HealthTech

Resource Documents
for
KOSCP
October, 2025

HealthTech

Crosswalk Appendix W and Appendix PP

If you have any questions, please contact

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Reassessment After Significant Change	C-1620		F637	
Resident Rights	C-1608	C-1612	F550 F551 F552 F553 F554 F555	F557 F558 F559 F561 F562 F563
Pharmacist Assessment / Medication Management	All requirements in Appendix W apply		F755 F756 F757	F758 F756
Physician Visits			F-712	
Rehabilitation	C-1622		F825	
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Social Service	C-1616		F-745	
Visitation	C-1056		F563	F564

Admission Assessment

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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	
Mood	☐ Little interest or pleasure in doing things ☐ Feeling down, depressed or hopeless ☐ Trouble falling or staying asleep, or sleeping too much ☐ Feeling tired or having little energy ☐ Poor appetite or overeating ☐ Feeling bad about yourself – or that you are a failure or have let yourself or your family down ☐ Trouble concentrating on things such as reading the newspaper or watching television ☐ Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual ☐ Thoughts that you would be better off dead, or of hurting yourself in some way	Social Work or Nursing	
Behavior	☐ Hallucinations ☐ Delusions ☐ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others)	Nursing	Provider

Assessment	Questions	Primary	Secondary
	☐ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing) ☐ Other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste		
History of traumatic events	☐ Has there been anything within the last six months to a year that has caused you to be upset or very worried? ☐ Have you experienced the loss of a close friend, relative or a pet that you loved recently? ☐ Have you had any past trauma in your life that we should know about so we can better care for you? ☐ If you have experienced some kind of trauma is there something that helps you feel better? ☐ Is there anything we can do to help while you are in the hospital?	Social Work	Nursing
Culture	☐ Determine if there are any cultural beliefs / customs that will impact care.	Social Work	Nursing
PASRR	☐ IF patient has a PASRR (usually completed if patient was a resident of LTC) review PASRR	Social Work	Nursing
Physical functioning and structural problems	☐ Independent ☐ Setup or Clean-up Assistance ☐ Supervision or touching assistance ☐ Partial/moderate assistance ☐ Substantial/maximal assistance ☐ Dependent	PT	Nursing
Continence, bladder and bowel	☐ Urinary incontinence ☐ Bowel incontinence	Nursing	
Active diagnosis		Provider	
Health conditions		Provider	
Dental	☐ Dentures (fitting / loose) ☐ Broken Teeth ☐ Overall dentation	Nursing	Dietician

Assessment	Questions	Primary	Secondary
Swallowing	☐ Loss of liquids/solids from mouth when eating or drinking ☐ Holding food in mouth/cheeks or residual food in mouth after meals ☐ Coughing or choking during meals or when swallowing medications ☐ Complaints of difficulty or pain with swallowing	Nursing	Dietician
Nutrition	☐ Nutrition Risk Assessment ☐ Loss of 5% or more in the last month or loss of 10% or more within last 6 months	Nursing	
	☐ Dietician Nutrition Assessment	Dietician	
Skin condition	☐ Braden Scale ☐ If pressure ulcers or skin breakdown, describe in nursing notes	Nursing	
Activity pursuit	What do you like to do? ☐ Reading – print or audio books ☐ Puzzles ☐ Word games ☐ Watching TV ☐ Knitting / Crocheting ☐ Visiting with friends ☐ Other NOTE: Assessment by an Activities Professional or an Occupational is no longer required for CAH Swing Beds – But recommend assessment by Nursing	Activities or Nursing	

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Continuous Survey Readiness

Certified Swing Bed

If you have any questions, please contact

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The audit tool is designed to assist you in completing an internal audit of your Swing Bed program, including documentation. If the regulation is not specific about timing, it is noted as such. This applies primarily to Certified Swing Bed.

