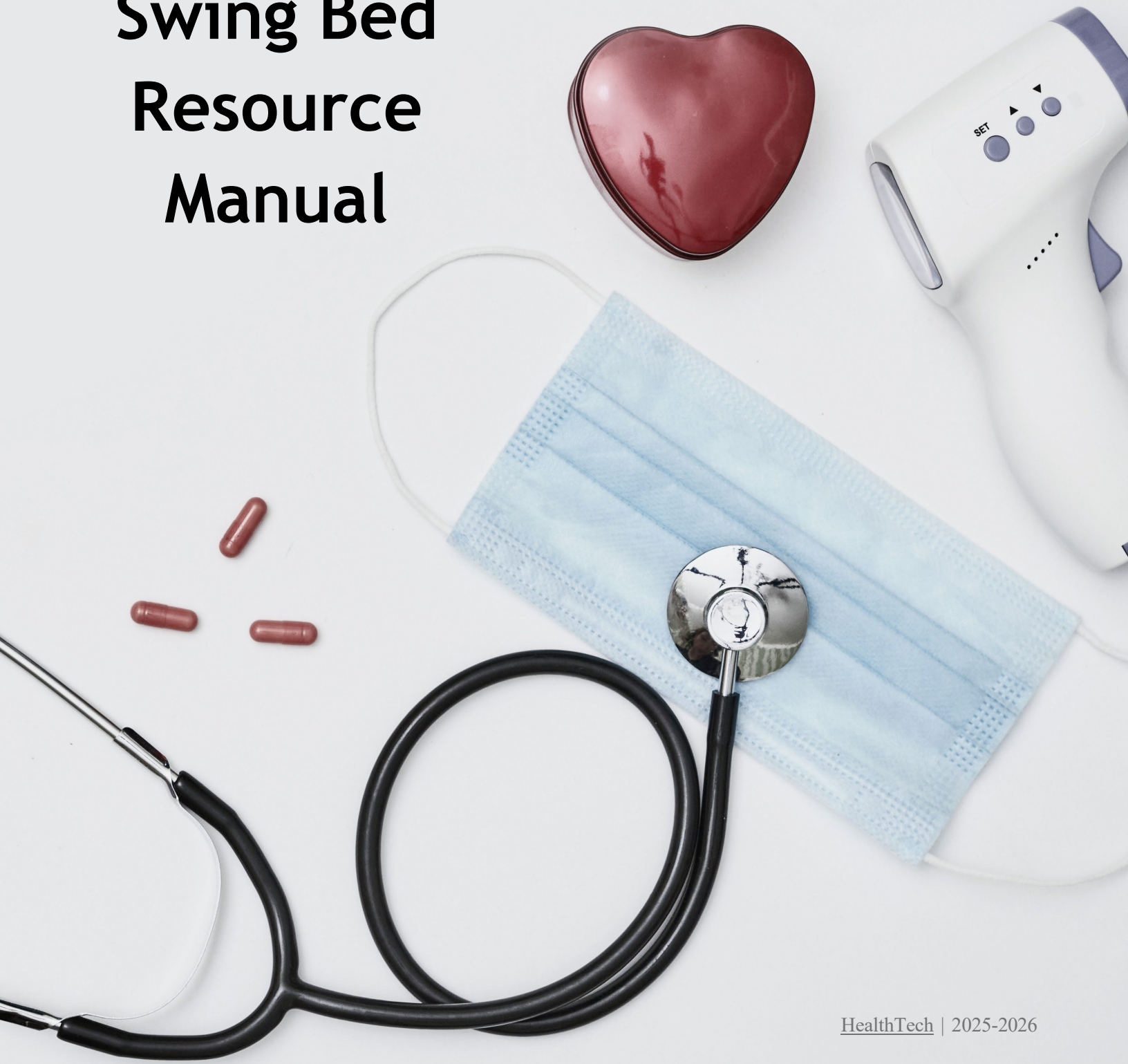
Washington

State Office of Rural Health

# Swing Bed Resource Manual



This publication was prepared by Carolyn St. Charles, Chief Clinical Officer at HealthTech, and funded by the Medicare Rural Hospital Flexibility (Flex) Grant administered by the Washington State Office of Rural Health (WA-SORH).

WA-SORH and HealthTech intend for this resource to support the development of Swing Bed policies and procedures and to assist organizations in maintaining continuous survey readiness. However, the content is provided for informational purposes only and should not be considered comprehensive or definitive. WA-SORH and HealthTech expressly disclaim all liability for the use or interpretation of this information. Hospitals, clinics, their staff, and other users should refer to original source materials and consult qualified healthcare regulatory counsel for specific regulatory guidance.

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## Introduction and Purpose

The first edition of the Swing Bed Resource Manual (Resource Manual) is designed to help swing bed programs meet regulatory requirements and strengthen their program.

The Resource Manual includes swing bed policies and procedures, admission documents, a crosswalk between Appendix W and Appendix PP, and a checklist to facilitate completion of an internal survey.

If you prefer to print the Resource Manual, it is organized to fit in a binder with a tab for each section.

The manual provides numerous templates and tools. Don't hesitate to contact the Washington State Office of Rural Health (WA-SORH) directly if you would like a Word version for your organization.

The Washington State Office of Rural Health hopes that you find the Resource Manual a valuable resource to improve and strengthen your Swing Bed program.

## AUTHOR

Carolyn St. Charles has over 30 years of healthcare experience, including more than 15 years in senior leadership roles.

As the Chief Clinical Officer for HealthTech, St. Charles provides various consulting services for healthcare facilities across the country, including leadership, productivity and staffing, quality assurance and performance improvement, survey readiness, and swing bed compliance and optimization.

St. Charles authored the Swing Bed manual for the Montana Flex program and the Quality Assurance Performance Improvement manual for the Illinois Critical Access Hospital Network.

St. Charles offers numerous webinars and educational programs on a variety of healthcare topics, including swing beds.

St. Charles earned an Associate Degree in Nursing from Pima Community College, a Bachelor of Science in Nursing from Northern Arizona University, and a Master of Business Administration from the University of Washington Foster School of Business.

She is a member of the American Organization of Nurse Executives, the Case Management Society of America, and Phi Kappa Phi.

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## ABOUT THIS MANUAL

1. Almost all facilities have swing bed policies and procedures in place. The provided policies and procedures, along with other resource materials, can be used to review your internal documents for any discrepancies or missing information and to modify them if needed. In some instances, it may be easier to adopt the policies outlined in the manual as a replacement for your current policies, particularly if there are substantial differences.

2. Throughout the manual, the terms certified and non-certified swing bed are used. Facilities may call the two types of Swing Bed care by various names.

   Certified swing beds are for patients who stay for a short period, typically 2–3 weeks. Organizations often refer to these patients simply as swing bed.

   Non-certified swing bed refers to residents who are admitted for long-term care for an extended period of time, often for the rest of their lives. Organizations may refer to these patients as intermediate or long-term swing bed.

3. The policies and procedures are divided into two main sections: swing bed and non-certified swing bed. Some of the policies in the swing bed section also apply to non-certified swing beds, which are noted at the beginning of each policy under scope.

4. There are no interpretive guidelines for swing bed in Appendix W, and instead, you are referred to Appendix PP, which is the Long-Term Care State Operations Manual. Applicable references to Appendix PP are included at the end of the policy in the reference section when they apply.

5. The reference section of each policy includes references to Appendix W and/or Appendix PP, and/or other Medicare manuals such as the Medicare Benefits Manual Chapter 8. There are also references to Washington RCWs.

6. The most recent regulatory sources were utilized as references. The most current Critical Access Hospital (CAH) Conditions of Participation (CoPs) were released 11/24/2025 in the electronic code of federal regulations (eCFR) and can be accessed at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F

The most recent State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities was released 7/9/2025 and can be accessed at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CMS/r231soma.pdf

It is important to update your policies and procedures whenever regulatory requirements change.

7. Deeming authorities such as ACHC, CIHQ, DNV, and the Joint Commission may have additional standards that apply to swing bed.

8. For most policies, there is a section at the end of the policy titled *Notes About This Policy*. The notes provide additional information and context. Since some of the policies are quite long, you may want to review the *Notes About This Policy* first.

9. CMS uses the term resident in all of its swing bed regulations. To the extent possible, the term patient has been used for certified swing bed and resident for non-certified swing bed.

# INDEX

# SECTION 1

# SWING BED
# POLICIES AND PROCEDURES

**Some policies in this section apply only to certified swing bed and others to both certified and non-certified swing bed, which is noted under scope**

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# Administrative

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# Abuse, Neglect, Exploitation, and Misappropriation of Property

**PURPOSE**

Describe the roles and responsibilities for preventing abuse, neglect, exploitation, and misappropriation of property, and the steps for reporting and investigation.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Patients have the right to be free from verbal abuse, mental abuse, sexual abuse, physical abuse, corporal punishment, or involuntary seclusion.

B. Patients will be free from physical or chemical restraints imposed for purposes of discipline or convenience that are not required to treat the patient's medical symptoms.

C. When the use of restraints is indicated, the least restrictive alternative for the least amount of time will be utilized.

D. Ongoing re-evaluation of the need for restraints will be documented if restraints are utilized.

E. All alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of patient property will be reported immediately, but no later than one (1) hour after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty (20) hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury to the CEO or designee.

F. All alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of patient property will be reported immediately, but no later than two (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 twenty-four (24) hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury to DSHS in accordance with state law through established procedures.

G. Evidence that all alleged violations are thoroughly investigated will be documented.

H. Further potential abuse, neglect, exploitation, or mistreatment while an investigation is in progress will be prevented.

I. Results of all investigations will be reported to the administrator or their designated representative within three to four (3-4) days and other officials in accordance with State law, including to the state survey agency, within five (5) working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken.

J. There will be zero tolerance for any behavior on the part of any employee, provider, or contract staff that could be perceived to constitute verbal abuse, sexual abuse, mental abuse, physical abuse, corporal punishment, and/or involuntary seclusion.

K. Immediate disciplinary action will be taken, up to and including the immediate termination of employment or contract, for any employee or contract staff involved in abuse, neglect, exploitation, or misappropriation of property.

L. The organization will not employ or otherwise engage individuals who:

    1. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law

    2. Have had a finding entered in the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of patients, or misappropriation of property

M. Professionally licensed staff and nurse aide position applicants will have their licenses checked to ensure that they are current and in good standing. The database for the excluded parties list (EPLS) and other databases required by facility policy will be checked.

