HealthTech

SWING BED BASICS for KOSCP October 2025 1:00 – 2:00

Carolyn St.Charles
Chief Clinical Officer, HealthTech

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

HealthTech

Thank You for Having Me Back Again!

Disclaimer

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive.

HealthTech and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof.

HealthTech does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel.

HealthTech recommends that hospitals, clinics, their respective personnel, and all other third-party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters

HealthTech

1. How long have you been your role?
   * Less than a year
   * 1 – 5 years
   * More than 5 years

2. On a scale of 1 – 10 how successful do you think your Swing Bed program is?

3. What is the most important thing you would like to learn from today's presentations?

HealthTech

Ask Questions
Learn From Each Other

Resources

1. Crosswalk Appendix W and Appendix PP
2. Comprehensive Assessment by Discipline
3. Continuous Survey Readiness Tool for Swing Bed
4. Continuous Survey Readiness Tool for Intermediate Swing Bed

HealthTech

A Little History

Swing Bed History

The swing bed was a solution offered by Dr. Bruce Walter, a physician who was Utah's director of Medicare services back in the late 1970s and early '80s. Walter's swing bed concept, with its six potential reimbursement options, was a model he envisioned to be

"*Utilized in small hospitals, urban and rural, across the country*."

"Such a program nationwide should not be measured merely in terms of balance sheets and occupancy percentages, but also in terms of personal benefits gained by patients and their families."

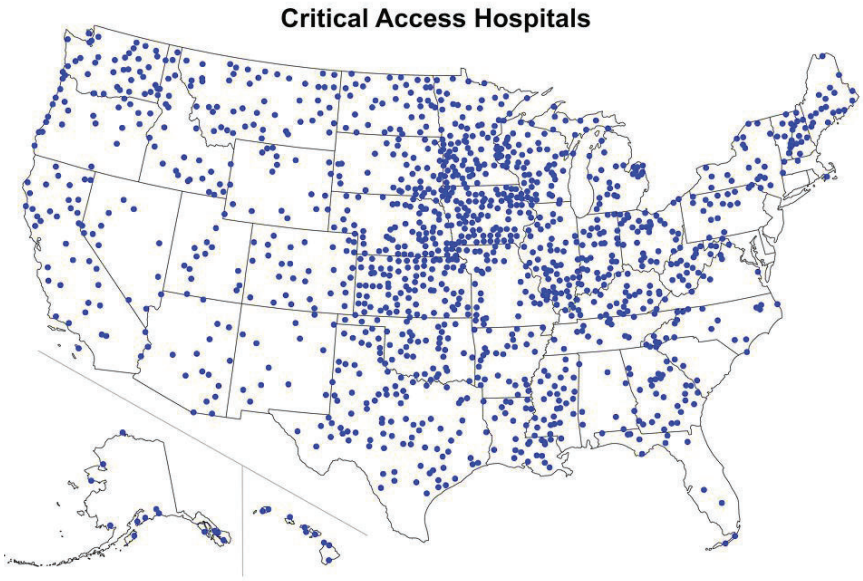
Swing Bed History

In 1973, the Health Care Financing Administration (HCFA), then part of the Social Security Administration, funded the Utah Cost Improvement Project (UCIP) in response to the need for SNF beds and to make better use of under-occupied rural hospitals.

Federal regulations for the program were published on July 20, 1982 and amended on September 1, 1983.

Today, the term "swing bed" refers to acute care hospital beds that can be used interchangeably for the skilled or intermediate care patient.

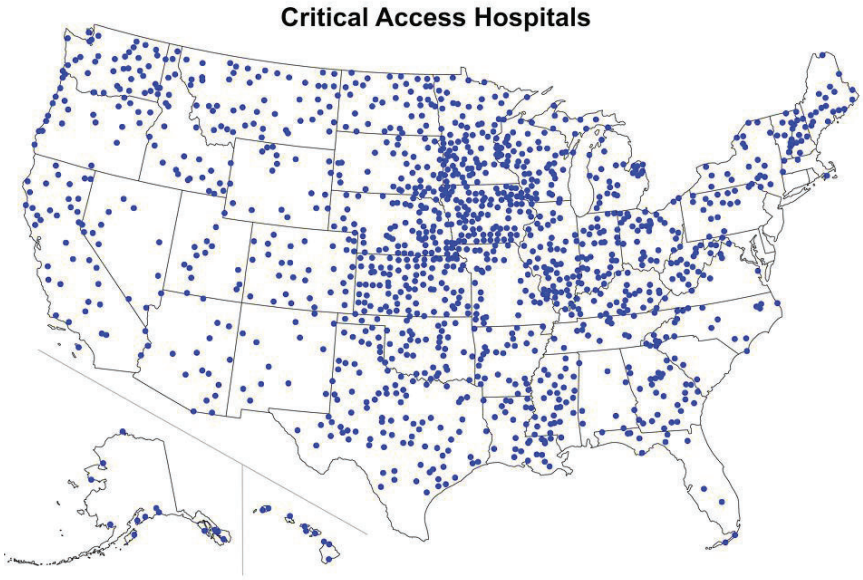
As of July 2025, there are 1,377 Critical Access Hospitals in the U.S.



RHIhub Rural Health Information Hub

Data Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, July 2025

Most have a Swing Bed program



RHIhub Rural Health Information Hub

Data Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, July 2025

HealthTech

Reimbursement

SNF or Swing Bed

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Post-hospital extended care services furnished to inpatients of a SNF or a swing bed hospital are covered under the hospital insurance program.

Such a hospital, known as a swing bed facility, can “swing” its beds between the hospital and SNF levels of care, on an as-needed basis, if it has obtained a swing bed approval from the Department of Health and Human Services.

When a hospital is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules.

The regs. frequently use term SNF which also includes Swing Bed

Reimbursement & Coverage for Medicare

Medicare Claims Processing Manual Chapter 3
Duration of Covered Inpatient Services

Medicare Claims Processing Manual Chapter 4
Part B Hospital (Including Inpatient Hospital Part B and OPPS)

Medicare Claims Processing Manual Chapter 6
SNF Inpatient Part A Billing and SNF Consolidated Billing

Medicare Benefit Policy Manual Chapter 8 (Admission and Continued Stay Requirements)
Coverage of Extended Care (SNF) Services

Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections
Claims data, including Required Patient Notices

Medicare Reimbursement

Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
60 - Swing-Bed Services
Swing-bed services must be billed separately from inpatient hospital services.

Note that CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)).

Medicare Benefit Policy Manual Chapter 8
10.3 - Hospital Providers of Extended Care Services
A patient in a swing bed cannot simultaneously receive coverage for both SNF-level services under Part A and inpatient hospital ancillary services under Part B.

Bundling

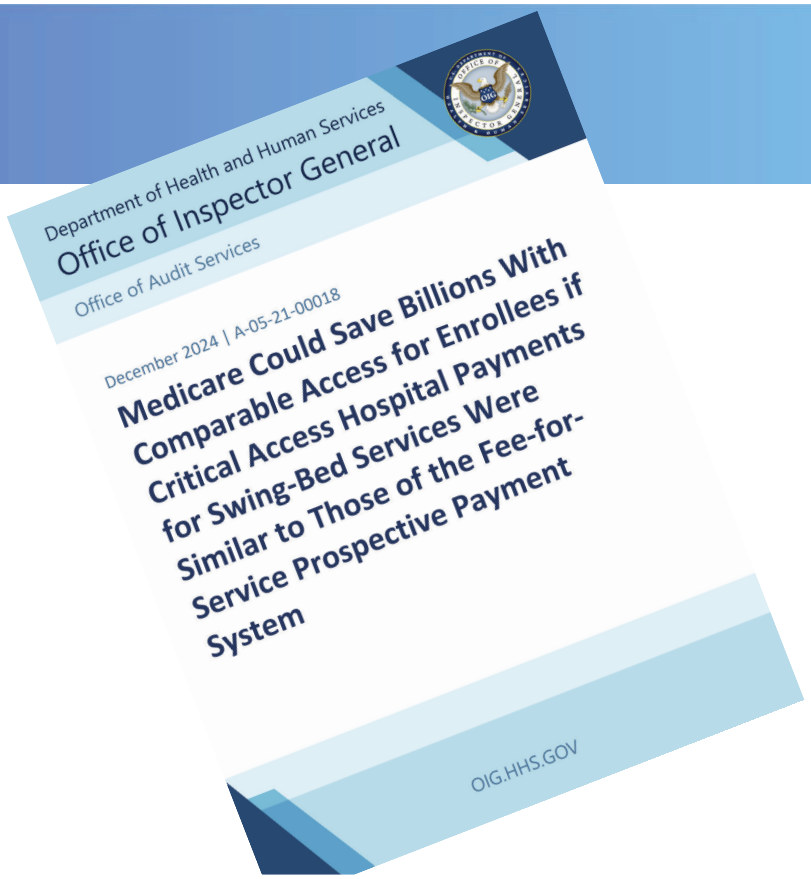
Basically, ALL services provided to the patient while they are in the Swing Bed are included in the per-diem reimbursement.

That means all services need to be included as part of the Part A (inpatient) bill and CANNOT be billed under Part B (outpatient).

If a patient needs a procedure that could potentially be done as an outpatient, it must still be included in the Swing Bed bill under Part A.

If an outpatient service is NOT related to the Swing Bed stay (i.e., dialysis), most experts believe this service can be billed separately.

It also means the patient **should not** be discharged from Swing Bed – receive the procedure – and then readmitted to Swing Bed.



