# A1900: Admission Date (Date this episode of care in this facility began)

**A1900. Admission Date (Date this episode of care in this facility began)**

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Month Day Year

## Item Rationale

To document the date this episode of care in this facility began.

## Coding Instructions

Enter the date this episode of care in this facility began. Use the format: Month-Day- Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

The Admission Date may be the same as the Entry Date (A1600) for the entire stay (i.e., if the resident is never discharged).

## Examples

*Resident* H was admitted to the facility from an acute care hospital on 09/14/20*20* for rehabilitation after a hip replacement. In completing *their* Admission assessment, the facility entered 09/14/20*20* in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0*4*, *Short-Term General Hospital (acute hospital, IPPS)* in item A180*5*, Entered From; and entered 09/14/20*20* in item A1900, Admission Date.

The facility received communication from an acute care hospital discharge planner stating that *Resident* H, a former resident of the facility who was discharged home return not anticipated on 11/02/20*20* after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/20*21* and wished to return to the facility for rehabilitation after hospital discharge. *Resident* H returned to the facility on 2/15/20*21*. Although *Resident* H was a resident of the facility in September of 20*20*, *they were* discharged home return not anticipated; therefore, the facility rightly considered *Resident* H as a new admission. In completing *their* Admission assessment, the facility entered 02/15/20*21* in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0*4*, *Short-Term General Hospital (acute hospital, IPPS)* in item A180*5*, Entered From; and entered 02/15/20*21* in item A1900, Admission Date.

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*Resident* K was admitted to the facility on 10/05/20*20* and was discharged to the hospital, return anticipated, on 10/20/20*20*. *They* returned to the facility on 10/26/20*20*. Since *Resident* K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, *Resident* K was considered as continuing in *their* current stay. Therefore, when the facility completed *Resident K's* Entry Tracking Record on return from the hospital, they entered 10/26/20*20* in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 0*4*, *Short-Term General Hospital (acute hospital, IPPS)* in item A180*5*; and entered 10/05/20*20* in item A1900, Admission Date.

Approximately a month after *their* return, *Resident* K was again sent to the hospital, return anticipated on 11/05/20*20*. *They* returned to the facility on 11/22/20*20*. Again, since *Resident* K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, *Resident* K was considered as continuing in *their* current stay. Therefore, when the facility completed *Resident K's* Entry Tracking Record, they entered 11/22/20*20* in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 0*4*, *Short-Term General Hospital (acute hospital, IPPS)* in item A180*5*; and entered 10/05/20*20* in item A1900, Admission Date.

*Resident* S was admitted to the facility on 8/26/20*21* for rehabilitation after a total knee replacement. Three days after admission, *Resident* S spiked a fever and *their* surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent *Resident* S to the emergency room and completed *their* OBRA Discharge assessment as return anticipated. The hospital called the facility to inform them *Resident* S was admitted. A week into *their* hospitalization, *Resident* S developed a blood clot in *their* affected leg, further complicating *their* recovery. The facility was contacted to readmit *Resident* S for rehabilitative services following discharge from the hospital on 10/10/20*21*. Even though *Resident* S was a former patient in the facility's rehabilitation unit and was discharged return anticipated, *they* did not return within 30 days of discharge to the hospital. Therefore, *Resident* S is considered a new admission to the facility. On *their* return, when the facility completed *Resident* S's Admission assessment, they entered 10/10/20*21* in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0*4*, *Short-Term General Hospital (acute hospital, IPPS)* in item A180*5*, Entered From; and entered 10/10/20*21* in item A1900, Admission Date.

## Coding Tips and Special Populations

Both swing bed facilities and nursing homes must apply the above instructions for coding items A1600 through A1900 to determine whether a patient or resident is an admission/entry or reentry.

In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

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If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same.

If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900.

Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1805 (Entered From). It is also tied to the concepts of a "stay" and an "episode." A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident's time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.

A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.

When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1805 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1805 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began *their* first stay in the episode).