

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

## PATIENT ASSESSMENT FORM - ADMISSION

Section A	Administrative Information
<b>A0050. Type of Record</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	1. <b>Add new assessment/record</b> 2. <b>Modify existing record</b> 3. <b>Inactivate existing record</b>
<b>A0100. Facility Provider Numbers.</b> Enter Code in boxes provided.	
	<b>A. National Provider Identifier (NPI):</b>  <b>B. CMS Certification Number (CCN):</b>  <b>C. State Medicaid Provider Number:</b>
<b>A0200. Type of Provider</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	3. <b>Long-Term Care Hospital</b>
<b>A0210. Assessment Reference Date</b>	
	Observation end date:  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0220. Admission Date</b>	
	<div style="display: flex; justify-content: space-around; width: 100%;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0250. Reason for Assessment</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>

<b>Section A</b>	<b>Administrative Information</b>
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<b>Patient Demographic Information</b>
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<b>A0500. Legal Name of Patient</b>
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	<p><b>A. First name:</b></p> <p><b>B. Middle initial:</b></p> <p><b>C. Last name:</b></p> <p><b>D. Suffix:</b></p>
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<b>A0600. Social Security and Medicare Numbers</b>
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	<p><b>A. Social Security Number:</b></p> <p style="text-align: center;">— — — — —</p> <p><b>B. Medicare number</b> (or comparable railroad insurance number):</p>
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<b>A0700. Medicaid Number</b> - Enter "+" if pending, "N" if not a Medicaid recipient
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<b>A0800. Gender</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px;"></div>	<p>1. <b>Male</b></p> <p>2. <b>Female</b></p>
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<b>A0900. Birth Date</b>
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	<p style="text-align: center;">— — — — —</p> <p style="text-align: center;">Month      Day      Year</p>
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<b>A1000. Race/Ethnicity</b>
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↓	<b>Check all that apply</b>
<input type="checkbox"/>	<b>A. American Indian or Alaska Native</b>
<input type="checkbox"/>	<b>B. Asian</b>
<input type="checkbox"/>	<b>C. Black or African American</b>
<input type="checkbox"/>	<b>D. Hispanic or Latino</b>
<input type="checkbox"/>	<b>E. Native Hawaiian or Other Pacific Islander</b>
<input type="checkbox"/>	<b>F. White</b>

<b>Section A</b>	<b>Administrative Information</b>
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**A1100. Language**

Enter Code <input type="text"/>	<b>A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?</b> 0. <b>No</b> → <i>Skip to A1200, Marital Status</i> 1. <b>Yes</b> → <i>Specify in A1100B, Preferred language</i> 9. <b>Unable to determine</b> → <i>Skip to A1200, Marital Status</i>  <b>B. Preferred language:</b>
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**A1200. Marital Status**

Enter Code <input type="text"/>	1. <b>Never married</b> 2. <b>Married</b> 3. <b>Widowed</b> 4. <b>Separated</b> 5. <b>Divorced</b>
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**A1400. Payer Information**