HealthTech

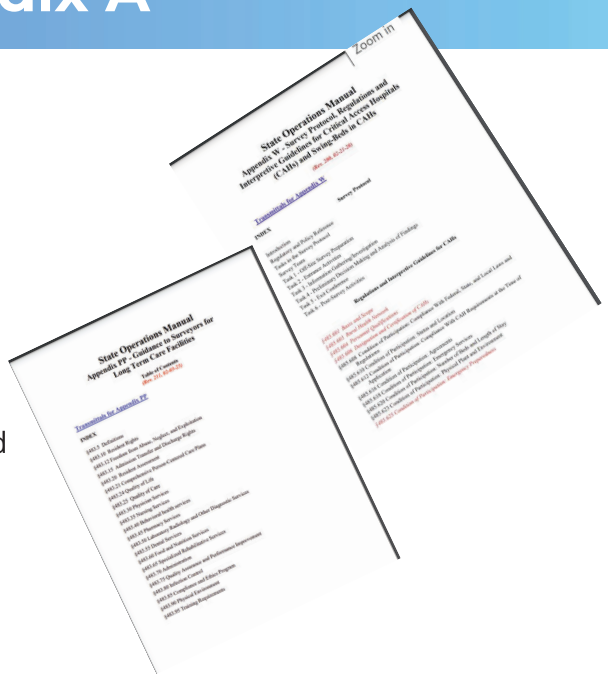
Regulatory Requirements

Swing Bed Conditions of Participation Appendix W and Appendix A

The Conditions of Participation Appendix W and Appendix A outline the regulatory requirements for the care of a patient in a Swing Bed

Requirements apply to **ALL** Swing Bed patients regardless of payor

The Interpretive Guidelines for the care of Swing Bed patients are in Appendix PP (Long Term Care Facilities)



Appendix W ---- 12 Tags for Swing Bed OTHER Regs. in Appendix W also apply

C-1600 §485.645 **Special Requirements** for CAH Providers of Long-Term Care Services ("Swing-Beds")

C-1600 §485.645(a) **Eligibility**

C-1604 §485.645(b) **Eligibility**

C-1606 §485.645(c) **Payment**

C-1608 §485.645(d) **SNF Services/Resident Rights**

C-1610 (§485.645(d)(2) **Admission, Transfer and Discharge Rights**

C-1612 §485.645(d)(3) **Freedom from abuse, neglect and exploitation**

C-1616 §485.645(d)(4) **Social Services**

C-1620 §485.645(d)(5) **Comprehensive assessment, comprehensive care plan, and discharge planning**

C-1622 §485.645(d)(6) **Specialized Rehabilitative Services**

C-1624 §485.645(d)(7) **Dental Services**

C-1626 §485.645(d)(8) **Nutrition**

Appendix A ---- 12 Tags OTHER Regs. in Appendix A also apply

A-0629 §482.28(b) **Nutrition** (not specific to Swing Bed)

A-1500 §482.58 **Special requirements**

A-1501 §482.58 (a) **Eligibility.** A hospital must meet the following eligibility requirements:

A-1562 §482.58(b) **Resident Rights**

A-1564 §482.58(b)(2) **Admission, transfer, and discharge rights**

A-1566 §482.58(b)(3) **Freedom from abuse, neglect, and exploitation**

A-1568 §482.58(b)(4) **Patient activities**

A-1569 §482.58(b)(5) **Discharge**

A-1567 §482.58(b)(4); A-1570 §482.58(b)(5) **Social services**

A-1572 §482.58(b)(6) **Discharge planning**

A-1574 §482.58(b)(7) **Rehab**

A-1576 §482.58(b)(8) **Dental services**

Differences between Appendix W and Appendix A

1. **Appendix A does not include a requirement for assessment or development of a plan of care.** Acute care hospitals with distinct part Swing Bed services are required to complete and submit a MDS (which includes assessment information) and forms the basis for the plan of care.

2. **Activities** are not required for CAHs (kind of) but are still required in acute care hospitals with a distinct part Swing Bed service.

NO Interpretive Guidelines in Appendix W or Appendix A

C-1626 §485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).

Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health.

Interpretive Guidelines §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

Appendix PP
Interpretive Guidelines (kinda')

F-800 §483.60 Food and nutrition services
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

INTENT §483.60
To ensure that facility staff support the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet.

GUIDANCE §483.60
This requirement expects that there is ongoing communication and coordination among and between staff within all departments to ensure that the resident assessment, care plan and actual food and nutrition services meet each resident's daily nutritional and dietary needs and choices. While it may be challenging to meet every residents' individual preferences, incorporating a residents' preferences and dietary needs will ensure residents are offered meaningful choices in meals/diets that are nutritionally adequate and satisfying to the individual. Reasonable efforts to accommodate these choices and preferences must be addressed by facility staff. Also, cite this Tag if there are overall systems issues relating to how the facility manages and executes its food and nutrition services.

Appendix PP ---- 22 Tags
(Rev. 225; Issued: 08-08-24)

- §483.5 Definitions
- §483.10 Resident Rights
- §483.12 Freedom from Abuse, Neglect, and Exploitation
- §483.15 Admission Transfer and Discharge Rights
- §483.20 Resident Assessment
- §483.21 Comprehensive Person-Centered Care Plans
- §483.24 Quality of Life
- §483.25 Quality of Care
- §483.30 Physician Services
- §483.35 Nursing Services
- §483.40 Behavioral health services
- §483.45 Pharmacy Services
- §483.50 Laboratory Radiology and Other Diagnostic Services
- §483.55 Dental Services
- §483.60 Food and Nutrition Services
- §483.65 Specialized Rehabilitative Services
- §483.70 Administration
- §483.75 Quality Assurance and Performance Improvement
- §483.80 Infection Control
- §483.85 Compliance and Ethics Program
- §483.90 Physical Environment
- §483.95 Training Requirements

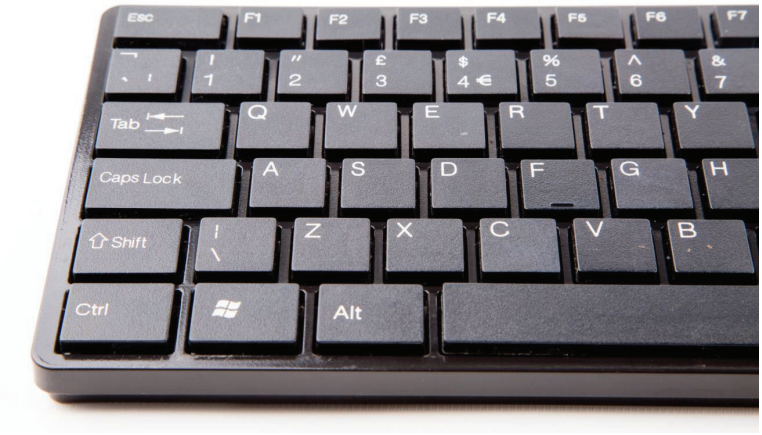
<u>Only some will apply to Swing Bed</u>
There needs to be a link between the Swing Bed requirement and the Appendix PP regulation – which is not always easy to find

Twists and Turns and Twists and Turns and .....

There is NO straight-forward / easy way to find Interpretive Guidelines in Appendix PP for Swing Bed

Control F – Your New Best Friend

You can use Control F to search for a specific word / topic but this may bring up multiple (or no) references



Crosswalk Appendix W and Appendix PP

Abuse, Neglect, Exploitation, and Misappropriation of Property	**C-1612**	**F540** **F600** **F602** **F603** **F-04**	**F605** **F606** **F607** **F609** **F943**
Activities	No specific requirement other than to meet psychosocial needs	F561	F679
Admission Process and Disclosures	C-1102	F555	F635
Baseline Plan of Care	NA	F655	
Certification and Recertification		F712	
Change in Condition		F726	
Choice of Physician	C-1608	F555	
Culturally Competent Trauma-Informed Care	C-1620	F699	
Dental Services	C-1624	F791	
Social Service	C-1616	F-745	
Visitation	C-1056	F563	F564

HealthTech

Medicare Admission Criteria

Admission Criteria

The criteria for admission and continued stay are specific to patients with traditional Medicare.

Other payors have their own

admission and length-of-stay rules


Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

For Example

Other payors can admit a patient to a swing bed from home or the emergency department or a provider office.....

without a 3-day qualifying stay which is required for traditional Medicare

Four Basic Criteria for Swing Bed

Medicare Benefits Manual Chapter 8
30 - Skilled Nursing Facility Level of Care – General

Care in a SNF is covered if <u>all of the following four factors are met</u>:

1. The patient requires skilled nursing services or skilled rehabilitation services,
    - i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4)
    - are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services

2. The patient requires these skilled services on a daily basis (see §30.6); and

Four Basic Criteria, cont.

3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7)

4. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury,
    - i.e., are consistent with the nature and severity of the individual's illness or injury,
    - the individual's particular medical needs,
    - and accepted standards of medical practice

The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

Treatment of the Same Condition As Hospital Stay

Medicare Benefits Manual Chapter 8
20.1 - Three-Day Prior Hospitalization (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.

30-Day Rule

Medicare Benefits Manual Chapter 8
20.1 - Three-Day Prior Hospitalization

The beneficiary must also have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §20.2.2 applies.

30-Day Rule Exception

Medicare Benefits Manual Chapter 8
20.2.2.1

An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

Readmission within 30 Days

Medicare Benefits Manual Chapter 8
20.2.3

If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met.

The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days after the first day of noncoverage.

Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.

HealthTech

Skilled Care

Principles for Determining Skilled Services

Medicare Benefits Manual Chapter 8
30.2.2 - Principles for Determining Whether a Service is Skilled

If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;

e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service.

Principles for Determining Skilled Services cont.

Medicare Benefits Manual Chapter 8
30.2.2 - Principles for Determining Whether a Service is Skilled

While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

Principles for Determining Skilled Services cont.

Medicare Benefits Manual Chapter 8
30.2.2 - Principles for Determining Whether a Service is Skilled

Maintenance Therapy
Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.

Skilled Nursing and Skilled Rehab

Medicare Benefits Manual Chapter 8
30.6 - Daily Skilled Services Defined

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-day-a-week.

Skilled Restorative Nursing – Skilled Nursing

- A skilled restorative nursing program to positively *affect* the patient's functional well-being, the expectation is that the program be rendered at least **7 days a week.**

Skilled Rehabilitative Therapy

- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and **receive those services on at least *5* days a week**. (If therapy services are provided less than *5* days a week, the "daily" requirement would not be met.)

Skilled Nursing

Medicare Benefits Manual Chapter 8
Skilled Nursing

30.2.3.1	Management and Evaluation of Plan of Care
30.2.3.2	Observation and Assessment of the Patient Condition
30.2.3.3	Teaching and Training
30.3	Direct Skilled Nursing Services to Patients

Skilled Nursing Examples

Medicare Benefits Manual Chapter 8
30.3 Direct Skilled Nursing Services to Patients

1. Intravenous or intramuscular injections and intravenous feeding
2. Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day
3. Naso-pharyngeal and tracheotomy aspiration
4. Insertion, sterile irrigation, and replacement of suprapubic catheters
5. Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception)
6. Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception)
7. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception)
8. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training program
9. Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
10. Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Skilled Therapy

Medicare Benefits Manual Chapter 8
30.4.1 General

Skilled physical therapy services must meet all of the following conditions:

The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that

the condition of the patient will improve materially in a reasonable and generally predictable period of time; or,

the services must be necessary for the establishment of a safe and effective maintenance program; or,

the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.

Maintenance Therapy

Medicare Benefits Manual Chapter 8
30.4.1.2 Application of Guidelines

Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.