N. All providers, staff, and contract staff will have a criminal background check completed before the first day of work. They will not be hired or engaged if the individual has been found guilty by a court of law of abuse, neglect, exploitation, misappropriation of property, or mistreatment. The administrator must review any other convictions.

O. The organization will 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.

P. All providers, employees, and contract staff will participate in education regarding the prevention and reporting of abuse, neglect, exploitation, and misappropriation of property at the time of hire and annually thereafter.

**DEFINITIONS**

**Abuse:** The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

**Chemical Restraint:** Any drug used for discipline or staff convenience, not required to treat medical symptoms.

**Emotional Abuse:** The willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal abusive conduct.

**Exploitation:** Taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion.

**Injuries of Unknown Source:** An injury is classified as an injury of unknown source when both of the following conditions are met:

1. The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient; and
2. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time

**Involuntary Seclusion:** The separation of a patient from other patients or from their room, or confinement to their room (with or without roommates), against the patient's will, or the will of the patient's legal representative. Emergency or short-term monitored separation from other patients will not be considered involuntary seclusion and may be permitted for a limited period as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the patient's needs.

**Mental Abuse**: Verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering. Includes, but is not limited to humiliation, harassment, threats of punishment, or deprivation.

**Misappropriation of Property:** Deliberate misplacement, exploitation, or wrongful temporary or permanent use of a patient's belongings or money without the patient's consent.

**Mistreatment:** Inappropriate treatment or exploitation of a patient.

**Neglect:** Failure of the facility, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

**Physical Abuse**: A willful act against a patient by another patient, staff, or other individuals. Includes hitting, beating, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment or restraining without authorization for disciplinary or convenience purposes.

**Physical Restraint:** Any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:

1. Is attached or adjacent to the resident's body
2. Cannot be removed easily by the resident
3. Restricts the resident's freedom of movement or normal access to his/her body

**Sexual Abuse:** Non-consensual sexual contact of any type with a patient. Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

**Verbal Abuse:** Any use of oral, written, and/or gestured language that includes disparaging and/or derogatory terms to patients or their families, or within their hearing distance, to describe patients, regardless of their age, ability to comprehend, or disability.

**Willful:** The individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

**PROCEDURE**

**A. Protection**

1. The organization will provide for the immediate safety of patients and take actions to prevent further potential abuse upon identification of suspected abuse, neglect, mistreatment, injuries of unknown origin, or misappropriation of property, while the investigation is in process. Means of providing protection include, but are not limited to:

a. Removing the alleged perpetrator from patient care areas immediately (unless another patient is the perpetrator)
b. Move patient to another room or unit
c. Provide 1:1 monitoring
d. Suspend suspected employee(s) pending outcomes of the completed investigation

**B. Reporting**

1. Employees or providers who witness or are informed of mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of patient property, will:
   a. Immediately report the allegations of what was witnessed or reported to the charge nurse or supervisor
   b. If the patient acts fearful or emotionally distraught, stay with the patient and use the call light to summon a nurse
   c. Document the information in the medical record

2. The charge nurse or supervisor will respond immediately upon notification and will:
   a. Assess the patient for:
      i. immediate safety
      ii. physical well-being
      iii. injuries
      iv. emotional distress
      v. any needed immediate treatment or intervention

   b. Take appropriate measures to prevent further potential abuse while the investigation is in progress

   c. Assess the incident (ask appropriate questions to attempt to ascertain what has happened)

   d. Preserve any potential evidence (soiled linen, gowns, etc.) in paper or open containers (not plastic or sealed)

   e. Notify the chief nursing officer (CNO), administrator, or administrator on-call and the attending physician no later than one (1) hour after the allegation has

been made if the events that caused the allegation involve abuse, including any abusive act or allegation, or result in serious bodily injury

f. Notify the CNO, administrator, or administrator on-call and the attending physician no later than twenty (20) hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury

g. The CNO will notify officials, including DSHS, no later than two (2) hours after an allegation has been made if the events that caused the allegation involve abuse or result in serious bodily injury

h. The CNO will notify officials, including DSHS, no later than twenty-four (24) hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury per the guidelines established in the state reporting guidelines and any other required agency, including the Ombudsman and local law enforcement

i. The administrator on-call may assume responsibility for notification to DSHS or other agencies if the CNO or care manager is not available

3. Chief Nursing Officer or Care Manager Responsibilities
    a. Notify the person legally responsible for the patient or individual(s) that the patient has given permission to share protected health information. This may be delegated to the administrator or the attending physician, depending on the circumstances of what has occurred. This should be done as soon as possible after the event occurred.

    b. Review the process to ensure that the charge nurse or supervisor has followed appropriate procedures, documented the event, and that any evidence is secure.

**C. Alleged Violations by Staff**

1. For any alleged violations by a staff member, the following additional steps will be taken:
    a. The nursing supervisor, CNO, or administrator will arrange to remove the involved employee from direct care and contact with all patients pending the outcome of the investigation

b. If the incident warrants, the administrator or CNO will:
    i. Notify law enforcement
    ii. Notify the human resource director, the employee's supervisor, and the risk manager
    iii. Work with the human resource director and risk manager to take appropriate steps to investigate and manage the event according to the organization's policy and procedures. The risk manager will be responsible for coordinating the investigation and ensuring that all appropriate documentation is collected and preserved.

**D. Investigation**

1. The CNO or risk manager will thoroughly investigate any alleged instances of abuse, neglect, exploitation, or misappropriation of property.

2. The in-house investigation will be documented and include the date and time of the incident, records of statements and interviews of the patient, other patients, and staff as applicable, steps taken to prevent further abuse, action taken, and notifications to state agencies as appropriate.

3. The investigation will be reported to the administrator or their designated representative within three to four (3 - 4) working days of the incident, and if the alleged violation is verified, appropriate corrective action taken.

4. The CNO or risk manager will report the results of all investigations to officials in accordance with state law, including DSHS, within five (5) working days of the incident. If the alleged violation is verified, appropriate corrective actions will be reported.

5. If the incident appears to be a criminal act, the administrator or designee will also notify the appropriate local law enforcement agencies.

**E. Education**

1. All new providers, employees, and contract staff will participate in education regarding the identification and prevention of abuse and their responsibility to report, as a component of orientation. The department manager, medical staff office, or education coordinator will arrange for the education.

2. All providers, employees, and long-term contract staff will complete annual education on the identification and prevention of abuse, including internal reporting.

3. All training will be documented and maintained with training records in the facility.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1612 §485.645(d)(3)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F600 §483.12; F606 §483.12(a); F607 §483.12(b); F609 §483.12(b); F610 §483.12(c); F942 §483.95

WAC 246-320-010 (Hospital)

WAC 388-97-0640 (Long-Term Care)

WAC 388-97-1800 (Long-Term Care)

***NOTES ABOUT THIS POLICY***

1. Organizations may have a different chain of command for reporting. However, ensure that timelines are met as required in the CoPs for both internal and external reporting, and that the appropriate parties are notified of the incident.

2. Please note this policy is different from the one you may have for reporting abuse identified in the emergency department or other hospital departments.

3. The time for internal reporting is shorter than the required reporting times to DSHS. This allows time to report to DSHS within the mandatory reporting period.

4. Depending on the seriousness of the event, law enforcement may need to be notified.

# Education and Training

**PURPOSE**

To outline the requirements for education and training.

**SCOPE: Certified and Non-Certified Swing Bed**

**DEFINITIONS**

**Staff:** Providers, facility staff (direct and indirect care functions), contract staff, and volunteers.

**POLICY**

Providers, employed staff (including both direct and indirect care functions), contract staff, and volunteers will receive education and training regarding the swing bed program at the time of hire.

**PROCEDURE**

A. Education and training will be provided at the time of hire, regardless of position, for providers, clinical and non-clinical staff, contract staff, and volunteers. The education will include:

1. Swing Bed Program Overview
2. Patient Rights
3. Abuse, Neglect, Exploitation, and Misappropriation of Property, including recognition and reporting

B. Documentation of the education will be included in the personnel file, medical staff file, or education file.

***NOTES ABOUT THIS POLICY***

There is a policy in the non-certified swing bed section that includes additional training and education requirements.

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# Admission Criteria
# Pre-Admission

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# Admission Criteria and Pre-Admission

**PURPOSE**

Outline the admission criteria and the pre-admission process for swing bed admission.

**SCOPE: Certified Swing Bed**

**POLICY**

A. No patient shall be denied admission based on sex, race, religion, ancestry, national origin, age, handicap, or sexual orientation, as long as they meet skilled needs, and the organization has the resources to meet the patient's needs.

B. All potential swing bed admissions will be reviewed in advance to ensure that they meet swing bed criteria and that patient needs can be met.

C. All potential swing bed admissions will be provided a choice of swing bed providers and other post-acute providers before being admitted to the swing bed program.

D. All Medicaid patients and patients with pending Medicaid will have a PASRR Level 1 screening completed before admission. A PASRR Level II screening will be completed when the Level 1 screening indicates that the individual may have serious mental illness, intellectual disability, or a related condition.

**DEFINITIONS**

**Daily Skilled Services:** Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a daily basis. 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 five (5) days a week. This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished, and discharge from the facility would not be practical.

**Skilled Nursing and/or Skilled Rehabilitation Services:** Skilled nursing or skilled rehabilitation services are those services, furnished according to provider orders, that:

1. Require the skills of qualified technical or professional health care personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, or audiologists; and

2. Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result

**PROCEDURE**

**A. Admission Limitations**

1. No patient will be accepted with the following needs, as it is beyond the capability of the swing bed program:
    a. Drug and alcohol treatment or rehabilitation
    b. Ventilator-dependent or ventilator weaning
    c. Blood transfusion(s)
    d. Dialysis
    e. Radiation therapy
    f. Chemotherapy
    g. Prisoners
    h. History of violent behavior
    i. Under the age of 18
    j. No clear discharge plan

2. Patients with secondary psychiatric diagnoses will be evaluated on a case-by-case basis to determine if their needs can be met.

3. External referrals of patients with a communicable disease or diagnosis will be evaluated based on diagnosis, specific care requirements, availability of a room to manage isolation if needed, and as directed by the organization's policy on communicable disease.

