#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	LTCH CARE Data Set V 4.00 (Note: Modifications to existing items highlighted in yellow)	Rationale for Change / Comments
1.	All	N/A	Version 3.00	Version 4.00	Updated version number.
2.	All	Footer	Effective April 1, 2016	Final LTCH CARE Data Set Version 4.00, Admission/Planned Discharge/Unplanned Discharge/Expired - Effective July 1, 2018	Updated effective date.
3.	All	N/A	N/A	Punctuation and style revisions applicable throughout the instrument	Punctuation and style revisions to be consistent with MDS and IRF-PAI.
4.	All	Section Headings and Titles	White and gray font	Black and bold font	Updated font formatting for better contrast.
5.	Admission	A1802	A1802. Admitted From 09. ID/DD facility	A1802. Admitted From 09. Intellectually Disabled/Developmentally Disabled (ID/DD) facility	Spelled out code 09 for clarity.
6.	Admission, Planned Discharge, Unplanned Discharge, Expired	A1400	A1400. Payer Information K. No payor source	A1400. Payer Information K. No payer source	Revised spelling for consistency.
7.	Planned Discharge, Unplanned Discharge	A2110	A2110. Discharge Location 09. ID/DD facility	A2110. Discharge Location 09. Intellectually Disabled/Developmentally Disabled (ID/DD) facility	Spelled out code 09 for clarity.
8.	Planned Discharge	A2500	**A2500. Program Interruption(s)** **Program Interruptions** 0. **No** → *Skip to B0100. Comatose* 1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	N/A – delete item	Deleted to reduce provider burden.

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9.	Unplanned Discharge	A2500	**A2500. Program Interruption(s)** **Program Interruptions** 0. **No** → *Skip to C1610. Signs and Symptoms of Delirium (from CAM©)* 1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	N/A – delete item	Deleted to reduce provider burden.
10.	Planned Discharge, Unplanned Discharge	A2510	**A2510. Number of Program Interruptions During This Stay in This Facility.** *Code only if A2500 equals to 1.*	N/A – delete item	Deleted to reduce provider burden.
11.	Planned Discharge, Unplanned Discharge	A2525	**A2525. Program Interruption Dates.** *Code only if A2510 is greater than or equal to 01.* A1. First Interruption Start Date A2. First Interruption End Date B1. Second Interruption Start Date *Code only if A2510 is greater than 01.* B2. Second Interruption End Date *Code only if A2510 is greater than 01.* C1. Third Interruption Start Date *Code only if A2510 is greater than 02.* C2. Third Interruption End Date *Code only if A2510 is greater than 02.* D1. Fourth Interruption Start Date *Code only if A2510 is greater than 03.* D2. Fourth Interruption End Date *Code only if A2510 is greater than 03.* E1. Fifth Interruption Start Date *Code only if A2510 is greater than 04.* E2. Fifth Interruption End Date *Code only if A2510 is greater than 04.*	N/A – delete item	Deleted to reduce provider burden.

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12.	Admission, Planned Discharge	BB0800	**BB0800. Understanding Verbal Content** (3-day assessment period) **Understanding 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**	**BB0800. Understanding Verbal and Non-Verbal Content** (3-day assessment period) **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**	Added clarification that Non-Verbal Content can also be considered. Added comma for clarification.
13.	Admission	GG0100	**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. **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**	**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**	Added "Coding" to GG0100 instructions for consistency.

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14.	Admission	GG0110	**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 or scooter C. Mechanical lift Z. None of the above	**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	Added "and/" for clarification.
15.	Admission	GG0130 Discharge goal coding	**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. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**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).**	Added instructions indicating that the activity not attempted codes may be used to code goal items.
16.	Admission, Planned Discharge	GG0130 Coding options	**From 6-point scale** 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.	**From 6-point scale** **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.	Added "contact guard" and changed "or" to "and/or" for clarification in code 04. Removed capitalization from code 05.

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17.	Admission, Planned Discharge	GG0130 Coding options	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** **88.** Not attempted due to **medical condition or safety concerns**	**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**	Added definition of 09 for clarification. Added new code to allow reporting of environmental limitations.
18.	Admission, Planned Discharge	GG0130A	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.	**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.	Revised wording of the item definition for clarification.
19.	Admission, Planned Discharge	GG0130B	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]	**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.	Revised wording of the item definition for clarification.
20.	Admission, Planned Discharge	GG0130C	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing 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.	Revised wording of the item definition for clarification.

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21.	Admission	GG0170 Discharge goal coding	**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. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**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).**	Added instructions indicating that the activity not attempted codes may be used to code goal items.
22.	Admission, Planned Discharge	GG0170 Coding option	**From 6-point scale** 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.	**From 6-point scale** 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.	Added “contact guard” and changed “or” to “and/or” for clarification in code 04. Removed capitalization from code 05.