NOT Skilled Care

Medicare Benefits Manual Chapter 8
30.5 - Nonskilled Supportive or Personal Care Services A3-3132.4, SNF-214.4

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

1. Administration of routine oral medications, eye drops, and ointments (the fact that patients cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);
2. General maintenance care of colostomy and ileostomy;
3. Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);
4. Changes of dressings for uninfected post-operative or chronic conditions;
5. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
6. Routine care of the incontinent patient, including use of diapers and protective sheets;
7. General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction);

NOT Skilled Care cont.

8. Routine care in connection with braces and similar devices;
9. Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
10. Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
11. Assistance in dressing, eating, and going to the toilet;
12. Periodic turning and positioning in bed; and
13. General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)

HealthTech

As A Practical Matter....

Services Provided on an Inpatient Basis As a Practical Matter

Medicare Benefits Manual Chapter 8
30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are **not available on an outpatient basis** in the area in which the individual resides **or transportation** to the closest facility would be:

- An excessive physical hardship - or
- Less economical – or
- Less efficient or effective than an inpatient institutional setting

Alternative Facilities or Services

30.7.1 Rationale Skilled Care
Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed. In determining the availability of more economical care alternatives, the coverage or non-coverage of that alternative care is not a factor to be considered.

Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases.

30.7.2 Rationale for Skilled Care
If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

30.7.3 More Economical Care
In determining the practicality of using more economical care alternatives, the A/B MAC (A) considers the patient's medical condition. **If the use of those alternatives would adversely affect the patient's medical condition, the A/B MAC (A) concludes that as a practical matter the daily skilled services can only be provided by a SNF on an inpatient basis.**

Alternative Facilities or Services

HOWEVER -----
30.7.1: The fact that Medicare cannot cover such care is irrelevant. **The issue is feasibility and not whether coverage is provided in one setting and not provided in another.** For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist.

However, the fact that Medicare payment could not be made for the services because an expense limitation (if applicable) to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

Documentation

In all of the examples, the common element is documentation that a skilled need exists – and that services are **not available or feasible on an outpatient basis!**

Without adequate documentation, the stay MAY be denied if there is an audit by the fiscal intermediary

HealthTech

Pre-Admission

Initial Review

All Potential Patients

- Comprehensive review of needs --- NO SURPRISES
- Needs can be met
- Team or at a minimum Care Manager and Provider agree to admission

Medicare

- 4 basic criteria met
- Medicare days available
- Inpatient within the last 30 days (or documented exception)
- Same condition as inpatient stay

Other Payors

- Pre-Authorization

Choice of Post-Acute Providers

C-1425: The CAH must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures**. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Federal Register: Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH, data on quality measures and data on resource use measures.

We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process.

Swing Bed Quality and Resource Use Data

Swing Bed: There is NO comparable / publicly available data for Swing Beds

Options

1. Provide patients with your internally collected data (recommended)

2. Provide patients with information from Hospital Compare (if available)
https://www.medicare.gov/care-compare/

3. Disclose that Swing Beds do not have publicly available data

Swing Bed Performance Measures Rural Health Research Center

1. **Discharge disposition** (e.g., number of swing-bed patients discharged home and to other settings; percent of swing-bed patients going back to same level of assistance as prior to stay; number of discharges to home or long-term care facility)
2. **Average length of stay** (e.g., average number of days for swing-bed stay, average length of stay compared to goal)
3. **Readmission** (e.g., number of swing-bed discharges readmitted to the CAH for acute care within 30 days; number of readmissions back to swing-bed; combined CAH acute care readmission rate for acute and swing-bed discharges
4. **Functional status** (e.g., admission and discharge scores on Barthel Index, Functional Independence Measure, or MDS Section GG; various physical therapy and occupational therapy tests to measure walking, gait and balance, sit to stand, and cognitive performance)
5. Process of care/teamwork (e.g., frequency of team rounds to patient bedside to discuss goals, updating of communication board in patient room, etc.)
6. **Patient Experience of Care/Patient Satisfaction** (e.g., HCAHPS survey for discharged swing-bed patients and inpatients combined, consultant-developed survey for discharged swing-bed patients, food satisfaction card with meals, post-discharge follow-up phone calls)
7. **Additional measures (e.g., falls, skin integrity, infections)**

Swing Bed Performance Measures Stroudwater

1. Return to Acute (unplanned)
2. Return to Acute Post 30-Day Discharge
3. Risk-adjusted Performance Improvement in Mobility
4. Risk-adjusted Performance Improvement in Self-Care
5. Discharge to Community

Which Facilities to Include

Identify facilities that provide skilled care in your geographic area:

1. Skilled Nursing Facilities
2. Other CAHs with Swing Beds

CMS does not specify for what geographic area you are required to provide data, but typically, it is your county or your service area.

Nursing Home Compare

For Skilled Nursing Facilities (SNF) quality and resource data is published on Nursing Home Compare (https://www.medicare.gov/care-compare/).

The information is not organized as quality and resource use measures. However, resource use is typically defined as spending per beneficiary and preventable readmissions.

Quality measures are generally related to care processes and outcomes, including functional status, skin integrity, falls or injuries, cognitive function, and medication management.

It is important to note that out of the seventeen indicators listed on Nursing Home Compare, six of the seventeen or 35% are related to improvements in functional status.

Nursing Home Compare

Overall rating

Above average

The overall rating is based on a nursing home's performance on 3 sources: health inspections, staffing, and quality measures.

Learn how Medicare calculates this rating

Health inspections

Above average

View Inspection Results

Staffing

Above average

View Staffing Information

Quality measures

Above average

View Quality Measures

Example

Facility Name	Overall Star Rating	Health Inspections	Quality Data				Resource Use Data	
			Overall Quality Rating	Short-Stay Quality Rating	Nursing Hours Per Patient Day	# of Patients	Return to prior residence	Readmission < 30 days
Hospital Swing Bed Program	NA*	NA*	NA*	NA*	12.0	6	74%	10%
Facility 1	1	1	1	1	4.1	66	40%	23%
Facility 2	3	3	3	3	4.2	43	45%	28%
Facility 3	5	5	5	5	4.5	25	50%	15%
Facility 4	1	1	1	1	4.0	46	30%	28%
Facility 5	2	2	2	2	3.8	52	55%	26%

You can also use an I-pad to go to Nursing Home Compare. (Pre-load those in your area.) But if you do this make sure you document. Ensocare for example has this option

If you develop a handout make sure you update whenever Nursing Home Compare data is updated

HealthTech

Admission

Distinct / Separate Medical Record

C-1102 §485.638(a)

When a patient reimbursement status changes from acute care services to swing bed services, **a single medical record may be used for both stays as long as the record is sectioned separately**.

Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.

(Most facilities open a new medical record with a new medical record number)

New History and Physical

C-1114 §485.638(a)(4)(ii)
Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

Interpretive Guidelines §485.638(a)(4)(ii) All or part of the history and physical exam (H & P) may be delegated to other practitioners in accordance with State law and CAH policy, but the MD/DO must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P.

HealthTech

Certification

Certification

Medicare General Information, Eligibility, and Entitlement Chapter 4
40 - Physician Certification and Recertification of Extended Care Services

Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.

There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met. Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

Note: Edited – not all text included

Certification, cont.

Medicare General Information, Eligibility, and Entitlement Chapter 4
40.1 - Who May Sign the Certification or Recertification for Extended Care Services

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case,

or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant)

who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Certification, cont.

Medicare General Information, Eligibility, and Entitlement Chapter 4
40.2 - Certification for Extended Care Services

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF (or for a new condition that arose while in the SNF for treatment of that ongoing condition).

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable

The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program

Note: Edited – not all text included

Initial Physician Certification

Patient Name **Admission Date**

I certify that _____ (name of patient) requires skilled care on a daily basis that as a practical matter can only be provided in an inpatient setting.

The Swing Bed admission is for an ongoing condition for which the patient was receiving inpatient hospital services before admission to Swing Bed.

The reasons the patient is being admitted to Swing Bed is for: (list reasons)

Expected length of stay ***Last two are only required at recertification – but recommended***

Expected discharge disposition (i.e., SNF, LTC, Assisted Living, Home)

Recertification

Medicare General Information, Eligibility, and Entitlement Chapter 4
40.3 - Recertifications for Extended Care Services
The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care.

The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress notes.

CANNOT BE SIGNED BY NP OR PA WITH DIRECT EMPLOYMENT RELATIONSHIP WITH HOSPITAL

Note: Edited – not all text included

Physician Re-Certification

Patient Name **Admission Date**

Reason(s) for continued Swing Bed Stay

Estimated Time patient will continue to need Swing Bed care

Expected discharge disposition (i.e., SNF, LTC, Assisted Living, Home)

Timing of Certification and Recertification

Medicare General Information, Eligibility, and Entitlement Chapter 4
40.2 - Certification for Extended Care Services

The first recertification must be made no later than the 14th day of inpatient extended care services.

A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

HealthTech

Admission Notices and Disclosures

Patient Admission Notices / Disclosures

- ❑ Description of Swing Bed (Recommended)
- ❑ Patient Rights and Responsibilities **(Required)**
- ❑ Visitation Rights (May be part of Patient Rights document)
- ❑ Advance Directives **(Required)**
  - A description of hospital policies regarding advance directives
  - Information – If the patient does not have an Advance Directive
  - Copy of the Advance Directive placed in the medical record if the patient has an advance directive
- ❑ Choice of physicians – and - Information on how to contact all providers, including consultants **(Required)**

Patient Admission Notices / Disclosures, cont.

- ❑ Financial Obligations **(Required)**
- ❑ Transfer and discharge rights (Required – may be part of Patient Rights)
- ❑ Notice of privacy practices (Required – may be the same as provided to all patients)
- ❑ Hospital responsibility for preventing patient abuse – how to report abuse (Recommended)
- ❑ Information for reporting abuse and neglect **(Required)**
- ❑ Contact information for Hospital and State Agencies, including State Ombudsman **(Required)**

Patient Admission Notices / Disclosures Example Signature Page

Signature Page

NAME OF HOSPITAL is required to provide you with certain information at the time you are admitted to a Swing Bed.

By signing this document, you acknowledge that ***Name of Hospital*** has gone over the documents listed below verbally in a language that you can understand and provide you with a written copy. ***Name of Hospital*** has given you the opportunity to ask any questions you may have. You may ask any questions you have at any time during your stay.