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

**Pre-Admission Service Use**
**A1802. Admitted From.** Immediately preceding this admission, where was the patient?

Enter Code <input type="text"/>	01. <b>Community residential setting</b> (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02. <b>Long-term care facility</b> 03. <b>Skilled nursing facility</b> (SNF) 04. <b>Hospital emergency department</b> 05. <b>Short-stay acute hospital</b> (IPPS) 06. <b>Long-term care hospital</b> (LTCH) 07. <b>Inpatient rehabilitation facility or unit</b> (IRF) 08. <b>Psychiatric hospital or unit</b> 09. <b>ID/DD Facility</b> 10. <b>Hospice</b> 99. <b>None of the above</b>
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<b>Section B</b>	<b>Hearing, Speech, and Vision</b>
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<b>B0100. Comatose</b>
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Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Persistent vegetative state/no discernible consciousness</b> 0. <b>No</b> → <i>Continue to B0200, Hearing</i> 1. <b>Yes</b> → <i>Skip to GG0100, Prior Functioning: Everyday Activities</i>
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<b>B0200. Hearing</b> (3-day assessment period)
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Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Ability to Hear</b> (with hearing aid or hearing appliances if normally used) 0. <b>Adequate:</b> No difficulty in normal conversation, social interaction, listening to TV 1. <b>Minimal difficulty:</b> Difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. <b>Moderate difficulty:</b> Speaker has to increase volume and speak distinctly 3. <b>Highly impaired:</b> Absence of useful hearing
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<b>B1000. Vision</b> (3-day assessment period)
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Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Ability to See in Adequate Light</b> (with glasses or other visual appliances) 0. <b>Adequate:</b> Sees fine detail, such as regular print in newspapers/books 1. <b>Impaired:</b> Sees large print, but not regular print in newspapers/books 2. <b>Moderately impaired:</b> Limited vision; not able to see newspaper headlines but can identify objects 3. <b>Highly impaired:</b> Object identification in question, but eyes appear to follow objects 4. <b>Severely impaired:</b> No vision or sees only light, colors or shapes; eyes do not appear to follow objects
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<b>BB0700. Expression of Ideas and Wants</b> (3-day assessment period)
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Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Expression of ideas and wants</b> (consider both verbal and non-verbal expression and excluding language barriers) 4. Expresses complex messages <b>without difficulty</b> and with speech that is clear and easy to understand 3. Exhibits some <b>difficulty</b> with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear 2. <b>Frequently</b> exhibits difficulty with expressing needs and ideas 1. <b>Rarely/Never</b> expresses self or speech is very difficult to understand
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<b>BB0800. Understanding Verbal and Non-Verbal Content</b> (3-day assessment period)
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Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Understanding Verbal and Non-Verbal Content</b> (with hearing aid or device, if used, and excluding language barriers) 4. <b>Understands:</b> Clear comprehension without cues or repetitions 3. <b>Usually Understands:</b> Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. <b>Sometimes Understands:</b> Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. <b>Rarely/Never Understands</b>
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<b>Section C</b>	<b>Cognitive Patterns</b>
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<b>C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?</b>
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Attempt to conduct interview with all patients.

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	0. <b>No</b> (patient is rarely/never understood) → <i>Skip to C1310, Signs and Symptoms of Delirium (from CAM©)</i> 1. <b>Yes</b> → <i>Continue to C0200, Repetition of Three Words</i>
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<b>Brief Interview for Mental Status (BIMS) (3-day assessment period)</b>
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<b>C0200. Repetition of Three Words</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>Ask patient: <i>"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: <b>sock, blue and bed.</b> Now tell me the three words."</i></p> <p><b>Number of words repeated after first attempt</b></p> <ul style="list-style-type: none"> <li>0. <b>None</b></li> <li>1. <b>One</b></li> <li>2. <b>Two</b></li> <li>3. <b>Three</b></li> </ul> <p>After the patient's first attempt, repeat the words using cues (<i>"sock, something to wear; blue, a color; bed, a piece of furniture"</i>). You may repeat the words up to two more times.</p>
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<b>C0300. Temporal Orientation (orientation to year, month, and day)</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>Ask patient: <i>"Please tell me what year it is right now."</i></p> <p><b>A. Able to report correct year</b></p> <ul style="list-style-type: none"> <li>0. <b>Missed by &gt; 5 years</b> or no answer</li> <li>1. <b>Missed by 2-5 years</b></li> <li>2. <b>Missed by 1 year</b></li> <li>3. <b>Correct</b></li> </ul>
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>Ask patient: <i>"What month are we in right now?"</i></p> <p><b>B. Able to report correct month</b></p> <ul style="list-style-type: none"> <li>0. <b>Missed by &gt; 1 month</b> or no answer</li> <li>1. <b>Missed by 6 days to 1 month</b></li> <li>2. <b>Accurate within 5 days</b></li> </ul>
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>Ask patient: <i>"What day of the week is today?"</i></p> <p><b>C. Able to report correct day of the week</b></p> <ul style="list-style-type: none"> <li>0. <b>Incorrect</b> or no answer</li> <li>1. <b>Correct</b></li> </ul>