4. External referrals will be considered for admission based on the ability to meet the patient's medical and rehabilitation needs, but also on bed availability.

**B. Original Medicare Admission Criteria**

1. Patients with original Medicare must meet the following criteria:
    a. An inpatient stay within the last thirty (30) days of at least three (3) consecutive midnights
    b. The swing bed admission is for a medical condition the patient was admitted for or was treated during the qualifying inpatient stay, or a skilled need that

developed while the patient was hospitalized, even if it was not the reason they were admitted to the hospital

c. Patients may be admitted and readmitted within the last thirty (30) days of discharge without a new three (3) day acute stay if the reason for the admission is related to the original acute, swing bed, or skilled nursing facility stay

2. An elapsed period of more than thirty (30) days is permitted where the patient's condition makes it medically inappropriate to begin an active course of treatment 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 swing bed or skilled nursing facility immediately upon discharge from a hospital, for either covered or non-covered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

   This exception to the thirty (30) day requirement recognizes that, for certain conditions, swing bed or skilled nursing facility care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within thirty (30) days after hospital discharge.

   Since the exception is intended to apply only where the skilled nursing care constitutes a continuation of care provided in the hospital, it is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of skilled care will be required within a predeterminable time frame.

3. All of the following four (4) factors must be met to qualify for swing bed admission:
   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; 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

3) As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis

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.

4. Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care.

5. 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.

6. 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 determining that a service is not skilled.

7. Skilled nursing must be required seven days per week, and skilled rehabilitation five days per week.

**C. Medicaid and Medicaid Pending Admission Criteria**

1. Prior to admission, a PASRR Level 1 screening will be completed, and if necessary, a Level II screening.

2. Prior to admission, the care manager will contact the contracted managed care organization (MCO) to authorize the rehabilitation or skilled nursing services.

3. The care manager must confirm coverage with the MCO before admitting the patient for rehabilitation or skilled nursing services.

4. The MCO will authorize the number of rehabilitation or skilled nursing days that are approved.

5. If additional days are needed, the care manager will coordinate with the MCO.

## D. Other Payor Admission Criteria

1. Payors other than Original Medicare, including Medicare Advantage plans, have their own criteria for admission, and pre-authorization is required before admission to a swing bed. The care manager or designee is responsible for obtaining pre-authorization for admission.

## E. Review of Potential Patients - Internal Referral

1. The potential for swing bed will be identified, if possible, at the time of the acute care admission as part of discussions with the provider and the care management team.

2. When the provider has determined that the patient may be appropriate for swing bed care, all of the following will be completed before the patient is admitted:
    a. The care manager will provide the patient with a choice of post-acute care providers. The data must be relevant and applicable to the patient's goals of care and treatment preferences. The information provided, along with the patient's choice, will be documented in the medical record.

    b. Information provided to the patient to make an informed choice will include:
        i. Data on quality and resource use measures of skilled nursing facilities within a _____mile radius - or the organization's service area
        ii. Information about the organization's swing bed program and any other swing bed programs within a _____mile radius or the organization's service area
        iii. Internally collected data for the organization's Swing Bed program, if available

    c. For patients with Original Medicare, the care manager or the business office will determine the number of benefit days available

    d. The care manager or the business office will request authorization for any payor other than Original Medicare before the patient is accepted for swing bed care

3. If at all possible, before being admitted to swing bed, the care manager will determine the patient's choice of an attending provider. If this does not occur before admission, and the patient ultimately chooses a provider other than the provider who admitted the patient to swing bed, care will be transferred as soon as possible to the new provider.

**F. Review of Potential Patients - External Referral**

1. The care manager or designee will review all potential admissions to determine if the patient meets admission criteria, if the patient's needs can be met, and if there is a discharge plan.

2. The care manager will review the potential admission with appropriate disciplines, including the provider, nursing, rehabilitation, pharmacy, and dietary, as applicable, to ensure that patient needs can be met. At a minimum, the referral will be reviewed with the provider.

3. The care manager or the business office will request payor authorization for any payor other than Original Medicare.

4. For patients with Original Medicare, the care manager or the business office will determine the number of benefit days available.

5. If possible, the care manager will discuss admission with the patient or legal representative before admission to ensure that they are aware of expectations and agree to the swing bed admission.

6. If the patient meets criteria for swing bed, the care manager will determine if a provider with privileges will accept the patient. If the patient ultimately chooses a provider other than the one who initially accepted them, care will be transferred to the new provider as soon as possible.

**RELATED POLICIES**

Choice of Physician

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1425 §485.642(a)(8)

Washington State Health Care Authority: Washington Apple Health (Medicaid) Nursing Facilities Billing Guide July 1, 2025
https://www.hca.wa.gov/assets/billers-and-providers/Nursing-facilites-bg-20250701.pdf

WAC 388-97-1915 (Long-Term Care)

### *NOTES ABOUT THIS POLICY*

1. Procedure A: Admission Criteria will be your facility-specific criteria.

2. Procedure E.2.b.: The geographic area is determined internally. All patients admitted to a swing bed from acute care in the same hospital must be given a choice of post-acute care providers, including quality and resource-use data. If there is no internally collected swing bed data, that must be disclosed to the patient.

3. Review the most recent state requirements for admitting a patient with Medicaid or pending Medicaid.

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# Admission

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# Admission Process

**PURPOSE**

Outline the admission processes for admitting a patient to swing bed, including the delivery of required patient notices and disclosures.

**SCOPE: Certified Swing Bed**

**POLICY**

A. When a patient's reimbursement status changes from acute care to swing bed, a new medical or visit number will be determined. The acute care and swing bed medical records will be separate and distinct.

B. Patient notices and disclosures will be provided to the patient at the time of admission or as soon as possible after admission.

**PROCEDURE**

**A. Admission Processes**

1. Health Information Management (HIM) will assign a new account number for the swing bed stay and create a new medical record if the patient was an inpatient in the facility.

2. The attending physician will write discharge orders from acute care if the patient is currently an inpatient.

3. The attending physician will write admitting orders to swing bed. All acute orders will be discontinued. The admission order to swing bed will be documented in the swing bed medical record.

4. The attending physician will complete the following at the time of admission to swing bed:
    a. A new history and physical examination

    b. Certification at or as soon as possible after admission. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services. The information may be on a separate form, included in the history and physical, or in a progress note. The certification

must state that swing bed care is necessary and can only, as a practical matter, be provided in a skilled nursing facility or swing bed on a daily basis for an ongoing condition for which the patient was receiving inpatient hospital services before transfer to swing bed, or for a new condition that arose while in a skilled nursing facility for treatment of that ongoing condition.

5. The care manager will review all admission documents with the patient or legal representative and ask them to sign (attest) that they have received and understand the documents. The documents will be reviewed verbally in a language the patient understands. The patient will be allowed to ask any questions that they may have. A written copy of all documents will be provided to the patient, including:
    a. Swing Bed Description
    b. Advance Directives
    c. Rights and Responsibilities
    d. Choice of Physician
    e. Physician Contact Information
    f. Financial Obligations
    g. Choice of Visitors with 24-hour access
    h. Grievances and Complaints
    i. Abuse and Neglect
    j. Transfer and Discharge
    k. Contact information for hospital representatives, Quality Improvement Organization (QIO), Department of Health, and the State Ombudsman

6. The care manager or designee will provide the Health Unit Coordinator (HUC) with all signed swing bed admission forms, and they will be placed in the medical record.

7. The HUC will notify the following departments of the patient's admission:
    a. Dietary
    b. Pharmacy
    c. Rehabilitation, including PT, OT, and Speech, as applicable
    d. Social Work or Care Manager, if not already aware of the admission

**RELATED POLICIES**

1. Choice of Physician

2. Financial Obligations

3. Rights and Responsibilities
4. Personal Privacy and Confidentiality
5. Visitation
6. Physician Certification and Recertification

### *NOTES ABOUT THIS POLICY*

An example of an admission packet is included in Section 3.

# Choice of Physician

**PURPOSE**

Outline the process for the Swing Bed patient to select a physician and how the patient can contact providers involved in their care.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Patients will be allowed to choose a personal physician before or at the time of admission to swing bed. The physician must be licensed to practice and be a member of the medical staff.

B. Each patient will remain informed of the names, specialties, and methods of contacting physicians and other primary care professionals responsible for their care.

**PROCEDURE**

A. The care manager or designee will discuss with the patient their choice of a physician before or at the time of admission to swing bed. The care manager will inform the patient that the physician must be a member of the medical staff**.** The choice of physician form will be included in the swing bed admission packet and used to document the patient's choice. (Attachment 1)

B. If the patient chooses a physician who does not currently provide swing bed care, the care manager or designee will contact the physician and determine if they are willing to provide care for the patient.

C. The care manager or designee will inform the patient if the physician chosen is unable or unwilling to act as the patient's physician. The care manager or their designee will discuss other available physicians with the patient and determine the patient's second preferred choice.

D. If the patient subsequently selects another physician who is on the medical staff, and the physician is willing to provide care for the patient, the choice will be honored.

E. The care manager or designee will provide the patient with information about the physician(s) and advanced practice provider(s) (APPs) that will be caring for them, including the name,

specialty, and way of contacting the physician and other primary care professionals responsible for their care. If the physician or APP is part of a group and other physicians or APPs cover for the designated physician, information on contacting the group will be included in the information provided to the patient. (Attachment 2)

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1608 §483.10(d), (d)(3)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F555 §483.10(d)

***NOTES ABOUT THIS POLICY***

1. Patients seldom, if ever, choose another physician than those who provide care for swing bed patients – but they must still be given a choice.

2. Appendix W does allow an APP to be designated as the primary provider if:
    a) A physician reviews and signs all inpatient records (including swing bed records)
    b) The care is within the scope of the APP

Please note, however, that an APP cannot sign the certification or recertification statements.

## Attachment 1
## Physician Choice

Swing Bed care is typically provided by our Hospitalist group. If you agree to having this group oversee your care, please check below:

☐ _____ Name of Hospitalist Group
**Include the names of all providers (Physicians, APPs) in the group**

If you prefer a different physician, please let us know which physician you choose. Please note that the physician must have privileges to practice in our facility and must agree to be your primary physician.

I would like to have _____ as my physician while I am in Swing Bed.

**PATIENT NAME**

**PATIENT SIGNATURE**

**DATE**

**WITNESS**

## Attachment 2
## Contact Information

We understand you may want to contact your physician or other primary care providers who are caring for you.