- ☐ Swing Bed General Information
- ☐ *Advance Directives
- ☐ Rights and Responsibilities
- ☐ *Choice of Physician
- ☐ Provider Contact Information
- ☐ Financial Obligations
- ☐ Privacy Practices
- ☐ Abuse and Neglect
- ☐ Transfer and Discharge
- ☐ Contact information for Hospital, QIO, and State Ombudsman

Patient Printed Name ---- Patient Signature ---- Date
Name and title of person who reviewed information with patient ---- **Date**

Patient Admission Notices / Disclosures Patient Rights

C-1608 §485.645(d) SNF Services.
The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) **Resident Rights** (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter).

F-941
Facilities must inform residents in a language they can understand of their total health status and to provide notice of rights and services both orally and in writing in a language the resident understands

Patient Admission Notices / Disclosures Financial Obligations

C-1608 §483.10(g)(17): The facility must—

(i) Inform each **Medicaid-eligible resident**, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

C-1608 §483.10(g)(18): The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under **Medicare/Medicaid** or by the facility's per diem rate

Patient Admission Notices / Disclosures Financial Obligations

There are no length of stay restrictions for Swing Bed – as long as patient meets skilled criteria

However, for Medicare patients, co-pay is required from Day 21 – 100 and after day 100, all costs

Skilled Nursing Facility (Swing Bed) stay In 2023, you pay

- $0 for the first 20 days of each benefit period
- $209.50 per day for days 21–100 of each benefit period (2025)
- All costs for each day after day 100 of the benefit period

Make sure you are providing both Medicare and Medicaid information – and update Medicare co-pay every year

Patient Admission Notices / Disclosures Choice of Providers

C-1608 §483.10(d) Choice of attending physician.
The resident has the right to choose his or her attending physician.
(1) The physician must be licensed to practice, and
(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.
(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.
(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

C-1608 • §483.10(d) Contact Information
(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

HealthTech

Admission Assessment

Comprehensive Assessment

C-1620 §485.645(d)(5): Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter),

except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b),

or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. Discharge potential
17. Review of PASSAR – if one has been done

Comprehensive Assessment

C-1620 §485.645(d)(5)

When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section**. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.**

Comprehensive Assessment

Time frames for the assessment must be appropriate for the length of stay in your facility.

If your average length of stay is 12 days (as an example) – the assessment should be completed within 24 – 48 hours. Some organizations allow 72 hours to span a weekend if necessary.

The assessment should be multi-disciplinary (not just nursing)

The assessment forms the basis for the multi-disciplinary plan of care

Trauma Informed Care

C-1620 §483.21(b)
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) **Be culturally-competent and trauma-informed.**

Appendix PP F-656 and PP F-699 Care Planning Cultural Preferences and Trauma

- Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?
- For residents with a history of trauma, does the care plan describe **corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident?**

The goal is not therapy but rather to eliminate or mitigate triggers that could cause re-traumatizing of the resident

A Word About Activities

There is no requirement in Appendix W to provide activities.. It was removed in 2020....

However, CMS stated..

IF the patient needs activities, then the facility is expected to provide them!

You must still meet psychosocial needs

MORE ABOUT ACTIVITIES LATER

Comprehensive Assessment

Assessment	Example of Assessment Questions	Primary	Secondary
Customary Routine	❑ Time wake up ❑ Time go to sleep ❑ Naps ❑ Time eat meals (Bkf / Lunch / Dinner ❑ Other	Activities Nursing	
Cognitive Patterns	❑ Cognition Measurement Tool at end	Provider	Nursing
Communication	❑ Ability to express ideas and wants, consider both verbal and non-verbal expression. ❑ Understood. ❑ Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. ❑ Sometimes understood - ability is limited to making concrete requests. ❑ Rarely/never understood.	Nursing	Provider
Vision	❑ Corrective Lenses ❑ Cataracts ❑ Blind	Nursing	

Plan of Care

Multi-Disciplinary Plan of Care

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes **measurable objectives and timeframes** to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's **highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's **exercise of rights** under §483.10, including the right to refuse treatment under §483.10(c)(6).

(1) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record

Multi-Disciplinary Plan of Care

C-1620 §483.21(b) Comprehensive care plans
(2) In consultation with the resident and the resident's representative(s)—

(A) The **resident's goals for admission and desired outcomes.**

(B) The **resident's preference and potential for future discharge**. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality

(i) Be provided by qualified persons in accordance with each resident's written plan of care

(iii) **Be culturally-competent and trauma-informed**

Multi-Disciplinary Plan of Care

C-1620 §483.21(b
(ii) **Prepared by an interdisciplinary team**, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments

Other Members of the Interdisciplinary Team

Case Manager / Discharge Planner
These individuals are almost always included! They are a critical part of the team.

Pharmacy
If there is a complicated medication regimen or the patient is receiving antibiotics or is receiving psychotropic drugs ---- include the pharmacist.

Cardiopulmonary
For patients who are on oxygen or have a respiratory-related diagnosis – include cardiopulmonary.

Nursing Manager
If at all possible include the nursing manager – they can support nursing staff and provide education as needed.

Business Office / Finance
Some organizations include a representative from finance to assist with financial questions.

Multi-Disciplinary Plan of Care What works for you?

MULTI-DISCIPLINARY CARE PLAN						
Long Term Goal	**Short Term Goals**	**Interventions**	**Discipline Responsible**	**Date**	**Date**	**Date**
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	1. OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modify
		2. Nursing will que patient to dress each morning Saturday - Sunday	Nursing			
	Patient will be independently put on shoes within 7 days (April 3)	1. OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy			
		2. Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing			
	Patient will undress independently within 7 days and put on pajamas (April 3)	1. OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy			
		2. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing			

Post Plan of Care in patient room And/Or have patient sign plan And/Or document patient approved

F-553 §483.10(c)(2)
The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

HealthTech

Discharge

Choice of Post-Acute Providers (AGAIN)

C-1425 (Rev.) (8) *"The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences."*

Federal Register: *"Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH, data on quality measures and data on resource use measures. We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process."*

Source: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

Discharge Information

C-1610 §483.15(c)(2)

When the facility transfers or discharges a resident .....

the facility must ensure that the transfer or discharge is documented in the resident's medical record

and appropriate information is communicated to the receiving health care institution or provider

Discharge Information

C-1610 §483.15(c)(2)
(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for ongoing care, as appropriate

(E) Comprehensive care plan goals

(F)All other necessary information, including a copy of the resident's **discharge summary**, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care

Discharge Information

C-1620: §483.21(c)(2)
(i) A **recapitulation of the resident's stay** that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results
(NOTE – USUALLY IN DISCHARGE SUMMARY)

(ii) A **final summary of the resident's status** to include items in paragraph **(b)(1) of §483.20**, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

§483.20(b)(1) Comprehensive assessments The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.

About the Comprehensive Assessment

It's really not practical to complete all of the comprehensive assessment AGAIN!

At a minimum....

1. Review each goal
2. Document if it was met – or not met – and why
3. Forward to the next post-acute care provider

Discharge Information

C-1620: §483.21(c)(2)

(iii) **Reconciliation of all pre-discharge medications** with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A **post-discharge plan of care** that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services

Notice Before Discharge

C-1610 §483.15(c)(5)
Revised Appendix PP F-623: Content of Discharge Notice

- Discharge notice must include all of the following
  - The specific reason for the transfer or discharge
  - The effective date of the transfer or discharge;
  - The **specific** location (**such as the name of the new provider or description and/or address if the location is a residence**) to which the resident is to be transferred or discharged;
  - An explanation of the right to appeal **the transfer or discharge** to the State;
  - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
  - Information on how to **obtain** an appeal form;
  - Information on obtaining assistance in completing and submitting the appeal hearing request; and
  - The name, address (**mailing and email),** and phone number of the representative of the Office of the State Long-Term Care ombudsman

Notice Before Discharge Example There is NO CMS form

Date: **Name:** **Admission Date:**

Your discharge from the Swing Bed program is expected to occur _____ (*When)*

You are being transferred or discharged because: (*Specific reason)*

You are being transferred or discharged to _____ *(Location*) (*If the location is a residence the location must be included)*

If you disagree with the transfer or discharge, you can file an appeal by contacting:
State Division of Health (*name/ mailing address / email address),* or
State-Long Term Care Ombudsman (*name/mailing address/email address/phone)*

You can access an appeal form at**:** *(name/web site/Email/phone)*

If you need assistance in obtaining, completing, or submitting the appeal request you can contact (*name/mailing address/email address/phone)*

Patient Signature / Date

Notice of Medicare Non-Coverage

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711 260.2

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy).

A **NOMNC** must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B.

A **NOMNC** must be delivered by the SNF when both Part B therapies are ending. Skilled Nursing Facilities includes beneficiaries receiving Part A and Skilled Nursing Facilities **includes beneficiaries receiving Part A and B services in Swing Beds.**

Appeal

C-1610 §483.15(c)(1)

The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

Notify Ombudsman

C-1610 §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. **The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**

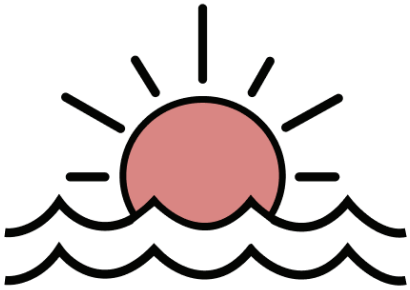
Send the Discharge Notice you provide to patient

Appendix PP F-623 §483.15(c)(3)

The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately transferred or discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for ombudsman notification in their state

Questions!

.



HealthTech

SWING BED BEYOND BASICS
for
KOSCP
October 2025
2:00 – 3:00

Carolyn St.Charles
Chief Clinical Officer, HealthTech

HealthTech

Abuse, Neglect, Exploitation, Misappropriation of Property

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(1) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must—

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(3) Not employ or otherwise engage individuals who—
(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(b) The facility must develop and implement written policies and procedures that:
(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
(1) Ensure that all alleged violations involving **abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,** are reported i**mmediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury,**

or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the **administrator** of the facility and to other officials (including to the **State Survey Agency and adult protective services** where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report **the results** of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within **5 working days of the incident**, and if the alleged violation is verified appropriate corrective action must be taken.

Policies and Procedures

Policies and Procedures
C-1008 §485.635(a)(2)

The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4)

These policies are reviewed **at least biennially** by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

Although a CAH's patient care policies are developed and periodically reviewed with the advice of members of the CAH's professional healthcare staff, **the final decision on the content of the written policies is made by the CAH's governing body** or individual responsible for the CAH, consistent with the requirement at §485.627(a). If recommendations of the advisory group are rejected, the governing body must include in the record of its adoption of the final written policies its rationale for adopting a different policy than that which was recommended.