Admission	
1. For patients in the same facility being admitted to Swing Bed, documentation that Quality and Resource information was provided, and the patient was given a choice of Swing Bed, Swing Bed programs in other CAHs, and SNFs *Note: Can be limited to a geographic area as determined in hospital policy.*	C-1425
2. Provider discharge order from inpatient acute care if in the same facility	C-1102

Admission: Provider Documentation	
3. Admission Order to Swing Bed	C-1600
4. Orders for Swing Bed, including orders for PT, OT, Speech if applicable	C-1600
5. Attestation for Swing Bed Stay by a physician • Patient requires daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition); and • Will require skilled care on a daily basis, which, as a practical matter, can only be provided in a SNF on an inpatient basis *Note:* • *CMS does not require a specific form, although most organizations use a form that is included in the EMR to ensure the certification is not missed.* • *Recertification is required at admission, 14 days, and then every 30 days thereafter.*	Medicare Benefits Manual Chapter 8, 40.0 Medicare General Information, Eligibility, and Entitlement Chapter 4, 40.3 and 40.4
6. History and Physical completed within the time frame specified in hospital bylaws *Note: A new H&P is required for Swing Bed admissions – a new record is required.*	C-1102

Regulatory Requirement	Regulatory Reference
Admission: Patient Required Disclosures	
7. Signature/attestation that the patient received the required disclosures	C-1608 C-1612
8. Choice of attending physician (must be documented in the EMR)	C-1608 F555
9. Contact Information for primary care providers, including primary care providers provided to the patient	C-1608
10. Swing Bed Rights and Responsibilities provided verbally and in a manner the patient can understand, and the patient was provided the opportunity to ask questions *Notes:* • *This must be specific Swing Bed rights. Not hospital rights or long-term care rights* • *If there are any patient rights in state regulations that are not included in the CMS rights, they must be included*	C-1608 C-1610 C-1612
11. Privacy and Confidentiality *Note: Right to privacy and confidentiality, including personal communication and mail.*	C-1608 F540
12. Visitation *Note: Right to 24-hour access by visitors if requested by the patient*	C-1056 C-1058 F653 F654
13. Freedom from abuse, neglect, exploitation, and misappropriation of property *Note: This is usually included in patient rights, but a separate disclosure about the hospital's responsibility for preventing abuse is recommended.*	C-1612
14. Advance Directives • Patient was asked if they had an advance directive, and if not if they wanted information • If the patient has an advance directive, is it in the medical record? • If the patient has a DNR, there is a physician's order for code status • Hospital staff and practitioners who provide care in the hospital comply with these directives	C-0812

15. Financial obligations for Medicare and Medicaid including what is covered and not covered under state plan. Include Medicare co-pay at day twenty-one	C-1608 F582

Transfer and Discharge Rights	
16. Hospital responsibility for preventing abuse. *Note: Freedom from abuse is required as part of patient rights. However, it is recommended that a statement or page be included in the admission packet regarding the hospital responsibilities for preventing abuse*	C-1612
17. Information on how to file a grievance/complaint both internally and externally, including state licensing agencies and ombudsman	C-1612

Admission: Assessment	
18. Assessment of patient's needs, strengths, goals, life history, and preferences completed within 72 hours of admission. • Identification and demographic information • Customary routine • Cognitive patterns • Communication • Vision • Mood and behavior patterns • History of trauma • Psychosocial well-being • Physical functioning and structural problems • Continence • Disease diagnoses and health conditions • Dental • Nutritional status • Skin condition • Activity pursuit • Medications • Special treatments and procedures • Discharge planning *Note: CMS requirement of 14 days to complete the comprehensive assessment, does not apply to Swing*	C-1620 F636 F637

Bed patients. 72 hours is recommended, if necessary to span a weekend	
19. Assessment by PT, OT, or Speech, if ordered by the provider, within 72 hours of admission. *Note:* • *72 hours is recommended if necessary to span a weekend* • *There is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay*	C-1620
20. Assessment by a dietician within 72 hours of admission. *Note:* • *A dietitian assessment should be completed even if the patient is determined not to be at nutritional risk based on the nursing risk assessment* • *There is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay*	C-1020 C-1620
21. Assessment of Trauma.	C-1620 F699
22. Review of PASRR (if a PASRR has been completed prior to admission). *Note: Will usually have been completed if the patient has been a LTC patient*	C-1620