<b>Section C</b>	<b>Cognitive Patterns</b>		
<b>C0400. Recall</b>			
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>		Ask patient: <i>"Let's go back to an earlier question. What were those three words that I asked you to repeat?"</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.  <b>A. Able to recall "sock"</b> 0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("something to wear") 2. <b>Yes, no cue required</b>	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>		<b>B. Able to recall "blue"</b> 0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("a color") 2. <b>Yes, no cue required</b>	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>		<b>C. Able to recall "bed"</b> 0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("a piece of furniture") 2. <b>Yes, no cue required</b>	
<b>C0500. BIMS Summary Score</b>			
Enter Score <div style="border: 1px solid black; width: 50px; height: 30px; margin: 0 auto;"></div>	<b>Add scores</b> for questions C0200-C0400 and fill in total score (00-15) <b>Enter 99 if the patient was unable to complete the interview</b>		
<b>C1310. Signs and Symptoms of Delirium (from CAM©)</b>			
Code after completing Brief Interview for Mental Status and reviewing medical record (3-day assessment period).			
<b>A. Acute Onset Mental Status Change</b>			
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>		Is there evidence of an acute change in mental status from the patient's baseline? 0. <b>No</b> 1. <b>Yes</b>	
<b>Coding:</b> 0. <b>Behavior not present</b> 1. <b>Behavior continuously present, does not fluctuate</b> 2. <b>Behavior present, fluctuates</b> (comes and goes, changes in severity)		↓ <b>Enter Code in Boxes</b>	
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>B. Inattention</b> - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>C. Disorganized Thinking</b> - 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)?
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>D. Altered Level of Consciousness</b> - Did the patient have altered level of consciousness as indicated by any of the following criteria? <div style="margin-left: 20px;">           ■ <b>vigilant</b> - startled easily to any sound or touch            ■ <b>lethargic</b> - repeatedly dozed off when being asked questions, but responded to voice or touch            ■ <b>stuporous</b> - very difficult to arouse and keep aroused for the interview            ■ <b>comatose</b> - could not be aroused         </div>

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Section D		Mood	
D0150. Patient Health Questionnaire 2 (PHQ-2©)			
<p><b>Say to patient:</b> "Over the last 2 weeks, have you been bothered by any of the following problems?"</p> <p>If symptom is present, enter 1 (yes) in column 1, Symptom Presence.</p> <p>If yes in column 1, then ask the patient: "About how often have you been bothered by this?"</p> <p>Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.</p>			
<b>1. Symptom Presence</b> 0. <b>No</b> (enter 0 in column 2) 1. <b>Yes</b> (enter 0-3 in column 2) 9. <b>No response</b> (leave column 2 blank)		<b>2. Symptom Frequency</b> 0. <b>Never or 1 day</b> 1. <b>2-6 days</b> (several days) 2. <b>7-11 days</b> (half or more of the days) 3. <b>12-14 days</b> (nearly every day)	
		<b>1. Symptom Presence</b>	<b>2. Symptom Frequency</b>
		↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things?		<input type="text"/>	<input type="text"/>
B. Feeling down, depressed, or hopeless?		<input type="text"/>	<input type="text"/>

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<b>Section E</b>		<b>Behavioral Symptoms</b>	
<b>E0200. Behavioral Symptom - Presence &amp; Frequency</b>			
Note presence of symptoms and their frequency.			
<b>Coding:</b> 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	<div>↓ Enter Code in Boxes</div>		
	<input type="text"/>	<b>A. Physical behavioral symptoms directed toward others</b> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)	
	<input type="text"/>	<b>B. Verbal behavioral symptoms directed toward others</b> (e.g., threatening others, screaming at others, cursing at others)	
	<input type="text"/>	<b>C. Other behavioral symptoms not directed toward others</b> (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)	



<b>Section GG</b>	<b>Functional Abilities and Goals</b>
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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.

