

### ADMISSION SAMPLE RECORD REVIEW

Facility Name: \_\_\_\_\_ Facility ID: \_\_\_\_\_ Date: \_\_\_\_\_

Surveyor Name: \_\_\_\_\_

Resident Name: \_\_\_\_\_ Resident ID: \_\_\_\_\_ Admit Date: \_\_\_\_\_ Resident Room: \_\_\_\_\_

For each resident use the admission date identified on the Stage 1 screen or in the Admission Sample report to complete this review.

<b>*Exclusions</b>	
<b>If the ASE-Q has MDS data for the resident, the terminal prognosis question will be inapplicable (will have a check mark) in the ASE-Q, and the surveyor does not need to answer this question.</b>	
1) Did the resident have an explicit terminal prognosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Was the resident's length of stay at this facility at least 15 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>B Death QP059</b>	
<b>If the resident has an explicit terminal prognosis, skip to Hospitalization.</b>	
1) Did the resident die within 30 days of the nursing home admission?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>C Hospitalization QP058</b>	
1) Was the resident hospitalized (admission greater than 24 hours), for other than a planned elective surgery, within 30 days of the NH admission?	<input type="checkbox"/> No <input type="checkbox"/> Yes

### ADMISSION SAMPLE RECORD REVIEW

#### **D Pressure Ulcer QP109**

**Review the admission skin assessment, and all subsequent skin assessments, treatment records, nursing progress notes, and MDS. The MDS should be the last source type reviewed.**

- |                                                                                                            |                                                                                                 |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1) Did the resident develop a pressure ulcer in the first 30 days following admission to the nursing home? | <input type="checkbox"/> No<br><input type="checkbox"/> Yes<br><input type="checkbox"/> Unknown |
| 2) Was the resident admitted with one or more pressure ulcers?                                             | <input type="checkbox"/> No ( <b>skip to Weight Loss</b> )<br><input type="checkbox"/> Yes      |
| 3) Was there an increase in the stage of the ulcer(s)?                                                     | <input type="checkbox"/> No<br><input type="checkbox"/> Yes                                     |

If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

**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.

**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.

**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.

**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.

**Unstageable** – Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of the wound bed by slough or eschar.

**Suspected Deep Tissue Injury (sDTI)** – Suspected deep tissue injury in evolution. Localized area of discolored (darker than surrounding tissue) intact skin or blood-filled blister related to damage of underlying soft tissue from pressure and/or shear. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

### ADMISSION SAMPLE RECORD REVIEW

#### E Weight Loss QP105

Do **not** complete this section if the resident has an explicit terminal prognosis or a length of stay of less than 15 days.

1) Is the resident on a planned weight loss program?  No  
 Yes (review is complete)

2) Height and Weights:

**Height:** \_\_\_\_\_ (inches) If the ASE-Q has MDS data for the resident, the Height field will be gray (inapplicable), and the surveyor does not need to enter the resident's height.

**Date and weight closest to admission date:**      \_\_\_\_/\_\_\_\_/\_\_\_\_      **Weight:** \_\_\_\_\_ lbs.  Unavailable (review is complete)

**Date and weight closest to day 15 after admission:**      \_\_\_\_/\_\_\_\_/\_\_\_\_      **Weight:** \_\_\_\_\_ lbs.  Unavailable

**Date and weight closest to day 30 after admission:**      \_\_\_\_/\_\_\_\_/\_\_\_\_      **Weight:** \_\_\_\_\_ lbs.  Unavailable

**Date and weight closest to day 60 after admission:**      \_\_\_\_/\_\_\_\_/\_\_\_\_      **Weight:** \_\_\_\_\_ lbs.  Unavailable

**Note: The ASE-Q calculates the requested dates and percentage weight loss. Weight loss QCLIs are included in ASE-Q QCLI Results.**