You may contact the physician or other providers directly by calling the numbers below.

If it is not confidential, you may ask the nurse or care manager to contact the physician or other providers on your behalf.

**Provider Name**
*Contact Info*

**Provider Name**
*Contact Info*

# Physician Certification and Recertification

**PURPOSE**

To outline the requirements for swing bed patient certification and recertification by a physician.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. A physician must sign the swing bed certification at the time of admission or as soon as possible thereafter.

B. A recertification must be completed no later than fourteen (14) days after admission, and every thirty (30) days thereafter.

C. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services. The certification may be on a separate form, included in the H&P, or progress notes.

D. An Advanced Practice Provider (APP) may not sign the certification or recertification if the organization employs them.

**PROCEDURE**

**A. Initial Certification**

1. The physician will document at admission or as soon as possible thereafter that the patient:
    a. 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 a hospital or skilled nursing facility for treatment of that ongoing condition)

    b. Swing bed care is necessary and can only, as a practical matter, be provided in a skilled nursing facility or swing bed on an inpatient basis

**B. Recertification**

1. The physician will document a recertification within fourteen (14) days of admission and every thirty (30) days thereafter, including:

a. The 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)

b. Continued need for extended care services, and that they are medically necessary

c. Estimated period of time required for the patient to remain in the facility

d. Plan, when appropriate, for home care

**C. Late Certification or Recertification**

1. Delayed certifications and recertifications will be allowed if there has been an isolated oversight or lapse.

2. In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence that is considered relevant for purposes of explaining the delay.

3. A delayed certification and recertification may appear in one statement. A separately signed statement for each certification and recertification would not be required, as they would if a timely certification and recertification had been made.

**REFERENCES**

Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing Table of Contents (Rev. 13089; Issued: 02-21-25)
50.5

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Table of Contents (Rev. 12283; Issued: 10-05-23)
40.0; 40.1; 40.2; 40.3; 40.4; 40.5; 40.61

***NOTES ABOUT THIS POLICY***

1. Please note that an APP **cannot** complete the certification or recertification if the organization employs them.

2. For non-certified swing bed patients, some facilities have implemented re-certification every ninety (90) days rather than every thirty (30) days. Since the requirements for the frequency of certification and recertification are found in the Medicare benefits manual, this may be permissible.

# Financial Obligations

**PURPOSE**

Identify the process for informing swing bed patients of their financial obligations.

**SCOPE: Certified Swing Bed**

**POLICY**

A. Each patient who is entitled to Medicaid benefits will be informed in writing, at the time of admission to swing bed or when the patient becomes eligible for Medicaid:

    1. The items and services that are included in nursing facility services under the state plan and for which the patient may not be charged

    2. Those other items and services that the facility offers and for which the patient may be charged, and the amount of charges for those services

    3. When changes are made to the items and services

B. Each patient, regardless of payor source, before or at the time of admission, and periodically during the patient's stay, will be informed of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or Medicaid, or by the facility's per diem rate.

**PROCEDURE**

A. The care manager will inform each patient before or at the time of admission of financial obligations. This will include examples of items and services that the facility may charge the patient, as well as any copay for Medicare or other third-party payors. (Attachment 1)

B. Each patient will be informed of any changes to financial obligations when they occur by the care manager.

C. A patient who has been adjudicated incompetent or incapacitated will be advised of financial obligations to the extent the patient can understand them. The individual with decision-making authority for the patient will be notified of financial obligations.

D. Patients or their legal representatives who have questions may be referred to the care manager or the business office.

E. The business office is responsible for updating the Medicare co-pay annually and ensuring that patient notifications have been updated.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1608 §483.10(g)(17), (g)(18)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F582 §483.10(g)(17)

Washington Medicaid / Apple Health Long Term Care Programs, Benefits & Eligibility Requirements at https://www.medicaidlongtermcare.org/eligibility/washington/#nursing-home

***NOTES ABOUT THIS POLICY***

1. Please review coverage for Medicaid patients and ensure it is current and correct.

2. The co-pay for Medicare patients after day 20 updates every year in January. Assign someone to update the information.

## Attachment 1
## Financial Obligations

**Medicaid**

Washington Medicaid, more commonly known as Apple Health, will cover the cost of Swing Bed services, but coverage depends on the specific plan and whether the services are determined to be medically necessary.

Coverage typically includes payment for room and board, as well as all necessary medical and non-medical goods and services, such as:

- Personal care assistance with the activities of daily living (mobility, bathing, dressing, eating, toileting)
- Skilled nursing care
- Physician's visits
- Prescription medication
- Medication management
- Mental health counseling
- Social activities

Items not covered include:

- Private room
- Specialized food
- Comfort items not considered routine (tobacco, sweets, and cosmetics, for example)
- Any care services not considered medically necessary

**Medicare**

If you have Original Medicare insurance, Medicare will cover 100% of Medicare-covered charges for the first 20 days as long as you meet Swing Bed criteria. Continued stay in a Swing Bed is always based on a continued need for skilled care.

| | |
|---|---|
| Days 1 – 20 | $0 for each benefit period |
| Days 21 – 100 | $___ patient responsibility per day in 20__ |
| Days 100 and beyond | All costs |

Medicare-Covered Services include:

- Bed and board
    - Semi-private room (a room you share with other patients)
    - Meals
- Nursing and other clinical services, including physical therapy, occupational therapy, and speech therapy
- Medical social services
- Drugs
- Biologicals
- Supplies, appliances, and equipment for inpatient hospital care and treatment, and diagnostic or therapeutic items or services they, or others, provide under arrangement
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available in swing bed

If you have private insurance, your policy may cover coinsurance after the first 20 days, depending on your plan's benefits. The care manager will contact your insurance company to determine your benefits, but it is also a good idea for you to call directly.

**Other Insurance**

Other insurance companies have their own requirements for what is covered, as well as any co-pay. The care manager will contact your insurance company to determine what is covered and not covered, and will provide you with that information.  You may also want to contact your insurance company directly.

# Rights and Responsibilities

**PURPOSE**

Describe swing bed patient rights and responsibilities, and the process of informing patients or their representative of those rights and responsibilities.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

Swing bed patient rights will be explained verbally in a manner that is easy for the patient and/or their representative to understand. This includes, but is not limited to, communicating in plain language, explaining technical and medical terminology in a manner that is understandable to the patient, offering language assistance services to patients with limited English proficiency, and providing qualified sign language interpreters or auxiliary aids for those with hearing impairments.

This does not mean that a facility is required to supply and pay for hearing aids.

**DEFINITIONS**

**Abuse:** Willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

**Advance Directive:** Written instructions, such as a living will or durable power of attorney for healthcare, that allow individuals to understand, reflect on, discuss, and plan for future healthcare decisions when they are unable to make their own healthcare decisions.

**Experimental Research:** Development, testing, and use of clinical treatment, such as an investigational drug or therapy that has not yet been approved by the FDA or medical community as effective and conforming to accepted medical practice.

**Confidentiality:** Safeguarding the content of information, including video, audio, or other computer-stored information from unauthorized disclosure without the consent of the patient

and/or the individual's surrogate or representative. If there is information considered too confidential to be included in the record used by all staff, such as the family's financial assets or sensitive medical data, it may be retained in a secure location within the facility, such as a locked cabinet in the administrator's office. The record must show the location of this confidential information.

**Neglect:** Failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

**Personal Privacy:** Personal privacy encompasses accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. However, this does not require the facility to provide a private room for each resident.

**Resident Representative:** Resident representative means any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications

2. A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications

3. Legal representative, as used in section 712 of the Older Americans Act

4. The court-appointed guardian or conservator of a resident

5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, state, or federal law, or a court of competent jurisdiction

**Total Health Status:** Total health status includes functional status, nutritional status, rehabilitation, and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

**Promptly:** Delivery of mail or other materials to the patient within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

**Treatment:** Medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve the functional level, or relieve symptoms.

**PROCEDURE**

A. The care manager or designee will meet with the patient or legal representative before admission to swing bed or at the time of admission and will:

1. Provide a written copy of swing bed rights and swing bed responsibilities (Attachment 1 and Attachment 2)

2. Discuss the rights and responsibilities verbally in a way that the patient or legal representative can understand

3. Answer any questions that the patient or legal representatives may have

4. Request that the patient or legal representative attest (sign) that they have received a copy of the patient rights, have had the patient rights and responsibilities explained verbally, and have had their questions answered

5. Place the attestation in the medical record

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1608 §485.645(d); C-1610 §485.645(d)(2); C-1612 §485.645(d)(3)

State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F550 §483.10(a); F551 §483.10(b)(3); F552 §483.10(c); F553 §483.10(c)(2) and (c)(3); F554 §483.10(c)(7); F555 §483.10(d); F557 §483.10(e)(2); F558 §483.10(e)(3); F559 §483.10(e)(4) and (e)(5) and (e)(6); F560 §483.10(e)(7); F561 §483.10(f); F562 §483.10(f)(4)(i); F563 §483.10(f)(4); F583 §483.10(h)

### *NOTES ABOUT THIS POLICY*

1. There is no regulatory requirement for who is responsible for providing the patient with their rights and responsibilities. However, it is essential that they be reviewed verbally and that there is documentation to confirm that the rights were reviewed in a language and manner the patient can understand, and that the patient received a written copy. The rights should be available in languages prevalent in the area other than English.

2. The rights should be provided in large font, so they are easy to read.

3. Consider adding the following rights for non-certified residents:
    a. Right to vote
    b. Access to records within 24 hours
    c. Notification of resident or representative of a change in room or roommate assignment
    d. Protection of resident funds
    e. Examination of survey results

## Attachment 1
## Your Rights

**REPRESENTATIVE**

1. If you are judged incompetent under the laws of a state by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under state law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law.

2. Your wishes and preferences must be considered in the exercise of rights by your representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process.

3. In the case of a patient representative whose decision-making authority is limited by state law or court appointment, you retain the right to make decisions outside the representative's authority.

**EXERCISE OF RIGHTS**

4. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights. You have the right to be supported by the facility in the exercise of your rights.

5. You have the right to participate in or refuse to participate in experimental research.

6. You have the right to formulate an advance directive.

**QUALITY OF LIFE**

7. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

8. You have the right to retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other residents.

9. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

**YOUR CARE**

10. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

11. You have the right to be informed, in advance, of changes to your plan of care.

12. You have the right to request, refuse, and/or discontinue treatment.

**FREEDOM FROM ABUSE**

13. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.

