

3. For **each** pressure ulcer/injury identified on **admission**, code the number of pressure ulcers/injuries at each stage in items M0300A-G1 on the Admission assessment. Any pressure ulcer/injury identified and coded in M0300A-G1 on the Admission assessment, is assumed to have been **present on admission**.
4. Review for location and stage of pressure ulcers/injuries at the time of discharge. For **each** pressure ulcer/injury identified on **discharge**, code the number of pressure ulcers/injuries at each stage in items M0300A-G1 on the Discharge assessment. Then for each pressure ulcer/injury identified in M0300B1-G1 on discharge, determine whether that pressure ulcer/injury was present at the time of admission at that stage.
 - If the pressure ulcer/injury that is assessed on discharge was present on admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at that higher stage on discharge. That higher stage **should not be coded as present on admission** in items M0300B2-G2 on the Discharge assessment. In this instance, the discharge present on admission item for that higher numerical stage would be coded as 0.
 - If on admission a pressure ulcer/injury was unstageable, but becomes and remains numerically stageable later in the patient's stay, it **should be coded as present on admission on the Discharge assessment at the stage at which it first becomes numerically stageable**. However, if that same pressure ulcer/injury subsequently **increases** in numerical stage, it would be coded at that higher stage and **should not be coded as present on admission on the Discharge assessment**.
 - If a patient is discharged to another facility/hospital for longer than 3 calendar days and subsequently returns to the LTCH, and a current pressure ulcer increases in numerical stage, **it is coded at the higher stage on the patient's new Admission assessment for the second LTCH stay**.
 - Clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that patient clinical Admission assessments are completed as close to the actual time of admission as possible, and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the LTCH CARE Data Set Admission assessment would be coded based on that assessment and coincide with the findings that were completed within that same timeframe.
 - **If a patient is admitted to an LTCH with a healed pressure ulcer/injury, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and would not be coded as present on admission on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new, or facility acquired.**
 - The 3-day assessment period used in the LTCH CARE Data Set is not intended to replace the timeframe required for clinical Admission assessments as established by accepted standards of practice, facility policy, and State and Federal regulations. Therefore, the LTCH CARE Data Set Admission assessment's sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are observed at the time of admission are based on the skin assessment that is in conjunction with the admission). So, if a patient that is clinically assessed upon admission has a pressure ulcer/injury identified and staged, that initial clinical assessment

is what should be used to assist in coding the LTCH CARE Data Set Admission assessment pressure ulcer/injury items. If the pressure ulcer/injury that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day LTCH assessment period, the **initial** stage of the pressure ulcer/injury would be documented on the LTCH CARE Data Set Admission assessment. The higher numerical stage (i.e., worsening pressure ulcer/injury) would be captured on the LTCH CARE Data Set Discharge assessment (unless it heals) and would not be coded as present on admission.