First ..... Many Hospital Policies and Procedures Also Apply to Swing Bed

- ❑ Advance Directives
- ❑ Patient Grievance/Complaint
- ❑ Medication Management
- ❑ Restraints
- ❑ Infection Prevention
- ❑ Employee Health
- ❑ Quality Assurance Performance Improvement

ETC.

Swing Bed Policies Checklist

- ❑ Choice of post-acute provider (Swing Bed, SNF, IRF)
- ❑ Swing Bed admission criteria
- ❑ Swing Bed admission processes
- ❑ Choice of physician and provision of contact information
- ❑ Physician certification
- ❑ Patient Disclosures
  - Advance Directives
  - Patient rights
  - Financial obligations
  - Personal Privacy and Confidentiality
  - Visitation
- ❑ History and Physical
- ❑ Admission orders
- ❑ Comprehensive assessment (Does not apply to PPS Swing Bed)
- ❑ Comprehensive care plan including: disciplines involved and patient participation; frequency; documentation (Does not apply to PPS Swing Bed)
- ❑ Reassessment after significant change
- ❑ Culturally competent and trauma-informed care, including assessment of trauma
- ❑ Dental care
- ❑ Nutritional assessment and care
- ❑ Activities
- ❑ Choice of post-acute provider (SNF/LTC, Home Health)
- ❑ Reassessment
- ❑ Medication Reconciliation
- ❑ Discharge or Transfer including:
  - Notice of Discharge
  - NOMNC
  - Information to the next provider of care
  - Discharge assessment and documentation
- ❑ Ombudsman notification of discharge or transfer
- ❑ Abuse, Neglect, Exploitation, and Misappropriation of Property
- ❑ Personal property (may be part of patient rights)
- ❑ Transportation for outside medical and dental care

Separate or Combined

Swing Bed Policies and Procedures **MAY** be combined
They don't all need to be separated

However.... Make sure you have **all** that are required.
And it is easy to find those that apply to Swing Bed

HealthTech

Activities

Appendix A

A-1568 §482.58(b)(4) Patient activities (§483.24(c))

1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—
   (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is:
      (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
      (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or
      (C) Is a qualified occupational therapist or occupational therapy assistant; or
      (D) Has completed a training course approved by the State.

Appendix W

No requirements in Appendix W EXCEPT……

When the requirement was removed, information in the Federal Register stated,

If the patient needs activities to meet psycho-social needs - the hospital must do an assessment and provide activities that are included in the nursing plan of care.

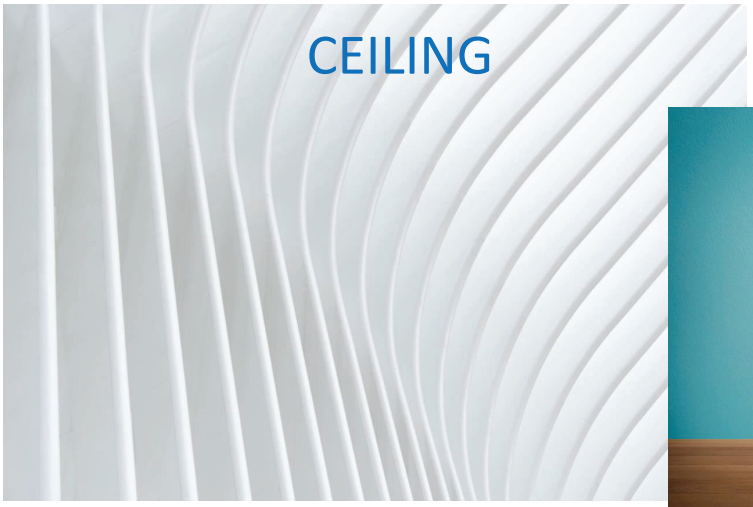
Appendix PP F-679
Activities Intent & Definitions

§483.24(c) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Intent §483.24(c)
To ensure that facilities implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a **resident's physical, mental, and psychosocial well-being and independence**. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

Definition §483.24(c)
Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is **intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health**. **These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence**

These are NOT Activities

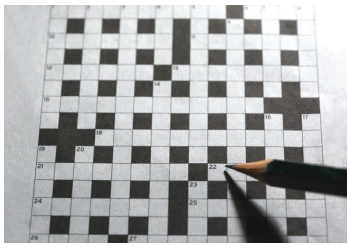


What To Do????

1. Swing Bed Rural Hospital (not CAH) ---- must provide activities per regulation

2. Swing Bed CAH
   - Identify **WHO** will complete activities assessment
   - Identify **WHO** will complete the activities plan
   - Identify **WHO** will provide and document activities

Strongly recommend activities are offered to ALL Swing Bed patients



HealthTech

Intermediate Swing Bed

We are not going to discuss reimbursement issues/concerns

We will talk about best practices for care of Intermediate Swing Bed patients/residents

Non-Certified / Intermediate Swing Beds are funded by Medicaid in some states

Alaska
Swing beds allow rural hospitals to provide nursing home care in otherwise empty hospital beds, which provides rural residents increased access to long term care services and allows the hospital use empty beds. The swing-bed concept allows a hospital to use their beds interchangeably for either acute-care or post-acute care, for either SNF or ICF level of care.

Montana
Swing beds are to be used only when there is no appropriate nursing facility bed available within a 25-mile radius of the swing bed hospital or critical access hospital that can meet the member's needs. Swing bed hospitals and critical access hospitals must canvas all the nursing facilities within the 25-mile radius to determine the availability of an appropriate nursing facility bed prior to admission of the member to the swing bed.

Kanas
Kansas Medicaid covers care in facilities that are certified to provide either intermediate care or skilled nursing services. In Kansas,

(ooo) "Swing bed" means a hospital bed that can be used interchangeably as a hospital, skilled nursing facility, or intermediate care facility bed, with reimbursement based on the specific type of care provided
Kan. Admin. Regs. § 129-1-1 – Definitions

Intermediate Swing Bed

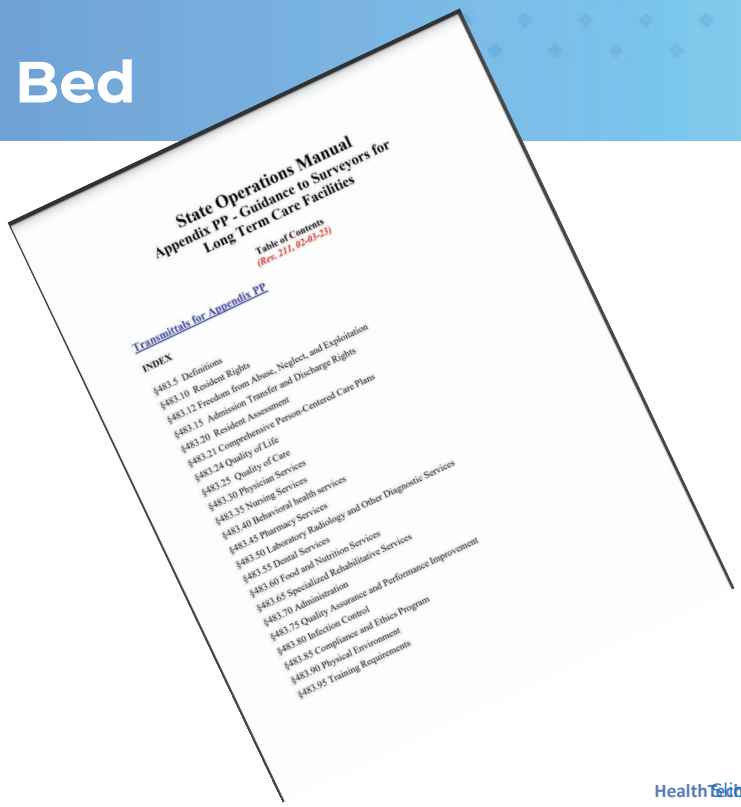
I understand that surveyors **do not currently** review your Intermediate Swing Bed, although that doesn't mean they won't in the future!

Intermediate Swing Bed….
- Are still classified as Swing Bed patients
- Are still patients in your hospital
- Need to be provided quality and evidence-based care

C-0962 §**485.627(a)** Standard: Governing Body or Responsible Individual
The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

Intermediate Swing Bed

To the extent possible, the regulatory requirements in Appendix PP should be followed!



State Operations Manual
Appendix PP - Guidance to Surveyors for
Long Term Care Facilities

Table of Contents
(Rev. 211, 02-03-23)

Transmittals for Appendix PP

INDEX

Short-Term / Certified
3 – 4 weeks - I'm going home!

Intermediate
I live here – this is my home!

HealthTech

Quality of Life
Best Practices

Not Always Easy!

It's not easy in a hospital environment to provide patient-centered care for Long Term / Non-Certified patients

Especially since staff are also caring for acute inpatients and certified Swing Bed patients.

And…. It's not just about the regulations – It's about making the environment **HOME**

Personal Possessions

- ❑ Use Familiar Items
  - Encourage patients to decorate rooms and bring in personal items

F557 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

F584 §GUIDANCE §483.10(i) A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The intent of the word "homelike" in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible.

Socialization and Communication

- ❑ Address Isolation
  - Encourage family visits -- Group social interaction -- Activities
- ❑ Provide Access to Technology
  - Access to computers, tablets, etc., for communication and entertainment
- ❑ Foster a Sense of Community
  - Shared meals -- Shared activities -- Social Events

F550 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

Activities

- ❑ Provide Comfortable and Functional Spaces
  - Provide at least one space where there is access to games/puzzles/TV/Dining
- ❑ Offer a Variety of Activities
  - Provide routine activities --- Ideally in a group environment

Activities Calendar

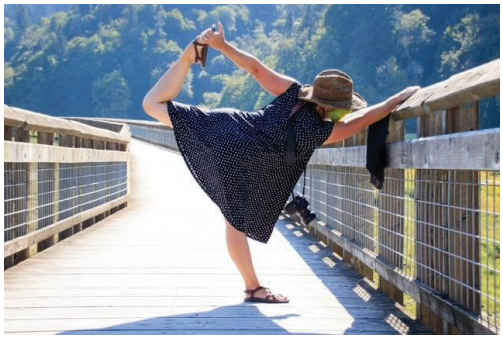
February 2025

In a world where you can be anything you want... BE KIND!