Admission: Plan of Care	
23. Interdisciplinary Plan of Care (POC) developed (first IDT meeting) within the time frame appropriate for the length of stay	C-1620

Regulatory Requirement	Regulatory Reference
24. Plan of Care developed by interdisciplinary team that includes at a minimum: • Attending physician • Registered nurse with responsibility for the patient • CNA with responsibility for the patient • Member of food and nutrition staff • To the extent practicable, the participation of the patient and the patient's representative(s) (If do not attend – signs that they are in concurrence with plan) • Other appropriate staff or professionals in disciplines as determined by the patient's needs or as requested by the patient. (If patient is being seen by rehab, then they should attend. If there are complex medication issues, pharmacist should attend) *Notes:* • *An explanation must be included in a patient's medical record if the participation of the patient and their patient representative is determined not practicable for the development of the plan of care* • *There must be documentation that all required members of the interdisciplinary team attended the care conference to develop the plan of care. If the attending physician cannot attend, there can be documentation that the physician agreed with the plan of care. However, this should be an isolated occurrence and not routine* • *If there are no CNAs on duty, document in the care plan meeting minutes* • *If the patient is receiving PT, OT, or Speech, they should be in attendance* • *If the patient has a complex medication regimen, the pharmacist should attend*	C-1620
25. POC includes measurable objectives and timeframes to meet patient's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment *Note: Goals MUST be measurable and must have timeframes for completion of each goal*	C-1620

26. Plan of Care includes any specialized services or specialized rehabilitative services provided as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, the rationale must be documented in the medical record.	C-1620
27. Plan of Care developed in consultation with the patient and the patient's representative(s), the patient's goals for admission and desired outcomes. Includes the patient's preference and potential for future discharge *Note: Must include documentation of the patient's desire to return to the community, and any referrals to local contact agencies and/or other appropriate entities*	C-1620
28. Plan of Care updated once or twice per week with input from the interdisciplinary team and the patient *Note: There is no specific regulatory requirement for weekly. However, with the length of stay, the POC should be updated at least weekly, and ideally twice per week*	C-1620

Continued Care	
29. Dietitian recommendations implemented and documented *Note: If the dietician recommends weekly weights, check and see if they were done and recorded.* *Note: If the dietician recommends a snack at bedtime – check and make sure the snack was offered and documented*	C-1020 C-1620
30. Nutrition • Food in form to meet individual needs (F-805) • Drinks available to meet needs/preferences (F-807) • Assistive devices-eating equipment/utensils if needed (F-810) • Allergies, preferences & substitutes taken into consideration (F-804)	C-1020 C-1040 F800 F801 F802 F-804 F-805 F-807 F-810

Regulatory Requirement	Regulatory Reference
31. Weight at admission and as required based on patient status. *Note: Maintaining weight and hydration are critical elements of Swing Bed care.*	F692
32. Documentation of food intake. *Note: Maintaining weight and hydration are critical elements of Swing Bed care. Documentation may not be necessary depending on the patient assessment.*	F692
33. Rehab, if ordered, is provided at least five days per week.	Medicare Benefit Policy Manual Chapter 8 - 30.4; 30.6
34. Rehab, if ordered, is provided at the frequency determined by the assessment and provider order.	C-1622 F825
35. If the patient refuses rehab, documentation in the medical record as to why and what was done to ensure the patient will not refuse in the future (i.e., medication prior to therapy, etc.)	C-1622
36. Evidence that nursing is supporting therapy goals (i.e., assisting the patient to walk, dress, etc.) *Note: Nursing support of therapy goals is extremely important to maintaining functional status, especially on the weekends*	C-1620
37. Therapeutic interventions, wound care, oxygen therapy, medications, etc., provided as ordered and documented in the medical record	C-1049
38. Activities are provided, as needed, based on the patient assessment. *Note: CMS no longer requires a formal activities program. However, it is important to ensure that the patient is not just lying-in bed and does not have mental stimulation between therapy or other treatments. The assessment still includes activities*	C-1620
39. Therapeutic Leave *Note: Provider order, Release of liability signed, Patient or individual patient is released to receive proper instructions for care*	C1620 F625 F626
40. Comprehensive reassessment completed with any significant change in condition	C-1620 F726