**PRIVACY AND COMMUNICATION**

14. You have the right to personal privacy, including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each resident.

15. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

16. You have the right to access stationery, postage, and writing implements at your own expense.

**CHOICE OF PHYSICIAN / PROVIDER**

17. You have the right to choose an attending physician. You have the right to be informed if the physician you have selected is unable or unwilling to be your attending physician, and to choose an alternative physician if you request.

18. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

**VISITORS**

19. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.

20. You have the right to immediate access by others who are visiting with your consent, subject to reasonable clinical and safety restrictions, and your right to deny or withdraw consent at any time.

**FINANCIAL OBLIGATIONS**

21. If you are entitled to Medicaid benefits, you will be informed of:
    a. The items and services that are included under the state plan and for which you may not be charged
    b. Those other items and services that the facility offers and for which you may be charged, and the amount of charges for those services
    c. When changes are made to the items and services

22. You will be informed, regardless of payor source, before or at the time of admission, and periodically during your stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or Medicaid, or by the facility's per diem rate.

**MEDICAL RECORDS**

23. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with state law.

**COMPLAINT OR GRIEVANCE**

24. You have the right to contact the Department of Health Services, the Long-Term Care Ombudsman, Adult Protective Services, or other state officials if you have a complaint or grievance. You may also let the care manager, risk manager, or administrator know if you have a complaint or grievance.

**DISCHARGE OR TRANSFER**

25. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility is endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if you do not submit the necessary paperwork for third-party payment, or after the third party, including Medicare or Medicaid, denies the claims, and you refuse to pay for your stay
    - The facility ceases to operate

26. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility.

## Attachment 2
## Your Responsibilities as a Swing Bed Resident

1. To provide, to the best of your knowledge, accurate and complete information about your present illness, past illnesses, hospitalizations, medications, mobility, and other matters relating to your health.

2. To report unexpected changes in your condition to your physician or other members of the health care team.

3. To let us know if you clearly understand your plan of care or need further explanation.

4. To actively participate in your plan of care.

5. To follow hospital rules and regulations.

6. To be considerate of the rights of other residents and facility personnel.

7. To be respectful of the property of other residents and of the hospital.

8. To follow the smoke-free campus policy.

# Personal Privacy and Confidentiality

**PURPOSE**

Describe the swing bed patient's right to personal privacy and confidentiality.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. The patient has a right to personal privacy and confidentiality of his or her personal and medical records.

B. The patients' right to personal privacy, including the right to privacy, will be respected, including oral (spoken) communications, written communication, and electronic communications.

C. The patient has the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility for the patient, including those delivered through a means other than the postal service.

D. The patient has the right to secure and confidential personal and medical records.

E. The patient has the right to refuse the release of personal and medical records except as provided by applicable federal or state laws.

F. The Office of the State Long-Term Care Ombudsman may examine a patient's medical, social, and administrative records in accordance with state law.

**DEFINITIONS**

**Confidentiality:** Safeguarding the content of information, including video, audio, or other computer-stored information, from unauthorized disclosure without the consent of the patient and/or the individual's surrogate or representative. If information is considered too confidential to include in the record used by all staff, such as the family's financial assets or sensitive medical data, it may be retained in a secure location within the facility, such as a locked cabinet in the administrator's office. The record must show the location of this confidential information.

**Personal Privacy:** Personal privacy includes:

- Accommodations
- Medical treatment
- Written and telephone communications
- Personal care
- Visits and meetings of family and patient groups

Personal privacy does not require the facility to provide a private room for each patient.

**Promptly:** Delivery of mail or other materials to the patient within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

**Right to Personal Privacy:** Includes the patient's right to meet or communicate with whomever they want without being watched or overheard. Private space may be created as needed and need not be dedicated solely to visitation.

**PROCEDURE**

**A. Personal Privacy**

1. Staff will respect the patient's right to privacy.

2. Staff will provide privacy for written, telephone, electronic, and verbal communications, including visits and meetings with family or friends.

3. Staff will offer a separate area, if requested and if the patient's room does not provide sufficient privacy, or as requested by the patient.

4. Staff will knock on the door when entering a room and introduce themselves, as appropriate.

5. A patient will be given privacy when going to the bathroom and performing other personal hygiene activities.

6. Only authorized staff directly involved in examination, treatment, or procedures will be present when treatments or procedures are provided unless expressly agreed to by the patient.

**B. Mail and Packages**

1. All mail or packages will be delivered to the patient or the nursing floor by the purchasing department within 24 hours of being received, including Saturdays and Sundays, except when there is no regularly scheduled postal delivery and pick-up service.

2. If the mail is delivered to the nursing unit, the nursing staff will promptly deliver the mail to the patient.

3. Nursing staff will notify the purchasing department of any mail or packages to be mailed in a timely fashion to comply with the 24-hour timeline.

4. All mail or packages being sent by the patient will be mailed by the purchasing department within 24 hours, including Saturdays and Sundays, except when there is no regularly scheduled postal delivery and pick-up service.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1608 §483.10(g)(8)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F576 §483.10(g)(6), (g)(7), (g)(8), (g)(9)

RCW 74.42.070; RCW 74.420.100 (Long Term Care)

***NOTES ABOUT THIS POLICY***

It is important to identify someone to deliver mail at least 6 days/week for the U.S. Postal Service and 7 days/week for all other carriers.

# Visitation

**PURPOSE**

Outline the swing bed patient's right to receive visitors.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Immediate access will be granted to the patient's family members and other relatives of the patient, subject to the patient's right to deny or withdraw consent at any time.

B. Immediate access to a patient by other individuals who are visiting, with the consent of the patient, subject to reasonable clinical and safety restrictions, and the patient's right to deny or withdraw consent at any time.

C. Reasonable access to a patient will be provided to any entity or individual that provides health, social, legal, or other services to the patient, subject to the patient's right to deny or withdraw consent at any time

D. Immediate access will be granted to:
    1. Any representative of the Secretary
    2. Any representative of the state
    3. Any representative of the Office of the State Long-Term Care Ombudsman
    4. The patient's individual physician
    5. Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000
    6. Any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000
    7. The patient's representative

**DEFINITIONS**

**Family / Visitors:** Immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a state's common-law equivalent. It is important to understand that there are many types of families, each of which is equally viable as a supportive, caring unit. For example, it might include a foster family in which one or more adults serve as a temporary guardian for one or more children, who may or may not be biologically related.

Patients have the right to define their family and who they would like to visit.

**Reasonable Clinical and Safety Restrictions**: Procedures or practices that protect the health and security of all patients and staff. These may include, but are not limited to:

1. Restrictions placed to prevent community-associated infection or communicable disease transmission to the patient. A patient's risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) will be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until they are no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication). If deferral cannot occur, for example, at the end of life, the visitor should follow respiratory hygiene/cough etiquette, as well as other infection prevention and control practices, such as appropriate hand hygiene.

2. Keeping the facility locked or secured at night with a system in place for allowing visitors approved by the patient

3. Denying access or providing limited and supervised access to an individual if that individual is suspected of abusing, exploiting, or coercing a patient until an investigation into the allegation has been completed

4. Denying access to individuals who have committed criminal acts, such as theft

5. Denying access to individuals who are inebriated or disruptive

**PROCEDURE**

A. During the admission process, the care manager or designee will ask the patient who they define as family and any others that they would like to have visitation privileges with 24-hour immediate access. The information will be recorded in the medical record. If the patient is unable to express or communicate with whom they would like to have access to and visit, the care manager will discuss with the patient's representative.

B. If the patient makes any changes in whom they would like to have immediate 24-hour access, it will be noted in the medical record and communicated to the nursing staff.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1608 §485.635(f)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F563 §483.10(f)(4), §483.10(f)(4)(vi)

# Assessment
# Plan of Care

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# Comprehensive Assessment

**PURPOSE**

Outline the process for completing the swing bed interdisciplinary comprehensive assessment.

**SCOPE: Certified Swing Bed**

**POLICY**

A. An interdisciplinary assessment will be completed for all swing bed patients within three (3) days of admission.

B. The interdisciplinary assessment will include direct observation and communication with the patient, as well as communication with both licensed and non-licensed direct care staff on all shifts.

**DEFINITIONS**

**Interdisciplinary Team:**

- Attending physician or provider
- Registered nurse with responsibility for the patient
- Nurse aide with responsibility for the patient
- Member of the food and nutrition services staff
- To the extent practical, the patient and the patient's representative(s). An explanation must be included in a patient's medical record if the participation of the patient and their patient representative is determined not to be practicable for the development of the patient's care plan
- Other appropriate staff or professionals as determined by the patient's needs or as requested by the patient

**Significant Change:** A major decline in a patient's status that will not normally resolve itself without intervention by staff or the implementation of standard disease-related clinical interventions, which has an impact on more than one area of the patient's health status and requires interdisciplinary review and/or revision of the care plan, or both.

**PROCEDURE**

**A. Assessment**

1. The nursing assessment will be completed within twelve (12) hours of admission. Other disciplines will complete an assessment within two to three (2 – 3) days of admission.

2. The RN completing the assessment will include input from the patient as well as communication with both licensed and non-licensed direct care staff on all shifts.

3. The interdisciplinary assessment will include, but not be limited to, the following categories. The specific elements of each category are included in Attachment 1.
    a. Identification and demographic information
    b. Customary routine
    c. Cognitive patterns
    d. Communication
    e. Vision
    f. Mood and behavior patterns
    g. Psychosocial well-being, including a history of traumatic events
    h. Physical functioning and structural problems
    i. Continence - Bladder and bowel
    j. Active diagnoses
    k. Health conditions
    l. Dental
    m. Swallowing and Nutritional Status
    n. Skin condition
    o. Activity pursuit
    p. Medications
    q. Special treatments, procedures, and programs
    r. Restraints and alarms
    s. Participation in assessment and goal setting

4. The individuals, as identified in Attachment 1, will be responsible for completing their portion of the assessment.

5. The assessment will be documented in the medical record by the assigned discipline.

6. A reassessment will be completed within 24 - 48 hours of any significant change in the patient's physical or mental condition.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §485.645(d)(5)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F636 §483.20(b); F656 483.21(b) and (c)(2)
*CAHs are not required to use the resident assessment instrument as required under §493.20(b), or to comply with the requirements for frequency, scope, and number of assessments in §413.343(b)*

## *NOTES ABOUT THIS POLICY*

1. Attachment 1 includes suggested disciplines for each component of the assessment. However, responsibilities will depend on your assessment processes.