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
2 11:00 TV-10 Methodist Church Services 1:00 ISB Day Room Jetmore Methodist	3 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	4 10:00 Meaningful Movement 1:00 Resident Meeting 3:45 Kids Can	5 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	6 10:00 Bible Study 10:00 1 on 1 Visits 2:00 Hymn Singing 3:00 Ice Cream 3:45 Kids Can	7 10:00 Manicures 1:00 Bingo 2:00 Snacks	8 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
9 11:00 TV-10 Methodist Church Services 1:00 ISB Day Room Jetmore Baptist	10 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	11 9:00 Rummage Sale 1:00 1 on 1 Visits 2:00 Games 3:45 Kids Can	12 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	13 10:00 Bible Study 10:00 1 on 1 Visits 2:00 Valentine's Party	14 10:00 Manicures 1:00 Bingo 2:00 Snacks Happy Valentine's Day	15 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
16 11:00 TV-10 Methodist Church Services 1:00 ISB Day Room Jetmore Catholic	17 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	18 10:00 Meaningful Movement 1:00 1 on 1 Visits 2:00 Games 3:45 Kids Can	19 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	20 10:00 Bible Study 10:00 1 on 1 Visits 2:00 Hymn Singing 3:00 Ice Cream 3:45 Kids Can	21 10:00 Manicures 1:00 Bingo 2:00 Snacks	22 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
23 11:00 TV-10 Methodist Church Services	24 10:00 Word Games 10:45 Daily Devotion	25 10:00 Meaningful Movement	26 10:00 Dominoes 1:00 1 on 1 visits	27 10:00 Bible Study 10:00 1 on 1 Visits	28 10:00 Manicures 1:00 Bingo	

Functional Status

- ❑ Maintain or improve functional status
  - Restorative Aide program
  - Quarterly OT/PT assessment with recommendations
  - Quarterly measurement of functional status
  - Quarterly measurement of activities of daily living
- ❑ Encourage independence – **DO NOT DO FOR PATIENTS WHAT THEY CAN DO THEMSELVES** – even if it takes longer!



Choice

- ❑ Patient chooses routines (meals, activities, sleep schedule, etc.)

Family Support

- ❑ Encourage Family Participation
  - Facilitate family visits
  - Involve family in care planning
- ❑ Promote Open Communication
  - Open and transparent communication
- ❑ Provide Resources and Support
  - Ongoing resources and support for patients and families

HealthTech

Intermediate Swing Bed Assessment

Assessment

F636 §483.20 Comprehensive assessment **at admission**

F636 §483.20 The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts

F637 §483.20(b)(2)(ii) Reassessment within 14 days after significant change

F638 §483.20(c) Comprehensive Assessment at least **every 3-months**

Assessment Elements (Same as Certified Swing Bed)

F636 §483.20 Resident Assessment
The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. *(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) (not applicable).* (xviii) Documentation of participation in assessment.

Reassessment after Significant Change

DEFINITIONS §483.20(b)(2)(ii) "Significant Change" is a major decline or improvement in a resident's status that

1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered "self-limiting" (NOTE: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.);

2) impacts more than one area of the resident's health status; and

3) requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a resident's physician of changes as required under 42 CFR §483.10(i)(14), F580.

HealthTech

Plan of Care

Care Plan

F553 §483.10(c)(2) Patient's Right to Participate in Care Plan

F553 §483.21(a)(3) Patient Provided Summary of Care Plan

F655 §483.21 Baseline Care Plan within 48 hours (A) Initial goals based on admission orders; (B) Physician orders; (C) Dietary orders; (D) Therapy services; (E) Social services; (F) PASARR recommendation, if applicable.

F656 §483.21(b)(1) Care Plan has measurable objectives and timeframes to meet a medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment.

F656 §483.21(b)(3) (iii) Care Plan is Culturally-competent and trauma–informed

F657 §483.21(b)(2) Developed within 7 days after completion of the comprehensive assessment by the interdisciplinary team

Baseline Care Plan

F655 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— (i) Be developed **within 48 hours** of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—
(A) Initial goals based on admission orders
(B) Physician orders
(C) Dietary orders
(D) Therapy services
(E) Social services
(F) PASARR recommendation, if applicable.

Interdisciplinary Team

F657 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to–
- (A) The attending physician.
- (B) A registered nurse with responsibility for the resident.
- (C) nurse aide with responsibility for the resident.
- (D) A member of food and nutrition services staff.
- (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
- (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Patient Right to Participate in Care Planning

F553 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.

(iv) The right to see the care plan, including the right to sign after significant changes to the plan of care.

Plan of Care – Person Centered Initial – Quarterly – Annual – Change

From (date) To (date)

Assessment / Problem

I have visual impairment due to cataracts and glaucoma.

I am unable to read newspapers or print materials that are not in large print. I like to read and enjoy large print books.

I am usually safe in my environment, but sometimes when things are moved, it is difficult for me to find them.

I don't always see obstacles when I am walking.

I sometimes forget to wear my glasses.

Goal	Intervention	Responsibility	Time-Limited
I will have an eye exam by an ophthalmologist this quarter	Schedule an annual eye exam this quarter and arrange for transportation	Social Service	By January 1
I will be satisfied with the reading materials provided, and I will have at least one book I haven't read at all times	Provide large-print reading material based on the resident's preference for science fiction novels, as requested by the resident	Family will provide The nurse will notify the family if the resident needs additional books	As needed
	Provide the local newspaper at least daily	The family will subscribe to the newspaper to be delivered to the hospital The nurse aide will deliver the newspaper to the patient daily	Daily

Provider Responsibilities

Physician Visits

F712 §483.30(c) Frequency of physician visits. §483.30(c)(1)

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all require physician visits must be made by the physician personally

Physician Visits

DEFINITIONS §483.30(c)

Must be seen, for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement.

There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

NPP Visits

F712 GUIDANCE §483.30(c)

After the initial physician visit in SNFs, where States allow their use, an NPP ("Non-physician practitioner) may make **every other required visit**. (See §483.30(e), F714 Physician delegation of tasks in SNFs.)

These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP. (Physician co-signature is not required, unless required by State law).

Certification and Recertification

Medicare General Information, Eligibility, and Entitlement Chapter 4 40.2 - Certification for Extended Care Services

The first recertification must be made no later than the 14th day of inpatient extended care services.

A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

REMEMBER – AN APP CANNOT COMPLETE THE CERTIFICATION OR RECERTIFICATION

HealthTech

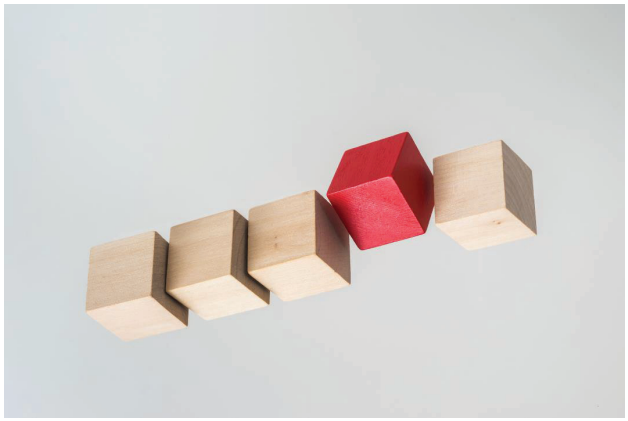
Resident Rights

Patient Rights

Swing Bed Patient Rights are different that LTC Patient Rights published in Appendix PP

You are only accountable for the Swing Bed Patient Rights in Appendix W (and additional rights if required by State regulations)

However ---- for Intermediate Residents ..... strongly recommend using at least some of the LTC Patient Rights



Patient Rights in Appendix PP (Not in Appendix W)

F-550: Right to exercise rights as a citizen or resident of the United States (Vote)

F-559: Right to share room with roommate of choice, when practicable

F-559: Right to receive written notice, including reason for change, before resident' room or roommate in the facility I changed

F-560: Right to refuse transfer to another room

F-561: Right to choose activities, schedules (including sleeping and waking times)

F-565: Right to organize and participate in resident groups

F-566: Right to choose or refuse to perform services for the facility

F-567: Right to manage financial affairs

F-577: Right to examine the results of the most recent survey
The facility must post the most recent survey results in a place accessible to residents, family members, legal representatives

Implementation of the additional rights ----- helps to provide Patient-Centered Care

HealthTech

Resident Funds

Appendix PP
Resident Funds

Develop a system for residents to deposit and access funds that meet Appendix PP requirements.

F567 §483.10(f)(10) Rights
F568 §483.10(f)(10)(iii) Accounting and Records.
F569 §483.10(f)(10)(iv) Notice of certain balances
F570 §483.10(f)(10)(vi) Assurance of financial security
F571 §483.10(f)(11) Not Charge Funds when payment made by Medicare/Medicaid

See end of the presentation for content of regulations

HealthTech

Restraints

Restraints

Restraints … should of course… never be used unless absolutely necessary.

F605 §483.10(e) *The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).*

There are examples of what constitutes a restraint in Appendix PP that we don't often think of as a restraint.

Ensure your policy is current and includes definitions in Appendix PP

Restraint Examples F604 §483.10(e)(1)

1. A **bed rail is** considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently

2. A **lap belt** is considered to be a restraint if the resident cannot intentionally release the belt buckle

3. Placing a **chair or bed close enough to a wall** that the resident is prevented from rising out of the chair or voluntarily getting out of bed

4. Placing a resident on a **concave mattress** so that the resident cannot independently get out of bed

5. **Tucking in a sheet tightly** so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted

Restraint Examples F604 §483.10(e)(1)

6. Placing a resident in a **chair**, such as a beanbag or recliner, that **prevents a resident from rising independently**

7. Using devices in conjunction with a chair, such as **trays, tables, cushions, bars or belts**, that the resident cannot remove and prevents the resident from rising

8. Applying **leg or arm restraints, hand mitts, soft ties or vests** that the resident cannot remove

9. **Holding down a resident** in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care

10. Placing a resident in an **enclosed framed wheeled walker**, in which the resident cannot open the front gate or if the device has been altered to prevent the resident from exiting the device

11. Using a **position change alarm** to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm

Restraint Documentation

F604 §483.10(e)(1)
The regulation limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints.

There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint [See §483.12(a)(2)].

However, the practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint.

Patient / Family Request for Restraint

F604 §483.10(e)(1)
The resident or resident representative may request the use of a physical restraint; however, the nursing home is responsible for evaluating the appropriateness of the request, and must determine if the resident has a medical symptom that must be treated and must include the practitioner in the review and discussion. If there are no medical symptoms identified that require treatment, the use of the restraint is prohibited.

Also, a resident, or the resident representative, has the right to refuse treatment; however, he/she **does not have the right to demand a restraint be used when it is not necessary to treat a medical symptom.**

HealthTech

Medication Management

Pharmacist Review of Drug Regimen

1. **F756 §483.45(c)** Pharmacist comprehensive review once per month for identification of irregularities

2. **F756 §483.45(c)(4)(ii)** Any irregularities sent to medical director, attending physician, and director of nursing for review

3. **F756 §483.45(c)(4)(iii)** Attending physician must document review of medication irregularities in the medical record as well as corrective actions if appropriate. If no change in medication, attending physician must document rationale.