<b>Coding:</b> <b>3. Independent</b> - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. <b>2. Needed Some Help</b> - Patient needed partial assistance from another person to complete activities. <b>1. Dependent</b> - A helper completed the activities for the patient. <b>8. Unknown</b> <b>9. Not Applicable</b>	<div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;">             ↓ Enter Codes in Boxes           </div> <table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center; vertical-align: middle;"> <input style="width: 40px; height: 20px;" type="text"/> </td> <td style="padding: 5px;"> <b>B. Indoor Mobility (Ambulation):</b> 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.         </td> </tr> </table>	<input style="width: 40px; height: 20px;" type="text"/>	<b>B. Indoor Mobility (Ambulation):</b> 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.
<input style="width: 40px; height: 20px;" type="text"/>	<b>B. Indoor Mobility (Ambulation):</b> Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.		

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

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

**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).**

<b>Coding:</b> <b>Safety and Quality of Performance</b> - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.  <i>Activities may be completed with or without assistive devices.</i> <b>06. Independent</b> - Patient completes the activity by him/herself with no assistance from a helper. <b>05. Setup or clean-up assistance</b> - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. <b>04. Supervision or touching assistance</b> - 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. <b>03. Partial/moderate assistance</b> - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. <b>02. Substantial/maximal assistance</b> - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. <b>01. Dependent</b> - 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.  <b>If activity was not attempted, code reason:</b> <b>07. Patient refused</b> <b>09. Not applicable</b> - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. <b>10. Not attempted due to environmental limitations</b> (e.g., lack of equipment, weather constraints) <b>88. Not attempted due to medical condition or safety concerns</b>	<b>1.</b> <b>Admission</b> <b>Performance</b>	<b>2.</b> <b>Discharge</b> <b>Goal</b>	
	↓ Enter Codes in Boxes ↓		
	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<b>A. Eating:</b> 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>B. Oral hygiene:</b> 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"/>	<b>C. Toileting hygiene:</b> 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"/>	<b>D. Wash upper body:</b> The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

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

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

Coding: <b>Safety and Quality of Performance</b> - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.  <i>Activities may be completed with or without assistive devices.</i>	1. <b>Admission Performance</b>	2. <b>Discharge Goal</b>	
	↓ Enter Codes in Boxes ↓		
	<input type="text"/>	<input type="text"/>	<b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
06. <b>Independent</b> - Patient completes the activity by him/herself with no assistance from a helper.	<input type="text"/>	<input type="text"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
05. <b>Setup or clean-up assistance</b> - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.	<input type="text"/>	<input type="text"/>	<b>C. Lying to sitting on side of bed:</b> 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.
04. <b>Supervision or touching assistance</b> - 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.	<input type="text"/>	<input type="text"/>	<b>D. Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	<input type="text"/>	<input type="text"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).
03. <b>Partial/moderate assistance</b> - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.	<input type="text"/>	<input type="text"/>	<b>F. Toilet transfer:</b> The ability to get on and off a toilet or commode.
02. <b>Substantial/maximal assistance</b> - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.	<input type="text"/>	<input type="text"/>	<b>I. Walk 10 feet:</b> 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>
01. <b>Dependent</b> - 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.	<input type="text"/>	<input type="text"/>	<b>J. Walk 50 feet with two turns:</b> Once standing, the ability to walk 50 feet and make two turns.
	<input type="text"/>	<input type="text"/>	<b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space.
<b>If activity was not attempted, code reason:</b>			<b>Q1. Does the patient use a wheelchair and/or scooter?</b> <b>0. No</b> → Skip to H0350, Bladder Continence <b>1. Yes</b> → Continue to GG0170R, Wheel 50 feet with two turns
07. <b>Patient refused</b>			
09. <b>Not applicable</b> - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.			
10. <b>Not attempted due to environmental limitations</b> (e.g., lack of equipment, weather constraints)	<input type="text"/>	<input type="text"/>	<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
88. <b>Not attempted due to medical condition or safety concerns</b>			<b>RR1. Indicate the type of wheelchair or scooter used.</b> <b>1. Manual</b> <b>2. Motorized</b>
	<input type="text"/>	<input type="text"/>	<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
			<b>SS1. Indicate the type of wheelchair or scooter used.</b> <b>1. Manual</b> <b>2. Motorized</b>