2. Attachment 1 includes suggested assessment elements for each category. However, the specific elements are not required by regulation and are provided as a suggestion. Please note, however, that an assessment of trauma is required, even though the specific questions are not.

3. An activities assessment by an activities professional or an occupational therapist is no longer required for CAH swing bed and can be completed by an RN or other qualified individual.

4. The timelines for the assessment are recommended based on the typical length of stay for a certified swing bed patient. However, there is no regulatory requirement specific to timelines.

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|

## Attachment 1
## Comprehensive Assessment

| | | | |
|---|---|---|---|
| Customary Routine | ❑ Time to wake up<br>❑ Time to go to sleep<br>❑ Naps<br>❑ Time eat meals (Bkf / Lunch / Dinner)<br>❑ Other | Activities<br>Nursing | |
| Cognitive Patterns | ❑ What is your name?<br>❑ Where are you right now?<br>❑ What day is it today?<br>❑ What is the current year? | Provider | Nursing |
| Communication | ❑ Ability to express ideas and wants, considering both verbal and non-verbal expressions<br>❑ Understood<br>❑ Usually understood. Difficulty communicating some words or finishing thoughts, but is able if prompted or given time<br>❑ Sometimes understood. Ability is limited to making concrete requests<br>❑ Rarely/never understood | Nursing | Provider |
| Vision | ❑ Corrective Lenses<br>❑ Cataracts<br>❑ Blind | Nursing | |
| Mood | ❑ Little interest or pleasure in doing things<br>❑ Feeling down, depressed, or hopeless<br>❑ Trouble falling or staying asleep, or sleeping too much<br>❑ Feeling tired or having little energy<br>❑ Poor appetite or overeating<br>❑ Feeling bad about yourself, or that you are a failure, or have let yourself or your family down<br>❑ Trouble concentrating on things such as reading the newspaper or watching television | Social Work or Nursing | |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| | ❑ Moving or speaking so slowly that other people have noticed -- or the opposite, such as being so fidgety or restless that you have been moving around a lot more than usual<br>❑ Thoughts that you would be better off dead, or of hurting yourself in some way | | |
| Behavior | ❑ Hallucinations<br>❑ Delusions<br>❑ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others)<br>❑ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing)<br>❑ 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) | Nursing | Provider |
| 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?<br>❑ Have you experienced the loss of a close friend, relative, or pet that you loved recently?<br>❑ Have you had any past trauma in your life that we should know about so we can better care for you?<br>❑ If you have experienced some trauma, is there something that helps you feel better?<br>❑ Is there anything we can do to help while you are in the hospital? | Social Work | Nursing<br>Provider |
| Culture | ❑ Are there any cultural beliefs/customs that will impact care, and that we need to know about | Social Work | Nursing |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| PASARR | ❑ If the patient has a PASRR (usually completed if the patient was a resident of LTC), review the PASRR (if available) | Social Work | Nursing |
| Physical functioning and structural problems | ❑ Independent<br>❑ Set-up or Clean-up Assistance<br>❑ Supervision or touching assistance<br>❑ Partial/moderate assistance<br>❑ Substantial/maximal assistance<br>❑ Dependent | PT | Nursing |
| Continence, bladder, and bowel | ❑ Urinary incontinence<br>❑ Bowel incontinence | Nursing | |
| Active diagnosis | | Provider | |
| Health conditions | | Provider | |
| Dental | ❑ Dentures (fitting/loose)<br>❑ Broken Teeth<br>❑ Overall dentation | Nursing | Dietitian |
| Swallowing | ❑ Loss of liquids/solids from the mouth when eating or drinking<br>❑ Holding food in the mouth/cheeks or residual food in the mouth after meals<br>❑ Coughing or choking during meals or when swallowing medications<br>❑ Complaints of difficulty or pain with swallowing | Nursing | Dietitian |
| Nutrition | ❑ Nutrition Risk Screening<br>❑ Loss of 5% or more in the last month or loss of 10% or more within the previous 6 months | Nursing | |
| | ❑ Dietitian Nutrition Assessment | Dietitian | |
| Skin condition | ❑ Braden Scale<br>❑ If pressure ulcers or skin breakdown, describe them in the nursing notes | Nursing | |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| Activities | What do you like to do?<br>❑ Reading – print or audiobooks<br>❑ Puzzles<br>❑ Word games<br>❑ Watching TV<br>❑ Knitting / Crocheting<br>❑ Visiting with friends<br>❑ Other | Activities or Nursing | |
| Medications | ❑ Medication Reconciliation | Nursing | Pharmacy |
| Special treatments and procedures | | Provider Orders | |
| Restraints and alarms | | Nursing | |

# Interdisciplinary Plan of Care

**PURPOSE**

Outline the process for developing the swing bed interdisciplinary plan of care.

**SCOPE: Certified Swing-Bed**

**POLICY**

A comprehensive person-centered care plan will be developed in consultation with the patient or a patient representative, consistent with the patient's rights. It will include measurable objectives and timelines to meet the patient's medical, nursing, rehabilitation, mental, and psychosocial needs identified in the comprehensive assessment. The plan of care will be culturally competent and trauma-informed.

The comprehensive care plan will describe:

1. The patient's goals for admission and desired outcome

2. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

3. Any interventions specifically related to providing culturally competent trauma-informed care

4. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment

5. Any specialized services or specialized rehabilitative services provided as a result of PASARR recommendations. If the interdisciplinary team disagrees with the PASARR findings, the rationale will be documented in the medical record.

**PROCEDURE**

A. The comprehensive care plan will be developed within three (3) and no later than four (4) days after admission.

B. The care manager will be responsible for coordinating the care conference and notifying attendees, including the patient or patient representative.

C. The care plan will be developed by an interdisciplinary team that includes:

1. The attending physician
2. A registered nurse with responsibility for the resident
3. A nurse aide with responsibility for the resident
4. A member of the food and nutrition services
5. To the extent practicable, the participation of the patient and the patient's representative(s). An explanation will be included in a resident's medical record if the participation of the resident and their resident representative is determined to be impracticable for developing the patient's care plan.
6. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident

D. The care plan will include:

1. Patient's goals for admission and desired outcomes, including discharge
2. The patient's preference and potential for future discharge. Documentation must include whether the patient's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities.
3. Measurable goals to be achieved and projected dates of achievement
4. Specific interventions/approaches to meet goals
5. Frequency of interventions
6. Timeline for meeting goals
7. Health care professional responsible for each intervention
8. Types of equipment/supplies needed

E. The care plan will be reviewed and revised by the interdisciplinary team at least weekly after each care conference or more frequently as needed. The review will include evaluation of the plan of care and any modifications that may be needed.

F. The patient or patient's representative will provide input into the plan of care. This may occur at the care conference or, if not feasible, before or immediately after it.

G. The patient or the patient's representative's concurrence or lack of concurrence with the plan of care will be documented in the medical record. If the patient or the patient's representative does not agree with the plan of care, the team will meet to review and revise if appropriate.

H. A summary of the care plan, including measurable goals and timelines, will be posted in the patient's room or provided to the patient by the care manager.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §485.645(d)(5)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F655 §483.21; F656 483.21(b)(1); F657 §483,21(b); F658 §483,21(b)(3)

***NOTES ABOUT THIS POLICY***

The policy will need to be modified based on the frequency of your interdisciplinary meetings and the templates you use for documentation. However, the interdisciplinary meetings must be appropriate for your length of stay. Ideally, the team meets twice per week so that new patients have a care plan developed as soon as possible.

# Trauma-Informed Culturally-Competent Care

**PURPOSE**

To define processes for providing trauma-informed, culturally-competent care.

**SCOPE: Certified and Non-Certified Swing-Bed**

**POLICY**

The facility will deliver care and services that, in addition to meeting professional standards, are delivered using culturally competent approaches, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.

**DEFINITIONS**

**Culture:** A conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

**Cultural Competency:** The developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

**Trauma:** Results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening, and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

**Trauma-informed Care:** An approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. Referred to variably as "*trauma-informed care*" or "*trauma-informed approach*."

**Trigger:** Psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization.

**PROCEDURE**

**A. Trauma-Informed Care**

1. Trauma Assessment
    a. A multi-pronged approach to identify a resident's history of trauma will be utilized, including:
        i. Asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event
        ii. Screening and assessment tools, including the admission assessment, history and physical, and social assessment

    b. As part of the initial assessment, the licensed nurse or care manager will complete a preliminary evaluation of trauma and include interventions in the plan of care if appropriate

    c. If the trauma survivor is reluctant to share their history, the licensed nurse or care manager will still try to identify triggers that may re-traumatize the patient by means other than asking the patient

    d. The physician, as part of the physical examination, will assess signs of trauma such as scars, numerical tattoos, and other signs of physical trauma

    e. The licensed nurse or care manager will, as appropriate, meet with the patient's family, friends, and any other health care professionals (such as psychologists, mental health professionals) to assist in identifying triggers that may re-traumatize residents with a history of trauma

2. Interventions to Prevent Re-Traumatization
    a. Based on the assessment, specific interventions will be identified to decrease exposure to triggers that re-traumatize the patient, as well as identify ways to mitigate or reduce the effect of the trigger on the patient. Examples of triggers and interventions include:

| Trigger | Interventions |
|---|---|
| Showers/shower fixtures | Provide alternative methods for bathing, such as tubs, sponge bath |
| Confinement in small/crowded spaces | Offer individual or small group activities |
| Loud noises | Decrease/eliminate exposures to loud noises during holiday celebrations or other events<br><br>Decrease volume or eliminate overhead paging systems<br><br>Decrease or eliminate exposure to movies with gunfire, fighting, or loud noises |
| Removal of clothing | Consideration of:<br>• Consistent staffing/same-sex caregiver<br>• Removing clothing slowly<br>• Explanation of what is happening |
| Exposure to smoke or fire | Remove from areas where smoking is permitted, or cookouts occur<br><br>Provide alternative meals inside the facility |

b. Specific triggers and interventions will be included in the plan of care and communicated to all caregivers

c. The interventions will be monitored to ensure that they are implemented as intended, and are having the desired effect to achieve the measurable objectives and the resident's goals for care, including whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization

d. The patient and/or family or representative will be included in the evaluation of the interventions to ensure a transparent and open discussion and better understanding of whether interventions must be modified