4. **F756 §483.45(c)(5)** Policies and procedures for monthly drug regimen review

Psychotropic Drugs

F758 §483.45(c)(3)
A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

Psychotropic Drugs

1. **F758 §483.45(e)(1)** Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

2. **F758 §483.45(e)(2)** Gradual dose reduction and behavioral interventions unless clinically contraindicated in effort to discontinue drugs

3. **F758 §483.45(e)(3)** NO PRN orders unless required to treat a diagnosed specific condition documented in clinical record

4. **F758 §483.45(e)(3)** Psychotropic PRN orders limited to 14 days unless documented by physician (including duration) in the medical record. The physician must evaluate the patient.

Behavior Log

Behavior	Description	Frequency	Severity	Duration
Agitation				
Aggression				
Wandering				

Trigger	Description	Related Events Context
Loud Noises		
Meals		
Staff Transitions		

Interventions	Description	Effectiveness
Reassurance		
Re-Direction		
Medication		

HealthTech

Education and Competency

Nursing Competency

F726 §483.35 Nursing Services: The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

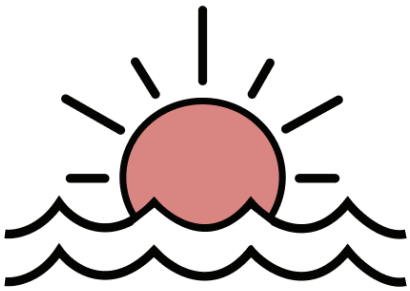
§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

F726 §483.35(c) Proficiency of nurse aides: The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Care of the Intermediate Swing Bed Resident – Education & Competency

Interpersonal communication that promotes mental and psychosocial well-being
Person-centered care and services that reflect the resident's goals for care
Culturally Competent Trauma-Informed Care
Person Centered Care
Care specific to residents with: • Aphasia • Behavioral Health diagnosis • Dementia • Vision impairment • Hearing impairment
Care of the combative resident
Activities
Non-Pharmacological approaches to care
Behavior log
Identifying a Change in Condition
Skin and Wound Care
Bowel and Bladder Retraining
Medication Management
Pain Management

Questions!



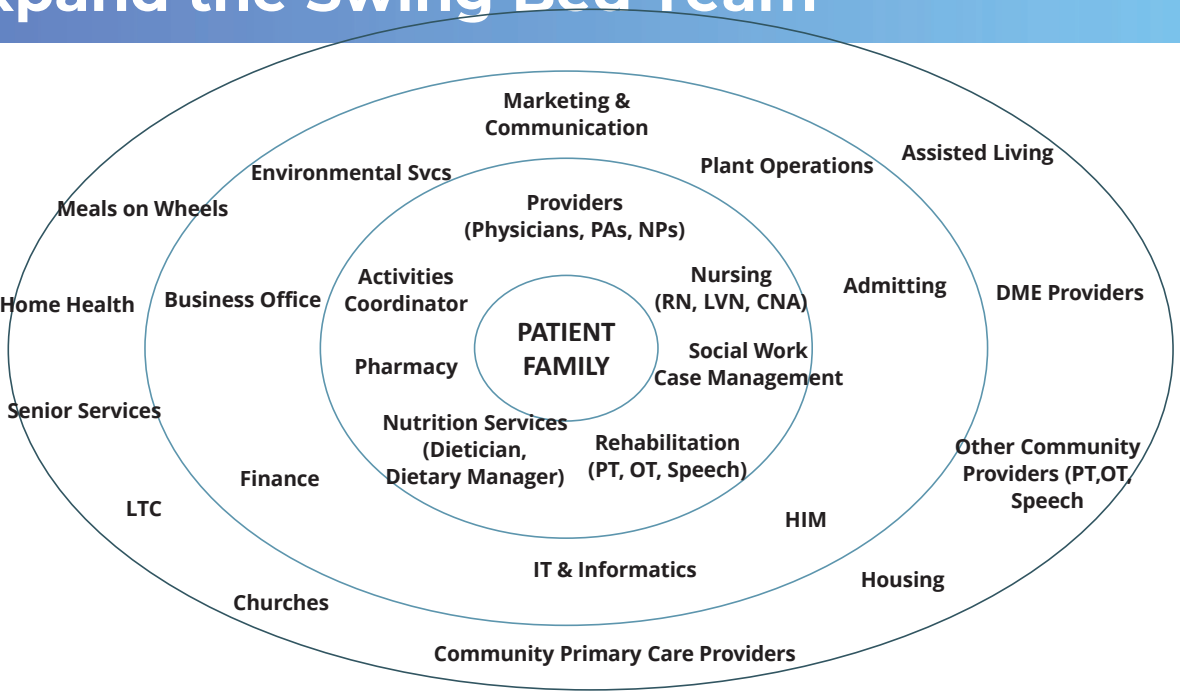
HealthTech

STRATEGIES TO HARDWIRE YOUR PROGRAM FOR SUCCESS for KOSCP October 2025 3:15 – 4:00

Carolyn St.Charles
Chief Clinical Officer, HealthTech

12 Strategies

Strategy 1
Expand the Swing Bed Team



Strategy 2
Meet as a team to discuss the program

Strategy 3
Keep up with regulatory changes

1. Check periodically by searching
   Appendix W (Critical Access Hospitals)
   Appendix A (Hospital)
   Appendix PP (Long Term Care)

2. CMS web site
   https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

3. Sign up for alerts/notifications from CMS

4. Subscribe to Federal Register

https://public.govdelivery.com/accounts/USGPOOFR/subscriber/new

Strategy 4
Collect and share Swing Bed outcome data

Length of Stay

Readmissions

Return to prior residence

Satisfaction
- Consider post-discharge phone calls

Compliance with:
- Attendance at Team Mtgs.
- Timeliness of documentation
- Patient concurrence with Plan of Care
- Completion of Patient Disclosures

Strategy 5
Educate

Education about Swing Bed value and regulatory requirements is essential. **Does your staff and providers understand the regulatory requirements?**

Schedule, at a minimum, annual education. But better to provide quarterly education on selected topics.

Education should be organization-wide including providers

Tailor education to audience

Strategy 6
Define Roles – Everyone Plays

Responsibilities

Responsibility	Primary or Required	Back-Up or Other	Responsibility	Primary or Required	Back-Up or Other
Maintain knowledge of current regulations and share with team			Discharge Summary		
Schedule periodic external or internal mock surveys			Discharge: Plan of Care		
Pre-Admission Screening and Insurance Verification			Discharge: Choice of PAC provider		
Admission Decision			Discharge: Medication Reconciliation		
Patient Notices at Admission			Discharge: Information to Next Provider of Care		
Comprehensive Assessment			Discharge: Notices to Patient		
IDT Coordinator – Schedule Mtgs / Notes			Discharge: Notice to Ombudsman		
IDT Attendees			Staff Job Descriptions, Education, Competency		
Interdisciplinary Plan of Care			Outcome Data (Collection, Analysis, Reporting)		
Communication with Patient About Plan of Care			Brand Marketing – Brochures, etc.		
			Daily outreach to referral hospitals		

Strategy 7
Establish clear expectations / time frames

Time frames have been established and are measured for:

- Response to referrals
- Completion of initial assessment by each member multi-disciplinary team
- Development of the plan of care that is measurable and time limited
- Attendance at IDT meetings
- Communication with patient and concurrence with Plan of Care

There are set times each week for IDT conferences

Strategy 8
Conduct audits

1. Pre-Admission
2. Admission
3. Continued Stay
4. Transfer & Discharge
5. Outcome Measures

- Audits work best if done with IDT team and/or staff caring for patient(s)
- Start with a comprehensive audit of several charts – then drill down to areas of concern
- Implement corrective actions (look for root cause)
- Re-Audit

Strategy 9
Focus on high-risk areas or areas of non-compliance

1. Admission - Patient Disclosures
   - Admission packet includes all required patient information - and provided to every Swing Bed patient
   - Choice of providers
   - Provider contact information
   - Financial obligations include annual Medicare co-pay

2. Admission Assessment
   - Assessment(s) completed within the time frame specified in policy
   - Assessment includes ALL required elements including history of trauma and review of Pre-Admission Screening and Resident Review (PASARR)

3. Plan of Care
   Required disciplines participate in development of plan of care
   - Plan of care includes measurable objectives and timeframes
   - Plan of care includes participation of patient
   - Plan of care updated as needed or when there is a significant change

4. Discharge
   - Choice of post-acute providers
   - Discharge notice to patient
   - Discharge notice to ombudsman
   - Required information to next provider of care

Strategy 10
Set Goals for Improvement

Communicate Goals

Develop a Plan

Communicate progress

Strategy 11
Ask WHY for areas of non-compliance

Identifying an issue DOES NOT solve the problem or identify why it is occurring!

Strategy 12
Inclusion

Involve the people directly working in a process to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.

- GO TO *gemba* the place where value is created
- Involve providers and staff in identifying improvement opportunities and developing solutions
- Make performance improvement visible

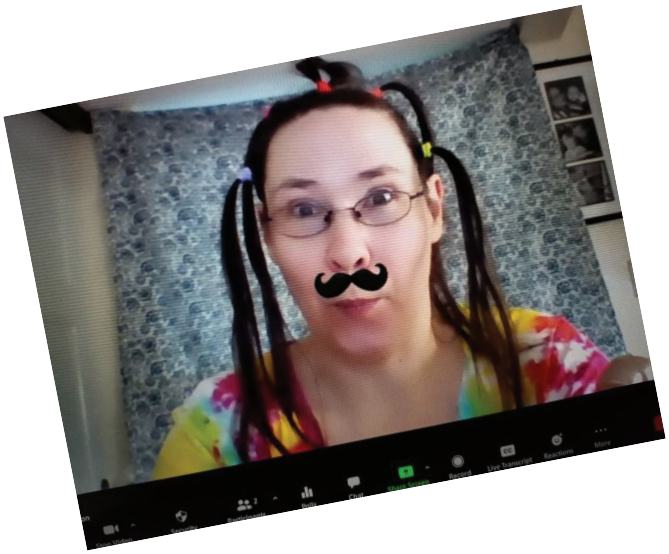
	Activities Provided	Why or Why Not?	What can we do tomorrow?
Mon			
Tues			
Wed			
Th			
Fri			
Sat			
Sun			

Strategy 13
Systems -- Not People

Not always easy. We often have an inability to see systems in the first place due to pre-conceived ideas.

