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Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.1 PATIENT ASSESSMENT FORM - PLANNED DISCHARGE

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**

A0270. Discharge Date

Month Day Year

Section Administrative

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)**:**

Section Administrative

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**

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ **Check all that apply**

- ☐ **A. Yes, it has kept me from medical appointments or from getting my medications**
- ☐ **B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**
- ☐ **C. No**
- ☐ **X. Patient unable to respond**
- ☐ **Y. Patient declines to respond**

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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 payer source**
- ☐ **X. Unknown**
- ☐ **Y. Other**

Section A Administrative Information

A2105. Discharge Location

Enter Code

1. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
2. **Nursing Home** (long-term care facility)
3. **Skilled Nursing Facility** (SNF, swing bed)
4. **Short-Term General Hospital** (acute hospital, IPPS)
5. **Long-Term Care Hospital** (LTCH)
6. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
7. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
8. **Intermediate Care Facility** (ID/DD facility)
9. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**

99. **Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code

0. **No** – Current reconciled medication list not provided to the subsequent provider → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*
1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	Check all that apply
A. Electronic Health Record	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

A2123. Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code

0. **No** – Current reconciled medication list not provided to the patient, family and/or caregiver → *Skip to B0100, Comatose*
1. **Yes** – Current reconciled medication list provided to the patient, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Patient

Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Route of Transmission	Check all that apply
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code

Persistent vegetative state/no discernible consciousness

0. **No** → *Continue to B1300, Health Literacy*
1. **Yes** → *Skip to GG0130, Self-Care*

B1300. Health Literacy (from Creative Commons©)

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

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

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)

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**

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

Section Cognitive

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

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

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

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Patient _____ Identifier _____ Date _____

Section D Mood

D0150. Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc.©)

Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9, No response, leave D0150A2 and D0150B2 blank, end the PHQ-2 interview, and leave D0160, Total Severity Score blank. Otherwise, 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***		
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
C. ***Trouble falling or staying asleep, or sleeping too much***		
D. ***Feeling tired or having little energy***		
E. ***Poor appetite or overeating***		
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

Section GG Functional Abilities

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

Code the patient's usual performance at discharge for each activity using the 6-point scale. If an activity was not attempted at discharge, code the reason.

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 themself 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**

3. Discharge Performanc	
↓ 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.

Section GG Functional Abilities

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If an activity was not attempted at discharge, code the reason.

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 themself 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**

3. Discharge Performan	
↓ 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 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. *If discharge performance is coded 07, 09, 10, or 88 Skip to GG0170I, Walk 10 feet*
	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	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 GG0170M, 1 step (curb)*
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 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.

Section GG Functional Abilities

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at discharge for each activity using the 6-point scale. If an activity was not attempted at discharge, code the reason.

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 themself 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**

3. Discharge Performan	
↓ **Enter Codes in Boxes**	
	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M. 1 step (curb): The ability to go up and down a curb or up and down one step. *If discharge performance is coded ~~07~~, 09, 10, or*
	N. 4 steps: The ability to go up and down four steps with or without a rail. *If discharge performance is coded ~~07~~, 09, 10, or 88*
	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	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*
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
	RR3. 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.
	SS3. 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)

Section J Health Conditions

J0510. Pain Effect on Sleep

Enter Code

Ask patient: "Over the past 5 days, ***how much of the time has pain made it hard for you to sleep at night?"***

0. **Does not apply – I have not had any pain or hurting in the past 5 days** *Skip to J1800, Any Falls Since Admission*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

Ask patient: "Over the past 5 days, ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code

Ask patient: "Over the past 5 days, ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J1800. Any Falls Since Admission

Enter Code

Has the patient **had any falls since admission?**

0. **No** → *Skip to K0520, Nutritional Approaches*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

J1900. Number of Falls Since Admission

Coding:
0. **None**
1. **One**
2. **Two or more**

Enter Codes in Boxes

	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days **5. At Discharge** Check all of the nutritional approaches that were being received at discharge	**4. Last 7 Days** **Check all that apply ↓**	**5. At Discharge** **Check all that apply ↓**
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (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	Skin

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 N0415, High-Risk Drug Classes: Use and Indication* 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 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 -** If 0 *Skip to M0300C, Stage 3* **2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number 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* → **2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number 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/device* **2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number 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** - 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

Section	Skin
Enter Number 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** - If 0 *Skip to M0300G, Unstageable - Deep tissue injury* **2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

M0300 continued on next page

Section	Skin

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

G. Unstageable - Deep tissue injury

Enter Number

1. Number of unstageable pressure injuries presenting as deep ~~tissue~~ injury - If 0 *Skip to N0415, High-Risk Drug Classes: Use and Indication*

Enter Number

2. Number of <u>these</u> unstageable pressure injuries that were present upon admission - enter how many were noted at the time of admission

Section N Medications

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking** Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. **Indication noted** If column 1 is checked, check if there is an indication noted for all medications in the drug class	1. **Is taking** **Check all that apply**	2. **Indication noted** **Check all that apply**
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

N2005. Medication Intervention

Enter Code	
☐	**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. **Not applicable – There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**

Section Special Treatments, Procedures, and

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply at discharge.

	c. At Discharge Check all that apply
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-Invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Midline	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the above	☐

O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)

Enter Code

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. **Not applicable** (code only if the patient was not on invasive mechanical ventilator support upon admission [O0150A = 0] or the patient was determined to be non-weaning upon admission [O0150A2 = 0])

O0350. Patient's COVID-19 vaccination is up to date.

Enter Code

0. No, patient is not up to date
1. Yes, patient is up to date

Sectio Assessment

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.

Signatu re	Title	Sectio ns	Date Section
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:

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Month Day Year