3. Staff Education for Providing Trauma-Informed Care
    a. All staff, including providers and contract staff, who interact regularly with residents will receive education about trauma-informed care at the time of hire and annually thereafter

**B. Culturally Competent Care**

1. At the time of admission, as part of the comprehensive assessment, the licensed nurse or care manager will assess the culture and cultural preferences of the resident. The assessment will include, but not be limited to:
    a. Food preparation and choices
    b. Clothing preferences such as covering hair or exposed skin
    c. Physical contact or provision of care by a person of the opposite sex
    d. Cultural etiquette, such as avoiding eye contact or not raising one's voice

2. Based on the assessment and input from the patient, the patient's family, and/or representative, the licensed nurse will include culturally competent care in the interdisciplinary plan of care. Examples of providing culturally competent care may consist of:
    a. Offering activities that are culturally relevant to the patient population
    b. Providing reading materials, movies, and newspapers in the resident's preferred language may help orient a patient to date, times, and events
    c. Allowing the performance of religious rites at the end of life to the extent possible
    d. Allowing LGBT residents to dress in their preferred style

**RELATED POLICIES**

Interdisciplinary Plan of Care

Patient Rights and Responsibilities (Certified and Non-Certified Swing Bed)

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §483.21(b)(3)(iii)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F656 §483.21(b)

Trauma Informed Care Implementation Resource Center at
https://www.traumainformedcare.chcs.org/

Trauma-Informed Care Toolkit, Virginia Commonwealth University at https://tictoolkit.vcu.edu/tic/Physician Certification and Recertification

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# Continuing Care

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# Aphasia, Care of the Resident

**PURPOSE**

Provide guidelines for assessing and assisting swing bed patients with aphasia to communicate effectively.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

All staff who provide care or interact with patients will be knowledgeable about techniques for assessing patients' verbal communication and for assisting residents with aphasia to communicate effectively.

**PROCEDURE**

A. For any patient with aphasia, request a physician order for a speech-language pathologist (SLP) assessment as soon as possible to evaluate the extent of the communication issue, the degree of comprehension, and the patient's ability to respond with recognized speech patterns.

B. Include the recommendations of the SLP in the care plan.

C. Provide speech therapy if recommended by the SLP and ordered by the physician.

D. Provide education for all nursing staff and any staff who interact regularly with patients at the time of hire and annually, to ensure that staff members promote opportunities for patients with aphasia to communicate effectively. Education may include, but not be limited to, the following techniques:

    1. Establish communication and talk to the patient while performing routine nursing procedures

    2. Make eye contact with the patient

    3. Encourage a relaxed environment and encourage social contact with people

    4. Speak slowly and distinctly, using simple words or short sentences, depending on the resident's comprehension ability

5. Utilize a writing board, pictures, magazines, flashcards, and money to stimulate communication and comprehension

6. Allow sufficient time and be patient. Encourage the patient to work with you, but do not force them to the point of frustration. Provide the patient with constant reassurance.

7. Encourage the resident to attempt verbal expression. If speech is jumbled, gently assist in correcting the speech pattern.

E. Include communication techniques tailored to the patient's needs in the interdisciplinary care plan.

F. Evaluate the resident's progress at regular intervals, but at least weekly for certified swing bed patients and quarterly for non-certified swing bed residents.

### *NOTES ABOUT THIS POLICY*

1. For patients with aphasia, an assessment by an SLP is very important. If you don't have an SLP on staff, consider a contractual arrangement.

2. Staff education for communication with a patient with aphasia is strongly recommended.

# Change of Condition

**PURPOSE**

Outline the process for identifying and reporting a change in condition.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

Staff who provide care to swing bed patients will recognize any changes in the patient's condition.

The licensed nurse and provider will be notified of any change in condition.

**DEFINITIONS**

**Change in Condition:** Any sudden and/or marked adverse change in signs, symptoms, or behavior exhibited by a patient, including but not limited to:

1. Acute illness
2. Anorexia and/or unplanned weight loss, or weight gain
3. Apathy
4. Behavioral changes, including unusual patterns (including increased expressions or indications of distress, social isolation, or withdrawal)
5. Bleeding or bruising, spontaneous or unexplained
6. Bowel dysfunction, including diarrhea, constipation, and impaction
7. Dehydration, fluid/electrolyte imbalance
8. Depression, mood disturbance
9. Dysphagia, swallowing difficulty
10. Falls, dizziness, or evidence of impaired coordination
11. Gastrointestinal bleeding
12. Headaches, muscle pain, generalized or nonspecific aching or pain
13. Lethargy
14. Mental status changes (e.g., new or worsening confusion, new cognitive decline, worsening of dementia (including delirium), and inability to concentrate)
15. Pain, new or worsening
16. Psychomotor agitation (e.g., restlessness, inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects)
17. Psychomotor retardation (e.g., slowed speech, thinking, and body movements
18. Rash, pruritus
19. Respiratory difficulty or changes

20. Sedation (excessive), insomnia, or sleep disturbance
21. Seizure activity
22. Urinary retention or incontinence

**PROCEDURE**

A. Notification of Change of Condition

1. The nursing assistant or other caregivers will notify the licensed nurse of any change in condition as soon as it is identified. Family or visitors may also identify a change in condition.

2. The licensed nurse will complete an assessment of the patient as soon as possible after being informed or identifying a change in condition

3. The licensed nurse will notify the provider of any change in condition

4. The licensed nurse will notify other licensed disciplines as appropriate (i.e., pharmacist, dietitian, etc.)

B. Staff Competency

1. The education director will provide or make arrangements for education and competency validation for all direct care staff, including contract staff, appropriate to their licensure, regarding the ability to identify and address a change in condition.

2. Education and competency will be completed within three months of hire and annually.

**RELATED POLICIES**

Resident Behavior, New or Worsening

Unintended Weight Change

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §483.20(3)(iii)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities
F637 §483.20(b)(2)(ii)

## *NOTES ABOUT THIS POLICY*

Although a change in condition is typically identified quickly for certified swing bed patients, it is sometimes missed in non-certified swing bed patients.

# Dental Care

**PURPOSE**

To identify a process for obtaining dental care for lost or damaged dentures.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Assist patients in obtaining routine and 24-hour emergency dental care, including assisting the patient in making appointments and arranging transportation to and from the dental services location.

B. Promptly, within three (3) days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within three (3) days, documentation will include the measures taken to ensure the resident can still eat and drink adequately while awaiting dental services, as well as the extenuating circumstances that led to the delay.

C. Medicare patients may be charged an additional amount for routine and emergency dental services.

D. Residents who are eligible and wish to participate in applying for reimbursement of dental services as an incurred medical expense under the state plan will be assisted to do so.

E. The patient will not be charged for the loss or damage of dentures determined to be the facility's responsibility.

**DEFINITIONS**

**Emergency dental services:** Services needed to treat an episode of acute pain in teeth, gums, or palate, broken or otherwise damaged teeth, or any other problem of the oral cavity.

**Routine dental services:** Inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as necessary, dental cleaning, fillings, minor dental plate adjustments, smoothing of broken teeth, and limited orthodontic procedures.

**Promptly:** Within three (3) days.

**PROCEDURE**

A. The RN completing the comprehensive assessment, or the provider, as part of the history and physical, will complete an oral and dental evaluation at the time of admission. The evaluation will include documentation of any damaged or broken teeth, broken dentures or ill-fitting dentures, any apparent signs of caries, and any evidence of ulcerations or abnormalities in the oral cavity.

B. Patient, patient's family members, concerned others, provider, dietitian, nurse, or other caregivers may identify dental care needs.

C. If the dental need is not urgent but should be addressed, the care manager will discuss with the patient and/or family. The care manager will assist the patient in scheduling an appointment with a dentist of their choice.

D. For urgent situations, including lost or damaged dentures, the care manager or nursing will notify the attending provider and then call the dentist of the patient's choice or a dentist identified by the organization to schedule an appointment within three (3) days.

E. If the referral to a dentist does not occur within three (3) days for any urgent dental need:

1. The care manager will document the circumstances creating the delay in the medical record

2. The dietitian will be notified to assess the patient's ability to eat and drink adequately, and if needed, develop an alternative diet for the patient while waiting for dental services

3. Nursing will document both food and liquid intake and notify the dietitian and attending physician if it is not adequate

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1624 §485.645(d)(7)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F790 §483.55; F791 §483.55 §483.55

### *NOTES ABOUT THIS POLICY*

The regulations also require that the hospital have a policy regarding when and under what circumstances lost or damaged dentures are the hospital's responsibility.

# Rehabilitation

**PURPOSE**

Identify rehabilitation services for swing bed patients.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Rehabilitation services, including physical therapy, occupational therapy, and speech therapy, will be available to patients who require rehabilitation therapy.

B. Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of rehabilitation services.

C. Rehabilitation services may be provided even when no improvement is expected, but there must be a need for skilled care. These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

D. There must be a provider order for rehabilitation services.

E. An order for rehabilitation services from acute care or the assessment from acute care does not apply to swing bed. A new provider order must be received, and a new assessment must be completed.

F. Rehabilitation services for certified swing bed patients will be available at least five days per week, or more often if required by the patient and ordered by a provider.

**DEFINITION**

**Skilled Therapy:** Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist.

**PROCEDURE**

A. A provider order for rehabilitation therapy will be entered in the medical order. The order may state, "*Evaluate and Treat*," or "*Evaluate*." If the provider orders only an evaluation, the provider must place an order before the patient can be treated.

B. The assessment must be completed by a physical therapist, occupational therapist, and/or speech therapist and cannot be completed by a physical therapy or occupational therapy assistant.

C. The assessment must be completed as soon as possible after the order is received, but not more than three (3) days after the order.

D. A treatment plan based on the assessment will be developed and include measurable short-term and long-term goals and timelines for achieving the goals. The plan must include therapy for a minimum of five days per week for certified swing bed patients.

E. The physical therapist, occupational therapist, and/or speech therapist will attend all scheduled Interdisciplinary care conferences to discuss goals and progress towards goals.

F. Treatment notes will be kept in the medical record.

G. If a physical therapy assistant or occupational therapy assistant is responsible for some or all of the therapy provided, the licensed physical therapist or occupational therapist will review the patient at least weekly and modify the treatment plan if needed.