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23.	Admission, Planned Discharge	GG0170 Coding option	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** **88.** Not attempted due to **medical condition or safety concerns**	**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**	Added definition of 09 for clarification. Added new code to allow reporting of environmental limitations.
24.	Admission, Planned Discharge	GG0170A	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.	**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.	Added "on the bed" for clarification.
25.	Admission, Planned Discharge	GG0170C	**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, and with no back support.	**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.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.
26.	Admission, Planned Discharge	GG0170D	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	**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.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items. Added "wheelchair" for clarification.

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27.	Admission, Planned Discharge	GG0170E	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.
28.	Admission, Planned Discharge	GG0170F	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.	**F. Toilet transfer:** The ability to get on and off a toilet or commode.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.
29.	Admission	GG0170H1	**H1. Does the patient walk?** 0. **No,** and walking goal **is not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 1. **No,** and walking goal **is** clinically indicated → *Code the patient's Discharge Goal(s) for items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/ scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*	N/A – delete item	The skip pattern is associated with the item Walk 10 feet.
30.	Planned Discharge	GG0170H3	**H3. Does the patient walk?** 0. **No** → *Skip to GG0170Q3. Does the patient use wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*	N/A – delete item	The skip pattern is associated with the item Walk 10 feet.

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31.	Admission	GG0170I	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**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?*	Added skip pattern that was previously associated with GG0170H1. Added comma for clarification.
32.	Planned Discharge	GG0170I	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170Q3, Does the patient use a wheelchair and/or scooter?*	Added skip pattern that was previously associated with GG0170H3. Added comma for clarification.
33.	Admission	GG0170Q1	**Q1. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to H0350. Bladder Continence* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*	**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*	Added for clarification.
34.	Planned Discharge	GG0170Q3	**Q3. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to H0350. Bladder Continence* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*	**Q3. 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*	Added for clarification.

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35.	Admission	GG0170RR1	**RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.
36.	Planned Discharge	GG0170RR3	**RR3. Indicate the type of wheelchair/scooter used.** **1. Manual** **2. Motorized**	**RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**	Added for clarification.
37.	Admission	GG0170SS1	**SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.
38.	Planned Discharge	GG0170SS3	**SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.
39.	Admission	I0050	**5. Other medical condition** If "other medical condition", enter the ICD code in the boxes. **I0050A.**	**5. Other medical condition** If "other medical condition," enter the ICD code in the boxes. **I0050A.**	Moved comma

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40.	Admission	I0103 I0104 I0605 I5455 I5480 I7100 I7101 I7102 I7103 I7104	N/A – new items	**Comorbidities and Co-existing Conditions** **↓ Check all that apply** **I0103. Metastatic Cancer** **I0104. Severe Cancer** **I0605. Severe Left Systolic/Ventricular Dysfunction** (known ejection fraction ≤ 30%) **I5455. Other Progressive Neuromuscular Disease** **I5480. Other Severe Neurological Injury, Disease, or Dysfunction** **Post-Transplant** **I7100. Lung Transplant** **I7101. Heart Transplant** **I7102. Liver Transplant** **I7103. Kidney Transplant** **I7104. Bone Marrow Transplant**	New items added to collect data for the ventilator weaning quality measures.
41.	Admission	I0101	I0101. Severe and Metastatic Cancer	N/A – delete item	I0101 will be replaced by I0103 and I0104.
42.	Planned Discharge	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210, Unhealed Pressure Ulcers/Injuries* 1. **Yes** → *Continue to J1900, Number of Falls Since Admission*	Revised to correct skip pattern.

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43.	Unplanned Discharge	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210, Unhealed Pressure Ulcers/Injuries* 1. **Yes** → *Continue to J1900, Number of Falls Since Admission*	Revised to correct skip pattern.
44.	Expired	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to O0250. Influenza Vaccine* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to N2005, Medication Intervention* 1. **Yes** → *Continue to J1900, Number of Falls Since Admission*	Revised to correct skip pattern.
45.	Admission, Planned Discharge, Unplanned Discharge	Section M heading	**Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage**	**Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage**	Added the term "injuries" to be inclusive of updated terminology supported by the National Pressure Ulcer Advisory Panel (NPUAP).

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46.	Admission	M0210	**M0210. Unhealed Pressure Ulcer(s)** **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries** **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*	Deleted text to clarify. Added the term "injury" to be inclusive of updated terminology supported by NPUAP.
47.	Planned Discharge, Unplanned Discharge	M0210	**M0210. Unhealed Pressure Ulcer(s)** **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries** **Does this patient have one or more unhealed pressure ulcers/injuries?** 0. **No** → *Skip to N2005, Medication Intervention* 1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*	Deleted text to clarify. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
48.	Admission, Planned Discharge, Unplanned Discharge	M0300	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**	**M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**	Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.