Discharge	
41. For patients being discharged to a post-acute provider (SNF, LTC, Home Health, IRF). Quality and Resource information for post-acute providers in the geographic area is provided in writing, discussed with the patient, and documented in the medical record.	C-1425
42. Patient provided with Notice of Medicare Non-Coverage 2 days before discharge.	Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, Chapter 30 §260.2
43. Discharge Notice provided: Contents of the notice. • The reason for transfer or discharge • The effective date of transfer or discharge • The location to which the resident is transferred or discharged • A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; • The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman • For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights	C-1610
42. Copy of the patient notice of transfer or discharge sent to the State Ombudsman	C-1610
43. Provider discharge summary that includes a recapitulation of the patient's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	C-1620 F550 F622 F623
44. Reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescribed and over the counter)	C-1620

Regulatory Requirement	Regulatory Reference
45. A post-discharge plan of care that is developed with the participation of the patient and, with the patient’s consent, the patient representative(s), which will assist the patient 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 patient's follow up care and any post-discharge medical and non-medical services	C-1620
46. A final summary of the patient's status to include items in §483.20 *Note: This requires a reassessment of the same items in the original comprehensive assessment. However, most facilities will just complete a review of goals as defined in the plan of care and whether they were met or not met*	C-1620
47. Other information to next provider of care: • Contact information of the practitioner responsible for the care of the patient • Patient representative information including contact information • Advance Directives • All special instructions or precautions for ongoing care, as appropriate	C-1620

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Intermediate Swing Bed

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Regulatory Requirement	Regulatory Reference

Admission	
1. Resident Rights *Note: These are resident rights for long-term care. You may use Swing Bed rights instead.*	F550
2. Trust Account if requested by resident or representative, including cash available if requested	F568 F659 F570
3. Financial obligations for Medicare and Medicaid, including what is covered and not covered under the state plan. Include Medicare co-pay at day twenty-one	C-1608 F582

Assessments	
4. Assessment by a physician within 5 days before admission or within 72 hours of admission	F710 F711 F712 F713
5. Assessment within 24 hours of admission to develop baseline plan of care by RN	C-1620 F636 F637 F655 F656 F657
6. Initial assessment within 14 days of admission completed by interdisciplinary team	
7. Quarterly assessments completed by interdisciplinary team	
8. Annual assessment completed by interdisciplinary team	

Comprehensive Plan of Care	
9. Baseline plan of care within 48 hours of admission	F656 F657
10. Initial comprehensive care plan within 14 days after completion of the comprehensive care plan	
11. Comprehensive care plan completed by interdisciplinary team, including patient or representative if possible	

Continuing Care	
12. Physician / Provider Visits First visit within 30 days of admission Then every 30 days for 90 days Then every 60 days after the first 90 days APP may make every other required visit after the initial visit	F710 F711 F712 F713
13. Activities	F561

Regulatory Requirement	Regulatory Reference
Activities Assessment and Program Activities documented	
14. Bowel and Bladder Program As needed	F690
15. Fall Prevention Program All residents	Policy
16. Nutrition and Hydration • Adequate nutrition and hydration • 3 meals served • Not more than 14 hours between evening meal and breakfast • Not less than 10 hours between breakfast and evening meal • Adaptive equipment if needed	F692 F693
17. Immunizations Influenza Pneumococcal Covid-19	F883
18. Pain Assessment	F697
19. Monthly pharmacist medication review and physician review	F756
20. Psychotropic Drug Review and Gradual Dose Reduction by pharmacist and physician	F605
21. Range of Motion and Restorative Program	F676 F688 F675
22. Resident Behavior, New or Worsening	F740
23. Safe, Clean, Comfortable, Home-Like Environment	F584 F
24. Safety Measures for Combative Residents	Policy
25. Behavior Log	Policy
26. Skin Assessment	Policy
27. Unintended Weight Change	F692
28. Vision and Hearing Impaired Residents	F685