<b>Section H</b>	<b>Bladder and Bowel</b>
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<b>H0350. Bladder Continence (3-day assessment period)</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p><b>Bladder continence</b> - Select the one category that best describes the patient.</p> <ul style="list-style-type: none"> <li>0. <b>Always continent</b> (no documented incontinence)</li> <li>1. <b>Stress incontinence only</b></li> <li>2. <b>Incontinent less than daily</b> (e.g., once or twice during the 3-day assessment period)</li> <li>3. <b>Incontinent daily</b> (at least once a day)</li> <li>4. <b>Always incontinent</b></li> <li>5. <b>No urine output</b> (e.g., renal failure)</li> <li>9. <b>Not applicable</b> (e.g., indwelling catheter)</li> </ul>
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<b>H0400. Bowel Continence (3-day assessment period)</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p><b>Bowel continence</b> - Select the one category that best describes the patient.</p> <ul style="list-style-type: none"> <li>0. <b>Always continent</b></li> <li>1. <b>Occasionally incontinent</b> (one episode of bowel incontinence)</li> <li>2. <b>Frequently incontinent</b> (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</li> <li>3. <b>Always incontinent</b> (no episodes of continent bowel movements)</li> <li>9. <b>Not rated</b>, patient had an ostomy or did not have a bowel movement for the entire 3 days</li> </ul>
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## Section I Active Diagnoses

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

Enter Code	<p><b>Indicate the patient's primary medical condition category.</b></p> <p><b>1. Acute Onset Respiratory Condition</b> (e.g., aspiration and specified bacterial pneumonias)</p> <p><b>2. Chronic Respiratory Condition</b> (e.g., chronic obstructive pulmonary disease)</p> <p><b>3. Acute Onset and Chronic Respiratory Conditions</b></p> <p><b>4. Chronic Cardiac Condition</b> (e.g., heart failure)</p> <p><b>5. Other Medical Condition</b> If "Other Medical Condition," enter the ICD code in the boxes.</p> <p><b>I0050A.</b></p>
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### Comorbidities and Co-existing Conditions

↓ Check all that apply

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

<b>Section I</b>	<b>Active Diagnoses</b>
<b>Post-Transplant</b>	
<input type="checkbox"/>	<b>I7100. Lung Transplant</b>
<input type="checkbox"/>	<b>I7101. Heart Transplant</b>
<input type="checkbox"/>	<b>I7102. Liver Transplant</b>
<input type="checkbox"/>	<b>I7103. Kidney Transplant</b>
<input type="checkbox"/>	<b>I7104. Bone Marrow Transplant</b>
<b>None of the Above</b>	
<input type="checkbox"/>	<b>I7900. None of the above</b>

Section K

Swallowing/Nutritional Status

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

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

K0520. Nutritional Approaches

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

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

## Section M

## Skin Conditions

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

### M0210. Unhealed Pressure Ulcers/Injuries

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

Enter Number <input type="text"/>	<p><b>A. Stage 1:</b> 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. <b>Number of Stage 1 pressure injuries</b></p>
Enter Number <input type="text"/>	<p><b>B. Stage 2:</b> 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. <b>Number of Stage 2 pressure ulcers</b></p>
Enter Number <input type="text"/>	<p><b>C. Stage 3:</b> 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. <b>Number of Stage 3 pressure ulcers</b></p>
Enter Number <input type="text"/>	<p><b>D. Stage 4:</b> 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. <b>Number of Stage 4 pressure ulcers</b></p>
Enter Number <input type="text"/>	<p><b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device</p> <p>1. <b>Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b></p>
Enter Number <input type="text"/>	<p><b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. <b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b></p>
Enter Number <input type="text"/>	<p><b>G. Unstageable - Deep tissue injury</b></p> <p>1. <b>Number of unstageable pressure injuries presenting as deep tissue injury</b></p>

<b>Section N</b>		<b>Medications</b>
<b>N2001. Drug Regimen Review</b>		
Enter Code <div></div>	<b>Did a complete drug regimen review identify potential clinically significant medication issues?</b> 0. <b>No - No issues found during review</b> → <i>Skip to O0100, Special Treatments, Procedures, and Programs</i> 1. <b>Yes - Issues found during review</b> → <i>Continue to N2003, Medication Follow-up</i> 9. <b>NA - Patient is not taking any medications</b> → <i>Skip to O0100, Special Treatments, Procedures, and Programs</i>	
<b>N2003. Medication Follow-up</b>		
Enter Code <div></div>	<b>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?</b> 0. <b>No</b> 1. <b>Yes</b>	



## Section O Special Treatments, Procedures, and Programs

### 00100. Special Treatments, Procedures, and Programs

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

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

Section O		Special Treatments, Procedures, and Programs	
<b>O0150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay</b>			
Enter Code <div></div>	<b>A. Invasive Mechanical Ventilation Support upon Admission to the LTCH</b> 0. <b>No, not on invasive mechanical ventilation support</b> → <i>Skip to O0250, Influenza Vaccine</i> 1. <b>Yes, weaning</b> → <i>Continue to O0150B, Assessed for readiness for SBT by day 2 of the LTCH stay</i> 2. <b>Yes, non-weaning</b> → <i>Skip to O0250, Influenza Vaccine</i>		
Enter Code <div></div>	<b>B. Assessed for readiness for SBT by day 2 of the LTCH stay</b> (Note: Day 2 = Date of Admission to the LTCH (Day 1) + 1 calendar day) 0. <b>No</b> → <i>Skip to O0250, Influenza Vaccine</i> 1. <b>Yes</b> → <i>Continue to O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay</i>		
Enter Code <div></div>	<b>C. Deemed medically ready for SBT by day 2 of the LTCH stay</b> 0. <b>No</b> → <i>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?</i> 1. <b>Yes</b> → <i>Continue to O0150E, SBT performed by day 2 of the LTCH stay</i>		
Enter Code <div></div>	<b>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?</b> 0. <b>No</b> → <i>Skip to O0250, Influenza Vaccine</i> 1. <b>Yes</b> → <i>Skip to O0250, Influenza Vaccine</i>		
Enter Code <div></div>	<b>E. SBT performed by day 2 of the LTCH stay</b> 0. <b>No</b> 1. <b>Yes</b>		
<b>O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.</b>			
Enter Code <div></div>	<b>A. Did the patient receive the influenza vaccine in this facility</b> for this year's influenza vaccination season? 0. <b>No</b> → <i>Skip to O0250C, If influenza vaccine not received, state reason</i> 1. <b>Yes</b> → <i>Continue to O0250B, Date influenza vaccine received</i>		
	<b>B. Date influenza vaccine received</b> → <i>Complete date and skip to Z0400, Signature of Persons Completing the Assessment</i>  <div> <div>—</div> <div>—</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>		
Enter Code <div></div>	<b>C. If influenza vaccine not received, state reason:</b> 1. <b>Patient not in this facility during this year's influenza vaccination season</b> 2. <b>Received outside of this facility</b> 3. <b>Not eligible</b> - medical contraindication 4. <b>Offered and declined</b> 5. <b>Not offered</b> 6. <b>Inability to obtain influenza vaccine</b> due to a declared shortage 9. <b>None of the above</b>		

Section Z

Assessment Administration

Z0400. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

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

Z0500. Signature of Person Verifying Assessment Completion

<div>A. Signature:</div>	<div>B. LTCH CARE Data Set Completion Date:</div> <div>— —</div> <div>Month Day Year</div>
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