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49.	Admission, Planned Discharge, Unplanned Discharge	M0300A	**Number of Stage 1 pressure ulcers**	1. **Number of Stage 1 pressure injuries**	Added the number one to be consistent with other items in the section. Replaced the term "ulcers" with "injuries" as the term "injuries" indicates intact skin which better aligns with criteria for Stage 1.
50.	Planned Discharge, Unplanned Discharge	M0300D1	**D1. Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E. Unstageable - Non-removable dressing*	**D1. Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E, Unstageable - Non-removable dressing/device*	Added the word "device" for clarity.
51.	Admission	M0300E M0300E1	**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**	**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**	Added the word "device" for clarity. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.

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52.	Planned Discharge, Unplanned Discharge	M0300E M0300E2	**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 <u>these</u> unstageable pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	**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 -** *If 0 → Skip to M0300F, Unstageable - Slough and/or eschar* **2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission -** enter how many were noted at the time of admission	Added the word "device" for clarity. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
53.	Admission	M0300G M0300G1	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution. 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury**	Removed the term "suspected deep tissue injury in evolution" and replaced with "deep tissue injury" to be consistent with updated NPUAP terminology.

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54.	Planned Discharge, Unplanned Discharge	M0300G M0300G1 M0300G2	**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 M0800. Worsening in Pressure Ulcer Status Since Admission* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → *Skip to N2005, Medication Intervention* 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission	Removed the term "suspected deep tissue injury in evolution" and replaced with "deep tissue injury" to be consistent with updated NPUAP terminology.
55.	Planned Discharge, Unplanned Discharge	M0800	**M0800. Worsening in Pressure Ulcer Status Since Admission** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. If no current pressure ulcer at a given stage, enter 0 **A. Stage 2** **B. Stage 3** **C. Stage 4** **D. Unstageable - Non-removable dressing** **E. Unstageable - Slough and/or eschar** **F. Unstageable - Deep tissue injury**	N/A – delete items	Deleted to reduce provider burden.

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56.	Admission, Planned Discharge, Unplanned Discharge, Expired	Section N	N/A – new section	**Section N. Medications**	New section added on admission and discharge to accommodate the drug regimen review quality measure items N2001, N2003, and N2005.
57.	Admission	N2001	N/A – new item	N2001. Drug Regimen Review 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*	New items added to collect data for the drug regimen review quality measure.
58.	Admission	N2003	N/A – new item	**N2003. Medication Follow-up** **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**	New item added to collect data for the drug regimen review quality measure.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	LTCH CARE Data Set V 4.00 (Note: Modifications to existing items highlighted in yellow)	Rationale for Change / Comments
59.	Planned Discharge, Unplanned Discharge, Expired	N2005	N/A – new item	**N2005. Medication Intervention** **Did the facility contact and complete physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** 0. **No** 1. **Yes** 9. **NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**	New item added to collect data for the drug regimen review quality measure.
60.	Admission	O0100F3 O0100F4	O0100F3. Invasive Mechanical Ventilator: weaning O0100F4. Invasive Mechanical Ventilator: non-weaning	N/A – delete items	Invasive mechanical ventilation, whether weaning or non-weaning will now be assessed using data collected as part of the ventilator weaning quality measures (including O0150 and O0200).
61.	Admission	O0100H O0100H2a	N/A – new item	**H. IV Medications** (if checked, please specify below) H2a. Vasoactive medications (i.e., continuous infusions of vasopressors or inotropes)	New item added to collect data for the ventilator weaning quality measures.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	LTCH CARE Data Set V 4.00 (Note: Modifications to existing items highlighted in yellow)	Rationale for Change / Comments
62.	Admission	O0150 O0150A O0150B O0150C O0150D O0150E	N/A – new items	**O0150. Spontaneous Breathing Trial (SBT)** (including Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial) **by Day 2 of LTCH Stay** **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* *(continued)*	New items added to collect data for the ventilator weaning quality measures.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	LTCH CARE Data Set V 4.00 (Note: Modifications to existing items highlighted in yellow)	Rationale for Change / Comments
				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* **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* **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* **E. SBT performed by day 2 of the LTCH stay** 0. **No** 1. **Yes**	

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	LTCH CARE Data Set V 4.00 (Note: Modifications to existing items highlighted in yellow)	Rationale for Change / Comments
63.	Planned Discharge, Unplanned Discharge	O0200 O0200A	N/A – new items	**O0200. Ventilator Liberation Rate** **A. Invasive Mechanical Ventilator: Liberation Status at Discharge** **0. Not fully liberated at discharge** (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) **1. Fully liberated at discharge** (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) **9. NA** (code only if the patient was non-weaning or not ventilated on admission [O0150A=2 or 0 on Admission Assessment])	New items added to collect data for the ventilator weaning quality measures.