☐
C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.	☐☐	☐☐
D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	☐☐	☐☐

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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 and/or touching/steadying and/or contact guard 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 activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**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 move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170Q1, Does the patient use a wheelchair and/or scooter?*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	☐	**Q1. Does the patient use a wheelchair and/or scooter?** **0. No** → *Skip to H0350, Bladder Continence* **1. Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

Section H Bladder and Bowel

H0350. Bladder Continence (3-day assessment period)

Enter Code ☐

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

0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

H0400. Bowel Continence (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

I0050. Indicate the patient's primary medical condition category.

Enter Code ☐

Indicate the patient's primary medical condition category.

1. **Acute Onset Respiratory Condition** (e.g., aspiration and specified bacterial pneumonias)
2. **Chronic Respiratory Condition** (e.g., chronic obstructive pulmonary disease)
3. **Acute Onset and Chronic Respiratory Conditions**
4. **Chronic Cardiac Condition** (e.g., heart failure)
5. **Other Medical Condition** If "Other Medical Condition," enter the ICD code in the boxes.

I0050A. ☐☐☐☐☐☐☐☐

Comorbidities and Co-existing Conditions

↓ **Check all that apply**

Cancers	
☐	**I0103. Metastatic Cancer**
☐	**I0104. Severe Cancer**
Heart/Circulation	
☐	**I0605. Severe Left Systolic/Ventricular Dysfunction** (known ejection fraction ≤ 30%)
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
Genitourinary	
☐	**I1501. Chronic Kidney Disease, Stage 5**
☐	**I1502. Acute Renal Failure**
Infections	
☐	**I2101. Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock**
☐	**I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis**
Metabolic	
☐	**I2900. Diabetes Mellitus (DM)**
Musculoskeletal	
☐	**I4100. Major Lower Limb Amputation** (e.g., above knee, below knee)
Neurological	
☐	**I4501. Stroke**
☐	**I4801. Dementia**
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5101. Complete Tetraplegia**
☐	**I5102. Incomplete Tetraplegia**
☐	**I5110. Other Spinal Cord Disorder/Injury** (e.g., myelitis, cauda equina syndrome)
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5450. Amyotrophic Lateral Sclerosis**
☐	**I5455. Other Progressive Neuromuscular Disease**
☐	**I5460. Locked-In State**
☐	**I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain**
☐	**I5480. Other Severe Neurological Injury, Disease, or Dysfunction**
Nutritional	
☐	**I5601. Malnutrition** (protein or calorie)
☐	**I5602. At Risk for Malnutrition**

Section I	Active Diagnoses
Post-Transplant	
☐	**I7100. Lung Transplant**
☐	**I7101. Heart Transplant**
☐	**I7102. Liver Transplant**
☐	**I7103. Kidney Transplant**
☐	**I7104. Bone Marrow Transplant**
None of the Above	
☐	**I7900. None of the above**

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).

K0520. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the first 3 days of admission.

	1. Performed during the first 3 days of admission Check all that apply ↓
A. Parenteral/IV feeding	☐
B. Feeding tube - nasogastric or abdominal (e.g., PEG)	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N2001, Drug Regimen Review*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number ☐

A. 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

1. **Number of Stage 1 pressure injuries**

Enter Number ☐

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

1. **Number of Stage 2 pressure ulcers**

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**

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**

Enter Number ☐

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

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**

Enter Number ☐

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**

Enter Number ☐

G. Unstageable - Deep tissue injury

1. **Number of unstageable pressure injuries presenting as deep tissue injury**

Section N Medications

N2001. Drug Regimen Review

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No - No issues found during review** → *Skip to O0100, Special Treatments, Procedures, and Programs*
1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up*
9. **NA - Patient is not taking any medications** → *Skip to O0100, Special Treatments, Procedures, and Programs*

N2003. Medication Follow-up

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?

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

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the first 3 days of admission. For chemotherapy and dialysis, check if it is part of the patient's treatment plan.

	3. Performed during the first 3 days of admission Check all that apply ↓
Cancer Treatments	
A. Chemotherapy (if checked, please specify below)	☐
A2a. IV	☐
A3a. Oral	☐
A10a. Other	☐
B. Radiation	☐
Respiratory Treatments	
C. Oxygen Therapy (if checked, please specify below)	☐
C2a. Continuous	☐
C3a. Intermittent	☐
D. Suctioning (if checked, please specify below)	☐
D2a. Scheduled	☐
D3a. As needed	☐
E. Tracheostomy Care	☐
G. Non-invasive Mechanical Ventilator (BiPAP/CPAP) (if checked, please specify below)	☐
G2a. BiPAP	☐
G3a. CPAP	☐
Other Treatments	
H. IV Medications (if checked, please specify below)	☐
H2a. Vasoactive medications (i.e., continuous infusions of vasopressors or inotropes)	☐
H3a. Antibiotics	☐
H4a. Anticoagulation	☐
H10a. Other	☐
I. Transfusions	☐
J. Dialysis (if checked, please specify below)	☐
J2a. Hemodialysis	☐
J3a. Peritoneal dialysis	☐
O. IV Access (if checked, please specify below)	☐
O2a. Peripheral IV	☐
O3a. Midline	☐
O4a. Central line (e.g., PICC, tunneled, port)	☐
O10a. Other	☐
None of the Above	
Z. None of the above	☐

Section O Special Treatments, Procedures, and Programs

O0150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial) **by Day 2 of the LTCH Stay**

Enter Code ☐

A. Invasive Mechanical Ventilation Support upon Admission to the LTCH

0. **No, not on invasive mechanical ventilation support** → *Skip to O0250, Influenza Vaccine*
1. **Yes, weaning** → *Continue to O0150B, Assessed for readiness for SBT by day 2 of the LTCH stay*
2. **Yes, non-weaning** → *Skip to O0250, Influenza Vaccine*

Enter Code ☐

B. Assessed for readiness for SBT by day 2 of the LTCH stay (Note: Day 2 = Date of Admission to the LTCH (Day 1) + 1 calendar day)

0. **No** → *Skip to O0250, Influenza Vaccine*
1. **Yes** → *Continue to O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay*

Enter Code ☐

C. Deemed medically ready for SBT by day 2 of the LTCH stay

0. **No** → *Continue to O0150D, Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?*
1. **Yes** → *Continue to O0150E, SBT performed by day 2 of the LTCH stay*

Enter Code ☐

D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?

0. **No** → *Skip to O0250, Influenza Vaccine*
1. **Yes** → *Skip to O0250, Influenza Vaccine*

Enter Code ☐

E. SBT performed by day 2 of the LTCH stay

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

O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.

Enter Code ☐

A. Did the **patient receive the influenza vaccine <u>in this facility</u>** for this year's influenza vaccination season?

0. **No** → *Skip to O0250C, If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B, Date influenza vaccine received*

B. Date influenza vaccine received → *Complete date and skip to Z0400, Signature of Persons Completing the Assessment*

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Patient not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment

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 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 submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. 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 Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

PRA Disclosure Statement

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