

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 <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record
A0100. Facility Provider Numbers. Enter Code in boxes provided.	
	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Medicaid Provider Number:</p>
A0200. Type of Provider	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 3. Long-Term Care Hospital
A0210. Assessment Reference Date	
	<p>Observation end date:</p> <p style="text-align: center;"> _____ Month Day Year </p>
A0220. Admission Date	
	<p style="text-align: center;"> _____ Month Day Year </p>
A0250. Reason for Assessment	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 01. Admission 10. Planned discharge 11. Unplanned discharge 12. Expired

Section A	Administrative Information
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Patient Demographic Information
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A0500. Legal Name of Patient

	<p>A. First name:</p> <p>B. Middle initial:</p> <p>C. Last name:</p> <p>D. Suffix:</p>
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A0600. Social Security and Medicare Numbers
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	<p>A. Social Security Number:</p> <p style="text-align: center;">_ - _</p> <p>B. Medicare number (or comparable railroad insurance number):</p>
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A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

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A0800. Gender

Enter Code	<p><input type="checkbox"/> 1. Male</p> <p><input type="checkbox"/> 2. Female</p>
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A0900. Birth Date

	<p style="text-align: center;">_ - _</p> <p style="text-align: center;">Month Day Year</p>
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A1000. Race/Ethnicity

↓	Check all that apply
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Section A	Administrative Information
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A1100. Language	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<p>A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No → <i>Skip to A1200, Marital Status</i></p> <p>1. Yes → <i>Specify in A1100B, Preferred language</i></p> <p>9. Unable to determine → <i>Skip to A1200, Marital Status</i></p> <p>B. Preferred language:</p>

A1200. Marital Status	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<p>1. Never married</p> <p>2. Married</p> <p>3. Widowed</p> <p>4. Separated</p> <p>5. Divorced</p>

A1400. Payer Information	
↓ Check all that apply	
<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	E. Workers' compensation
<input type="checkbox"/>	F. Title programs (e.g., Title III, V, or XX)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payer source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

Pre-Admission Service Use

A1802. Admitted From. Immediately preceding this admission, where was the patient?	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<p>01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)</p> <p>02. Long-term care facility</p> <p>03. Skilled nursing facility (SNF)</p> <p>04. Hospital emergency department</p> <p>05. Short-stay acute hospital (IPPS)</p> <p>06. Long-term care hospital (LTCH)</p> <p>07. Inpatient rehabilitation facility or unit (IRF)</p> <p>08. Psychiatric hospital or unit</p> <p>09. Intellectually Disabled/Developmentally Disabled (ID/DD) facility</p> <p>10. Hospice</p> <p>99. None of the above</p>

Section B**Hearing, Speech, and Vision****B0100. Comatose**

Enter Code

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0700, Expression of Ideas and Wants
1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities

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****C1610. Signs and Symptoms of Delirium (from CAM©)**

Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period)

CODING: 0. No 1. Yes	↓ Enter Code in Boxes	
	<input type="checkbox"/>	Acute Onset and Fluctuating Course A. Is there evidence of an acute change in mental status from the patient's baseline? B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?
	<input type="checkbox"/>	Inattention C. Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/>	Disorganized Thinking D. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
	<input type="checkbox"/>	Altered Level of Consciousness E. Overall, how would you rate the patient's level of consciousness? E1. Alert (Normal) E2. Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)

Adapted with permission from: Inouye SK et al, Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

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

<p>Coding:</p> <ul style="list-style-type: none"> 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 	<p style="text-align: center;">↓ Enter Codes in Boxes</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; height: 40px; vertical-align: middle; text-align: center;"> <input style="width: 100%; height: 100%;" type="text"/> </td> <td style="padding: 5px;"> <p>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.</p> </td> </tr> </table>	<input style="width: 100%; height: 100%;" type="text"/>	<p>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.</p>
<input style="width: 100%; height: 100%;" type="text"/>	<p>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.</p>		

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

<p>↓ Check all that apply</p>	
<input type="checkbox"/>	<p>A. Manual wheelchair</p>
<input type="checkbox"/>	<p>B. Motorized wheelchair and/or scooter</p>
<input type="checkbox"/>	<p>C. Mechanical lift</p>
<input type="checkbox"/>	<p>Z. None of the above</p>

Section GG	Functional Abilities and Goals
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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 ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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
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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 ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	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.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170Q1, Does the patient use a wheelchair and/or scooter?</i>
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.

Section GG	Functional Abilities and Goals
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GG0170. Mobility (3-day assessment period) - Continued

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 ↓		
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		<input type="checkbox"/> 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
<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		<input type="checkbox"/> RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		<input type="checkbox"/> 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 \leq 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

Section I		Active Diagnoses	
Nutritional			
<input type="checkbox"/>	I5601. Malnutrition	(protein or calorie)	
<input type="checkbox"/>	I5602. At Risk for Malnutrition		
Post-Transplant			
<input type="checkbox"/>	I7100. Lung Transplant		
<input type="checkbox"/>	I7101. Heart Transplant		
<input type="checkbox"/>	I7102. Liver Transplant		
<input type="checkbox"/>	I7103. Kidney Transplant		
<input type="checkbox"/>	I7104. Bone Marrow Transplant		
None of the Above			
<input type="checkbox"/>	I7900. None of the above		

Section K	Swallowing/Nutritional Status
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K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

<input style="width: 100%; height: 20px;" type="text"/> inches	A. Height (in inches). Record most recent height measure since admission.
<input style="width: 100%; height: 20px;" type="text"/> 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).

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

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p>Does this patient have one or more unhealed pressure ulcers/injuries?</p> <p>0. No → <i>Skip to N2001, Drug Regimen Review</i></p> <p>1. Yes → <i>Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</i></p>
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M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>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</p> <p>1. Number of Stage 1 pressure injuries</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>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</p> <p>1. Number of Stage 2 pressure ulcers</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>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</p> <p>1. Number of Stage 3 pressure ulcers</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>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</p> <p>1. Number of Stage 4 pressure ulcers</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</p>
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Enter Number <input style="width: 100%; height: 20px;" type="text"/>	<p>G. Unstageable - Deep tissue injury</p> <p>1. Number of unstageable pressure injuries presenting as deep tissue injury</p>
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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 the treatments at admission. For dialysis, check if it is part of the patient's treatment plan.

↓ **Check all that apply**

Respiratory Treatments

G. Non-invasive Ventilator (BiPAP, CPAP)

Other Treatments

H. IV Medications (if checked, please specify below)

H2a. Vasoactive medications (i.e., continuous infusions of vasopressors or inotropes)

J. Dialysis

N. Total Parenteral Nutrition

None of the Above

Z. None of the above

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 in this facility 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
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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

<p>A. Signature:</p>	<p>B. LTCH CARE Data Set Completion Date:</p> <p style="text-align: center;"> _____ Month Day Year </p>
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PRA Disclosure Statement

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