Shuffling deck chairs. A futile action in the face of impending catastrophe or one that contributes nothing to the solution of genuine problems.

A bad system will beat a good person every time. - *W Edward Deming*



Strategy 12
Celebrate

Celebrate
Healthy Snacks

Celebrate
Thank You Card

Don’t forget providers

Grow Your Swing Bed Program

Strategy 1: Increase Length of Stay

1. Review the length of stay in comparison to SNF and other CAHs
2. Review readmissions – why are patients being readmitted?
3. Consider additional time to ensure patient can sustain goals and is safe for discharge

Strategy 2: Expand Patients You Accept

- Complex wound care
- Bariatric
- Stroke
- Spinal Cord Injury
- Teaching and Training
- Management of Plan of Care
- Ventilator Weaning
- In-house Dialysis

Strategy 3: Develop Admission Guidelines

Types of patients that can be accepted to swing

- Rehab: PT/OT/Speech
- IV Antibiotics
- Wound Care
- Education / Training
  - Diabetic teaching
  - Care of colostomy
  - Complex medication management
  - Monitoring signs & symptoms (weight, blood pressure)
- Weakness / Failure to Thrive / Weight Loss / Strengthening
- Tube Feedings / PEG
- Diagnosis: Generally, patients are not admitted by diagnosis but rather need for skilled care.
  - Orthopedics (Fractures, Post-Surgery)
  - Post-Stroke
  - CHF
  - Pneumonia
  - Covid-19

Potential – Will be reviewed on a Case-by-Case basis

- Dialysis (incidental to other reason for admissions) only if patient is sufficiently mobile to be transported by family in private car or by public transportation.
- TPN – IF pre-made from manufacturer is acceptable for patient
- Bariatric

Cannot accept

- Ventilator dependent
- Pediatrics

Strategy 4: Communicate Bed Availability

Send email or fax at least 2 – 3 times weekly to let referral sources know of bed availability.

Make sure it's branded for your facility

Keep it brief – not more than one page

8/23/2023
Swing Bed Program at County Hospital

We have three (3) available Swing Beds. We provide both skilled nursing and skilled rehabilitation including speech therapy.

If you have a patient that needs short term rehab or skilled nursing, please reach out at any time.

You can send the referral thru the Enso-care portal or fax to 888-888-8888

You may also call me directly at 888-888-8888

Carolyn St.Charles
Swing Bed Coordinator
Carolyn.stcharles@health-tech.us

Strategy 5: Sign-up for Electronic Referrals

Many PPS hospitals use an electronic platform to see what beds might be available. For example Ensocare and Care Port

Electronic platforms may have a subscriber fee associated with the platform

Strategy 6: Decrease Time to Accept Patients

1. Set a goal of 2 -3 hours or less to respond
2. If there is an electronic platform for referrals – subscribe!
3. Have a dedicated fax number and publish it
4. Identify WHO is responsible for responding –including after-hours and weekends
5. Set CLEAR admission guidelines that have been agreed to by the team
6. Identify types of patients that can be accepted by the Case Manager - or – the Case Manager and provider without the entire team
7. Even if you are not sure – let the referring organization know - i.e., pending insurance

Strategy 7: Make Swing Bed a Strategic Service Line & Appoint a Swing Bed Leader

Although it may sound like a simple strategy, often, Swing Bed is seen as "just another patient on the Med-Surg unit.

Identifying Swing Bed as a service line can bring awareness and focus to the program and help to ensure success.

Service lines typically have more visibility in the organization, both with staff and providers.

To ensure a successful service line approach, appoint a leader to oversee the Swing Bed program. Ideally, this is a full-time person, but if it is part-time, there should be sufficient time to focus on the program, including marketing and outreach, staff and provider education, regulatory compliance, collecting and analyzing outcome data, and developing strategies for growth.

Strategy 8: Provide Transferring ER Patients Information About Swing Bed

Provide every patient that leaves your hospital for a higher level of care with information about your Swing Bed program and let them know they can return if needed to receive "*care close to home.*"

Strategy 9: Tell Your Story - Hospital Team

Swing Bed Facts

Did you know that a patient with Medicare coverage can stay in Swing Bed up to 20 days with no co-pay. Basically, Medicare pays the full cost if there is a skilled need.

What is going well

What a great month! WE had a total of 15 admissions and 90% of our patients were discharged back to their prior residence. This is so important to our patients & a testament to the good work everyone is doing.

Special Thanks

Special thanks to Esther from Housekeeping who noticed a potential fall hazard and stayed with the patient until it could be corrected. And also a special Thanks to Paul S., NP who came in over the weekend to admit a patient.

Scorecard

We are doing well on all our metrics except attendance at Care Plan meetings. We are looking at some additional strategies so everyone can attend.

	Resource Measures				Quality Measures												Growth			
	Readmission <30 days		Length of Stay		Plan of care posted in patient room		Return to prior living arrangement		Falls with injury		Attendance Care Plan Mtgs		Post-Discharge Call <3 days of discharge		Patient Satisfaction		Time from referral to accept / decline < 2 hours		Patient Days	
Baseline																				
YTD																				
	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal
Jan																				

Strategy 10: Tell Your Story - Referral Sources

Provide your scorecard or other metrics with a note asking the referral source if there is anything you can do better.

	Resource Measures				Quality Measures												Growth			
	Readmission <30 days		Length of Stay		Plan of care posted in patient room		Return to prior living arrangement		Falls with injury		Attendance Care Plan Mtgs		Post-Discharge Call <3 days of discharge		Patient Satisfaction		Time from referral to accept / decline < 2 hours		Patient Days	
Baseline																				
YTD																				
	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal
Jan																				

Strategy 11: Tell Your Story – Community

Distinctiveness and Creativity

Creativity creates the distinction between 2 products under the same category.

Nobody counts the number of ads you run; they just remember the impression you make

When creative is strong, it's the overwhelming driver of in-market success: up to 80% for traditional TV and 89% for digital advertising.

Is Swing Bed prominently featured on your Web Page?

Does your Swing Bed brochure tell your story? Is it on brand?

Patient Success Stories

Regaining Her Independence at 83

Bev turned 83 in October, but she is not letting that slow her down. After raising 9 children and countless grandchildren and great-grandchildren, she has earned her position as matriarch of the family. “My kids all look after me, but I have to remind them that I am still the captain of this ship.”

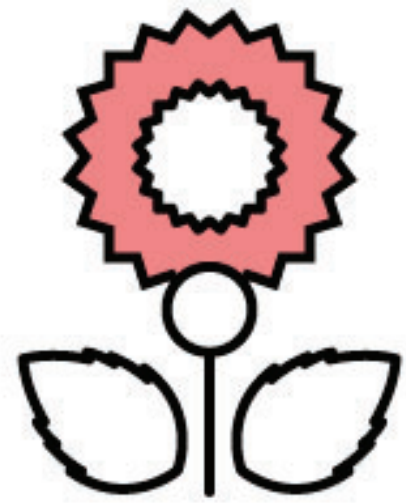
Recently, Bev’s independence was challenged when she was hospitalized because of a kidney stone. “I was in the hospital for a full week,” said Bev. When she was told that she would need short-term rehabilitative services, she was sure of one thing, “I guess I really didn’t think I was as bad as I was, but I was not going to be sent to a nursing home.”

County Hospital Swing Bed Services offered Bev the opportunity to be close-to-home while receiving short-term rehabilitative services. Swing Bed services give patients like Bev access to the full range of hospital services while focusing on an aggressive rehabilitation and medical program that helps build strength and endurance. Exactly what Bev needed to regain her independence. “*When I first got to Henry County Hospital, I couldn’t pick my feet up to get into bed,*” said Bev. “*By about the second day, I was able to take a shower and use the bathroom. I felt like a million dollars when I finally got a shower*!”

When it came time for Bev to go back home, she only had one regret. She would no longer have access to the meals provided at the hospital. “The food was absolutely excellent,” she said. “I could get what I wanted when I wanted it. It was great!” Today, Bev is looking forward to getting outside and working in her yard and flower garden. Although still as independent as ever, she is forever grateful for the care and support she received from County Hospital Swing Bed Services.

Excellent Resources from the National Rural Health Resource Center

.



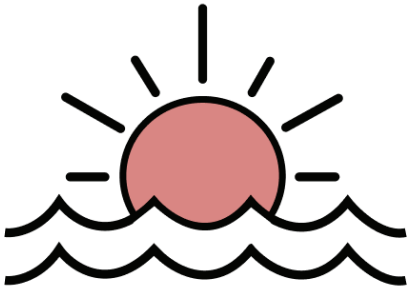
Resource: Swing Bed Campaign
National Rural Health Resource Center

The **"Between Healing and Home"** campaign highlights the additional recovery time that swing bed/transitional care services provide patients and notes that, even though it's an extra step, the additional care can actually shorten recovery time. By providing patients with the tools they need to live independently, swing beds/transitional care services allow patients to return home safely and successfully — and with a reduced risk of relapsing. "Shortening the distance," a phrase that appears in campaign materials, also has a double meaning and speaks to the patient's choice to rehab at a facility nearer to their home, even if their care was done at a neighboring health care system. This choice to recover closer to home is beneficial and convenient for both patients and their families.

The toolkit was developed through the Delta Region Community Health Systems Development (DRCHSD) program.

Questions!

.



HealthTech

ADDITIONAL INFORMATION

HealthTech

Resident Funds Additional Info

Resident Funds

F567 §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

Resident Funds

F567 §483.10(f)(10) - GUIDANCE

Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than:

- The same day for amounts less than $100.00 ($50.00 for Medicaid residents);
- Three banking days for amounts of $100.00 ($50.00 for Medicaid residents) or more.

Residents may make requests that the facility temporarily place their funds in a safe place, without authorizing the facility to manage those funds. The facility must have a system to document the date, time, amount, and who the funds were received from or dispersed to. The facility must have systems in place to safeguard against any misappropriation of a resident’s funds.

Resident Funds

F568 §483.10(f)(10)(iii) Accounting and Records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C) The individual financial record must be available to the resident through quarterly statements and upon request.

F569 §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits— (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.

Resident Funds

F570 §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

F571 §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). **(NOT ALL TEXT INCLUDED)**

HealthTech

Medication Management Additional Info

Drug Regimen Review

F756 §483.45(c) Drug Regimen Review
§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

Drug Regimen Review cont.

F756 §483.45(c) Drug Regimen Review
§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

Psychotropic Drug Review

F758 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that–
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

Psychotropic Drug Review cont.

F758 §483.45(c)(3) §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication