Change Table: LTCH CARE Data Set V 2.01 to DRAFT Corrected V 3.00

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 2.01	LTCH CARE Data Set V 3.00	Rationale for Change
1.	All	N/A	Version 2.01	Version 3.00	N/A
2.	Planned Discharge	A2500	**Program Interruption(s)** 0. **No ->** *Skip to M0210, Unhealed Pressure Ulcer(s)* 1. **Yes ->** *Continue to A2510, Number of Program Interruptions During This Stay in This Facility*	**Program Interruption(s)** 0. **No ->** *Skip to B0100. Comatose* 1. **Yes ->** *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	Revised to correct skip pattern.
3.	Unplanned Discharge	A2500	**Program Interruption(s)** 0. **No ->** *Skip to M0210, Unhealed Pressure Ulcer(s)* 1. **Yes ->** *Continue to A2510, Number of Program Interruptions During This Stay in This Facility*	**Program Interruption(s)** 0. **No ->** *Skip to C1610. Signs and Symptoms of Delirium (from CAM©)* 1. **Yes ->** *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	Revised to correct skip pattern.
4.	Planned Discharge, Unplanned Discharge	A2520	**A2520. Program Interruption Dates.** *Code only if A2510 is greater than or equal to 01.* A1. Most Recent Interruption Start Date A2. Most Recent Interruption End Date B1. Second Most Recent Interruption Start Date. *Code only if A2510 is greater than 01.* B2. Second Most Recent Interruption End Date. *Code only if A2510 is greater than 01.* C1. Third Most Recent Interruption Start Date. *Code only if A2510 is greater than 02.* C2. Third Most Recent Interruption End Date. *Code only if A2510 is greater than 02.*	N/A – delete item **A2520. Program Interruption Dates.** *Code only if A2510 is greater than or equal to 01.*	A2520 is deleted and replaced with A2525 to align interruption stay items with Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI).

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5.	Planned Discharge, Unplanned Discharge	A2525	N/A - new items	**A2525. Program Interruption Dates.** *Code only if A2510 is greater than or equal to 01.* A1. First Interruption Start Date A2. First Interruption End Date B1. Second Interruption Start Date *Code only if A2510 is greater than 01.* B2. Second Interruption End Date *Code only if A2510 is greater than 01.* C1. Third Interruption Start Date *Code only if A2510 is greater than 02.* C2. Third Interruption End Date *Code only if A2510 is greater than 02.* D1. Fourth Interruption Start Date *Code only if A2510 is greater than 03.* D2. Fourth Interruption End Date *Code only if A2510 is greater than 03.* E1. Fifth Interruption Start Date *Code only if A2510 is greater than 04.* E2. Fifth Interruption End Date *Code only if A2510 is greater than 04.*	A2520 is deleted and replaced with A2525 to align interruption stay items with IRF-PAI.
6.	Admission	B0100	**B0100. Comatose** **Persistent vegetative state/no discernible consciousness at time of assessment.** 0. **No** 1. **Yes**	**B0100. Comatose** **Persistent vegetative state/no discernible consciousness** 0. **No ->** *Continue to BB0700. Expression of Ideas and Wants* 1. **Yes ->** *Skip to C1610. Signs and Symptoms of Delirium (from CAM ©)*	Item revised to align with MDS 3.0.
7.	Planned Discharge	B0100	N/A – new item	**B0100. Comatose** **Persistent vegetative state/no discernible consciousness** 0. **No ->** *Continue to BB0700. Expression of Ideas and Wants* 1. **Yes ->** *Skip to C1610. Signs and Symptoms of Delirium (from CAM ©)*	New item added to collect data for function quality measures.

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8.	Admission, Planned Discharge	BB0700	N/A – new item	**BB0700. Expression of Ideas and Wants** (3-day assessment period) **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	New item added to collect data for function quality measures.
9.	Admission, Planned Discharge	BB0800	N/A – new item	**BB0800. Understanding Verbal Content** (3-day assessment period) **Understanding Verbal Content** (with hearing aid or device, if used and excluding language barriers) 4. **Understands:** Clear comprehension without cues or repetitions 3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. **Rarely/Never Understands**	New item added to collect data for function quality measures.

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10.	Admission, Planned Discharge, Unplanned Discharge	C1610A C1610B C1610C C1610D C1610E C1610E1 C1610E2	N/A – new items	**C1610. Signs and Symptoms of Delirium (from CAM©)** Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period) **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? **Inattention** **C.** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **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? **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)	New items added to collect data for function quality measures.

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11.	Admission, Planned Discharge, Unplanned Discharge	C1610	N/A	*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.*	New language added to indicate CAM© items are used in the LTCH CARE Data Set with permission from copyright holder.
12.	Admission	GG0100B	N/A – new item	**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. **B. Indoor Mobility (Ambulation):** Did the patient need 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? **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**	New item added to collect data for function quality measures.

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13.	Admission	GG0110A GG0110B GG0110C GG0110Z	N/A – new items	**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. **Check all that apply** **A. Manual wheelchair** **B. Motorized wheelchair or scooter** **C. Mechanical lift** **Z. None of the above**	New items added to collect data for function quality measures.
14.	Admission	GG0130 GG0170	N/A – new label	**1. Admission Performance**	New label to indicate patient's usual performance at admission.
15.	Admission	GG0130 GG0170	N/A – new label	**2. Discharge Goal**	New label to indicate patient's discharge goal(s).
16.	Planned Discharge	GG0130 GG0170	N/A – new label	**3. Discharge Performance**	New label to indicate patient's usual performance at discharge.
17.	Admission	GG0130A GG0130B GG0130C GG0130D	N/A – new items	**Section GG Functional Abilities and Goals** **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.** **Admission Performance and Discharge Goal** **A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and	New items added to collect data for function quality measures.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 2.01	LTCH CARE Data Set V 3.00	Rationale for Change
				to the mouth, and manage equipment for soaking and rinsing them.] **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. **D. Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	
18.	Planned Discharge	GG0130A GG0130B GG0130C GG0130D	N/A – new items	**Section GG Functional Abilities and Goals** **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.** **Discharge Performance** **A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	New items added to collect data for function quality measures.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 2.01	LTCH CARE Data Set V 3.00	Rationale for Change
				D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	
19.	Admission	GG0160A GG0160B GG0160C	**Section GG Functional Status: Usual Performance** **GG0160. Functional Mobility** (Complete during the 3-day assessment period.) **A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back. **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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.	N/A – delete Section GG header and item **GG0160. Functional Mobility** (Complete during the 3-day assessment period.)	Section GG Functional Status: Usual Performance and items GG0160A, B, and C are deleted and replaced with Section GG Functional Abilities and Goals and items GG0170A, B, and C.
20.	Admission	GG0170A GG0170B GG0170C GG0170D GG0170E GG0170F GG0170H1 GG0170I GG0170J GG0170K GG0170Q1 GG0170R GG0170RR1 GG0170S GG0170SS1	N/A – new items	**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.** **Admission Performance and Discharge Goal** **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back. **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.	New items added to collect data for function quality measures. GG0170A, B, and C replaced GG0160A, B, and C.

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				C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. **D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed. **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). **F. Toilet transfer:** The ability to safely get on and off a toilet or commode. **H1. Does the patient walk?** **0. No,** and walking goal **is not** clinically indicated **->** *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* **1. No,** and walking goal **is** clinically indicated **->** *Code the patient's Discharge Goal(s) for items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?* **2. Yes ->** *Continue to GG0170I. Walk 10 feet* **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space. **J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns. **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. **Q1. Does the patient use a wheelchair/scooter?** **0. No ->** *Skip to H0350. Bladder Continence*	

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				1. Yes -> *Continue to GG0170R. Wheel 50 feet with two turns* **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. **RR1. Indicate the type of wheelchair/scooter used.** **1. Manual** **2. Motorized** **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **SS1. Indicate the type of wheelchair/scooter used.** **1. Manual** **2. Motorized**	
21.	Planned Discharge	GG0170A GG0170B GG0170C GG0170D GG0170E GG0170F GG0170H3 GG0170I GG0170J GG0170K GG0170Q3 GG0170R GG0170RR3 GG0170S GG0170SS3	N/A – new items	**Section GG Functional Abilities and Goals** **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.** **Discharge Performance** **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back. **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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	New items added to planned discharge to collect data for function quality measures.

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				D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed. **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). **F. Toilet transfer:** The ability to safely get on and off a toilet or commode. **H3. Does the patient walk?** **0. No ->** *Skip to GG0170Q3. Does the patient use a wheelchair/scooter?* **2. Yes ->** *Continue to GG0170I. Walk 10 feet* **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space. **J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns. **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. **Q3. Does the patient use a wheelchair/scooter?** **0. No ->** *Skip to H0350. Bladder Continence* **1. Yes ->** *Continue to GG0170R. Wheel 50 feet with two turns* **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/scooter used.** **1. Manual** **2. Motorized**	

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				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/scooter used.** **1. Manual** **2. Motorized**	
22.	Admission, Planned Discharge	H0350	N/A – new item	**H0350. Bladder Continence** (3-day assessment period) **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)	New items added to collect data for function quality measures.
23.	Admission	H0400	**H0400. Bowel Continence** (Complete during the 3-day assessment period.)	**H0400. Bowel Continence** (3-day assessment period)	Revised to align with similar language used across LTCH CARE Data Set V 3.0.
24.	Admission	I0050	N/A – new item	**I0050. Indicate the patient's primary medical condition category.** **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)	New items added to collect data for function quality measures.

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				5. Other medical condition If "other medical condition", enter the ICD code in the boxes.	
25.	Admission	I0050A	N/A – new item	I0050A. [ICD code]	New item added to collect data for function quality measures.
26.	Admission	I0101 I1501 I1502 I2101 I2600 I4100 I4501 I4801 I4900 I5000 I5101 I5102 I5110 I5200 I5250 I5300 I5450 I5460 I5470 I7900	N/A – new items	**Comorbidities and Co-existing Conditions** **Check all that apply** **Cancers** **I0101. Severe and Metastatic Cancers** **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** **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**	New items added to collect data for function quality measures.

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				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** **I5460. Locked-In State** **I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain** **None of the Above** **I7900. None of the above**	
27.	Admission	I2900	**Metabolic** **I2900. Diabetes Mellitus (DM)**	**Metabolic** **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)	Revised item language to align with MDS 3.0.
28.	Admission	I5600 I5601	**Nutritional** **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition	**Nutritional** **I5601. Malnutrition** (protein or calorie) **I5602. At Risk for Malnutrition**	I5600 is deleted and replaced with I5601 and I5602.
29.	Planned Discharge, Unplanned Discharge	J1800	N/A – new item	**J1800. Any Falls Since Admission** Has the patient **had any falls since admission?** **0. No ->** *Skip to M0210. Unhealed Pressure Ulcer(s)* **1. Yes ->** *Continue to J1900. Number of Falls Since Admission*	New items added to collect data for falls quality measure.
30.	Expired	J1800	N/A – new item	**J1800. Any Falls Since Admission** Has the patient **had any falls since admission?** **0. No ->** *Skip to Z0400. Signature of Persons Completing the Assessment* **1. Yes ->** *Continue to J1900. Number of Falls Since Admission*	New items added to collect data for falls with major injury quality measure.

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31.	Planned Discharge, Unplanned Discharge, Expired	J1900A J1900B J1900C	N/A – new item	**J1900. Number of Falls Since Admission** **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	New item added to collect data for falls with major injury quality measure.
32.	Admission	K0200B	**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, etc.)	**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).	Revised item language to remove “etc.”
33.	Admission	M0210	**M0210. Unhealed Pressure Ulcer(s). Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No ->** *Skip to O0250, Influenza Vaccine.* 1. **Yes ->** *Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage.*	**M0210. Unhealed Pressure Ulcer(s). Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No ->** *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes ->** *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	Revised to correct skip pattern.

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34.	Admission	M0300B1 M0300C1 M0300D1 M0300E1 M0300F1	M0300B1. **Number of Stage 2 pressure ulcers**- If 0 -> *Skip to M0300C, Stage 3* M0300C1. **Number of Stage 3 pressure ulcers-** If 0 -> *Skip to M0300D, Stage 4* M0300D1. **Number of Stage 4 pressure ulcers-** If 0 -> *Skip to M0300E, Unstageable: Nonremovable dressing/device* M0300E1. **Number of unstageable pressure ulcers due to nonremovable dressing/device-** If 0 ->*Skip to M0300F, Unstageable: Slough and/or eschar* M0300F1. **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* M0300G1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 -> *Skip to O0250, Influenza Vaccine*	**N/A – deleted skip pattern following each item noted below:** M0300B1. **Number of Stage 2 pressure ulcers** M0300C1. **Number of Stage 3 pressure ulcers** M0300D1. **Number of Stage 4 pressure ulcers** M0300E1. **Number of unstageable pressure ulcers due to non-removable dressing/device** M0300F1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** M0300G1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	Revised items on admission to address new skip pattern due to item change.
35.	Admission	M0300B2 M0300C2 M0300D2 M0300E2 M0300F2 M0300G2	**M0300. Number of these Stage X pressure ulcers that were present upon admission** - enter how many were noted at the time of admission	**N/A – deleted items: M0300B2-C2-D2-E2-F2-G2 and associated text**	Items are deleted to reduce burden associated with duplicative items.

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36.	Planned Discharge, Unplanned Discharge	M0300B1 M0300C1 M0300D1 M0300E1 M0300F1 M0300G1	**M0300B1. Number of Stage 2 pressure ulcers** - If 0 -> *Skip to M0300C, Stage 3* **M0300C1. Number of Stage 3 pressure ulcers-** If 0 -> *Skip to M0300D, Stage 4* **M0300D1. Number of Stage 4 pressure ulcers** - If 0 -> *Skip to M0300E, Unstageable: Nonremovable dressing* **M0300E1. Number of unstageable pressure ulcers due to nonremovable dressing/device** - If 0 -> *Skip to M0300F, Unstageable: Slough and/or eschar* **M0300F1. 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* **M0300G1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 -> *Skip to M0800, Worsening in Pressure Ulcer Status Since Prior Assessment*	**M0300B1. Number of Stage 2 pressure ulcers** - If 0 -> *Skip to M0300C. Stage 3* **M0300C1. Number of Stage 3 pressure ulcers-** If 0 -> *Skip to M0300D. Stage 4* **M0300D1. Number of Stage 4 pressure ulcers** - If 0 -> *Skip to M0300E. Unstageable - Non-removable dressing* **M0300E1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 -> *Skip to M0300F. Unstageable - Slough and/or eschar* **M0300F1. 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* **M0300G1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 -> *Skip to M0800. Worsening in Pressure Ulcer Status Since Admission*	Revised to align with similar formatting used across LTCH CARE Data Set V 3.0. M0300G1 is revised to correct skip pattern.
37.	Planned Discharge, Unplanned Discharge	M0800	**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior	**M0800. Worsening in Pressure Ulcer Status Since Admission** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. If no current pressure ulcer at a given stage, enter 0	Revised item. Added M0800D, E, and F to support measure development.

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 2.01	LTCH CARE Data Set V 3.00	Rationale for Change
			assessment. If no current pressure ulcer at a given stage, enter 0 **A. Stage 2** **B. Stage 3** **C. Stage 4**	**A. Stage 2** **B. Stage 3** **C. Stage 4** **D. Unstageable - Non-removable dressing** **E. Unstageable - Slough and/or eschar** **F. Unstageable - Deep tissue injury**	
38.	Admission	O0100F3 O0100F4 O0100G O0100J O0100N O0100Z	N/A – new items	**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. **Respiratory Treatments** **F3. Invasive Ventilator: weaning** **F4. Invasive Ventilator: non-weaning** **G. Non-invasive Ventilator (BIPAP, CPAP)** **Other Treatments** **J. Dialysis** **N. Total Parenteral Nutrition** **None of the Above** **Z. None of the above**	New items added to collect data for function quality measures.