H. If the patient refuses therapy, the licensed therapist will discuss with the patient and/or representative potential reasons, including the time of therapy, pain with therapy, etc. Therapy will be modified, as applicable, to include the timing of treatments and/or pain medication before each treatment.

I. An isolated break of a day or two in therapy treatments may be allowed depending on extenuating circumstances. The reason for the break must be documented.

J. The therapist will provide the patient with information about independent activities the patient can perform between therapy sessions, if applicable.

K. At the time of discharge, a final therapy note will be completed indicating if the treatment plan goals were met or not, and the current status towards goals.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1622 §485.645(d)(6)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F825 §483.65

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Table of Contents (Rev. 12283; Issued: 10-05-23)
30.4; 30.4.1;30.4.1.2; 30.4.2; 30.4.3 ; 30.6

RCW 74.42.170 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

1. If you do not have occupational therapy or speech therapy, you will need to modify the policy.

2. Therapy is required at least five days per week for certified swing bed, but if the patient needs therapy more frequently, it must be provided, or the patient should not be accepted.

3. CMS does not allow therapy to be arbitrarily scheduled to meet a five-day-per-week schedule (i.e., physical therapy M-W-F and occupational therapy T-Th). Therapy must be provided based on the licensed therapist's assessment.

# Social Service

**PURPOSE**

Identify the process for medically related social services, including discharge planning.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

Medically related social services will be provided to assist patients in attaining or maintaining the highest practicable physical, mental, and psychosocial well-being.

**PROCEDURE**

A. The care manager or social worker will complete an initial psycho-social assessment of each patient within 72 hours of admission, including the patient's goals for discharge.

B. The care manager or social worker will update the interdisciplinary team at least weekly, as part of the interdisciplinary care conference regarding patient needs and discharge goals.

C. The care manager or social worker will provide discharge planning (i.e., arranging intake for home care services for patients returning home, assisting with transfer arrangements to other facilities, etc.).

D. The care manager or social worker will provide medically related social services, including, but not limited to:

    1. Advocating for patients and assisting them with exercising their rights

    2. Assisting patients in voicing and obtaining a resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs

    3. Assisting or arranging for a patient's communication of needs through the patient's primary method of communication and in a language that the patient understands

    4. Arrangements for obtaining items, such as clothing and personal items

    5. Assisting with informing and educating patients, their family, and/or representative(s) about health care options and ramifications

6. Making referrals and obtaining needed services from external entities (e.g., talking books, absentee ballots, community wheelchair transportation)

7. Assisting patients with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements)

8. Transitions of care services (e.g., assisting the patient with identifying community placement options and completion of the application process, arranging intake for home care services for patients returning home, assisting with transfer arrangements to other facilities)

9. Providing or arranging for needed mental and psychosocial counseling services

10. Identifying and seeking ways to support patients' individual needs through the assessment and care planning process

11. Encouraging staff to maintain or enhance each patient's dignity in recognition of each resident's individuality

12. Assisting patients with advance care planning, including but not limited to completion of advance directives

13. Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each patient

14. Meeting the needs of patients who are grieving from loss or coping with stressful events

E. A licensed social worker may be needed in any of the following circumstances:

1. Lack of an effective family or community support system, or legal representative

2. Expressions or indications of distress that affect the patient's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia-related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and patient-to-patient altercations

3. Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation)

4. Difficulty coping with change or loss (e.g., change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one)

5. Need for emotional support

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1616 §485.645(d)(4)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F745 §483.40(d)

RCW 74.420.180 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

A licensed social worker is not required, but medically related social services must be provided.

# Nutritional Care

**PURPOSE**

To identify a process for providing appropriate and adequate nutritional care.

**SCOPE: Certified Swing Bed**

**POLICY**

A. Each patient will be provided with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into consideration the preferences of each patient.

B. All swing bed patients will have a comprehensive nutritional assessment completed by a registered dietitian within two to three (2-3) days of admission and weekly thereafter, or more frequently if needed.

C. Based on the patient's comprehensive assessment, the patient will maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the patient's clinical condition demonstrates that this is not possible, or patient preferences indicate otherwise.

D. Based on the patient's comprehensive assessment, the patient will be offered sufficient fluid intake to maintain proper hydration.

**DEFINITIONS**

**Significant Change:** A major decline in a patient's status that will not normally resolve itself without intervention by staff or the implementation of standard disease-related clinical interventions, which has an impact on more than one area of the patient's health status and requires interdisciplinary review and/or revision of the care plan, or both.

**PROCEDURE**

A. The nursing unit will notify dietary services and the registered dietitian of all swing bed admissions.

B. The registered dietitian will complete and document a comprehensive nutritional assessment within two to three (2-3) days of admission. This assessment may be completed remotely.

C. The registered dietitian will reassess the patient at least weekly, or more often as needed, including when there is a significant change.

D. The assessment and any recommendations by the registered dietitian will be documented in the medical record.

E. Lab tests and therapeutic diets recommended by the registered dietitian, as indicated by the nutritional assessment, must be co-signed by a physician unless the organization allows the registered dietitian to order lab work and therapeutic diets. The registered dietitian may order supplements and snacks without a physician's co-signature.

F. The registered dietitian will participate in the development of the interdisciplinary plan of care.

G. The registered dietitian will attend the interdisciplinary care conferences, or if unable to participate, a member of the food and nutrition services staff will attend who has knowledge of the patient's nutritional status.

H. Nursing staff will observe and document patient weight, intake, output, wound healing, and other nutrition indicators in the medical record as appropriate for each patient, or as ordered by the physician, or as recommended by the registered dietitian.

I. Patient and family education will be provided as needed.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1626 §483.25(g)(1), (g)(2)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F692 §483.25(g); F693 §483.25(g)

### *NOTES ABOUT THIS POLICY*

1. There is no specific requirement for a dietitian assessment within two to three (2-3) days. However, given the short length of stay, it should be completed as soon as possible after admission.

2. The dietitian assessment, goals, and interventions must be included in the plan of care, not just in a progress note.

# Therapeutic Leave

**PURPOSE**

Identify the circumstances under which a patient may leave the facility.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. A therapeutic leave may be granted for a limited period of time if approved and ordered by a provider.

B. The leave may be granted for, but not limited to:

1. Medical procedures at another site
2. Physician visit that is not on the hospital campus
3. Significant life activity such as a wedding or funeral
4. Other events or social activities such as church, lunch with family or friends, etc. (These types of leaves are most commonly reserved for non-certified swing bed patients)

C. For certified swing bed patients, unless there are extraordinary or unusual circumstances, leave will not be granted overnight.

D. Patients who are out of the facility overnight will be provided with written information that specifies:

1. The duration of the bed-hold policy, if any, during which the resident is permitted to return
2. The reserve bed payment policy in the state plan
3. Facility policies regarding bed-hold

4. Medication administration schedule

**DEFINITIONS**

**Therapeutic Leave:** Absence for purposes other than hospitalization.

**PROCEDURE**

A. The patient, family, or representative will request a therapeutic leave and the purpose of the leave.

B. The provider will be informed by the nurse or care manager, and will write an order for therapeutic leave, including the amount of time away from the facility if determined to be appropriate for the patient.

C. Nursing or rehabilitation staff will ensure that the individual assuming care for the patient has the necessary skills to care for the resident, including transferring and ambulation.

D. Nursing or pharmacy will prepare medication in a labeled container for only the amount required during the leave if the medication cannot be held during the patient's absence. The individual caring for the patient will be instructed on administering the medicines.

E. The individual caring for the resident while on therapeutic leave will be instructed by the nurse on any issues that could arise and when to return to the hospital immediately or call 911.

F. For any patient who will be absent from the facility overnight, the care manager, or designee, will inform the patient or representative of the facility's bed hold policy and any charges they may incur.

G. The patient or representative will sign a release from liability form before leaving the facility.

H. Upon return to the facility, the nurse will complete an assessment, including, at a minimum, a skin assessment and reconciliation of medications that were sent with the patient.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §413.343(b)(2)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F627 §483.15(c)

***NOTES ABOUT THIS POLICY***

1. Typically, therapeutic leave for a certified swing bed patient is related to physician appointments. Non-certified swing bed patients may request leave from the facility to be with family or friends.

2. The decision to grant or not to grant leave is at the discretion of the provider.

3. It is essential that if the patient will receive medications while out of the facility, whoever is administering the medication is competent to do so.

# Transfer and Discharge

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# Transfer and Discharge

**PURPOSE**

Outline the transfer and discharge processes.

**SCOPE: Certified and Non-Certified Swing Bed**

**POLICY**

A. Patients will be permitted to remain in the facility, and a transfer or discharge will not be initiated unless one of the following occurs:

1. The transfer or discharge is necessary for the patient's welfare, and the patient's needs cannot be met in the facility

2. The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility

3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient

4. The health of individuals in the facility would otherwise be endangered

5. The patient has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the patient fails to submit the necessary paperwork for third-party payment, or if the third party, including Medicare or Medicaid, denies the claim, and the patient refuses to pay for their stay. For a patient who becomes eligible for Medicaid after admission to a facility, the facility may charge only allowable Medicaid charges.

6. The facility ceases to operate

B. Patients will be provided with the appropriate and required notices at the time of transfer or discharge.

C. Patients will be allowed to remain in the facility and not be transferred or discharged from the facility except as permitted by regulatory statutes.

D. A patient will not be transferred or discharged when the patient exercises their right to appeal, and the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility.

E. Patients will be provided with sufficient preparation and orientation to ensure safe and orderly transfer or discharge.

F. Receiving facilities and providers will be provided with the necessary information to provide continuity of care when a patient is transferred or discharged.

**DEFINITIONS**

**Facility-Initiated Transfer or Discharge:** A transfer or discharge that the patient objects to did not originate through a patient's verbal or written request, and/or is not in alignment with the patient's stated goals for care and preferences.

**Patient-Initiated Transfer or Discharge:** The patient or, if appropriate, the patient representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of patients with cognitive impairment).

**Transfer and Discharge:** Transfer and discharge include the movement of a patient to a bed outside of the facility, whether that bed is in the same physical plant or not. Transfer and discharge do not refer to the movement of a patient from one bed to another within the same certified facility.

**Discharge:** Movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community.

**PROCEDURE**

A. When a facility-initiated transfer or discharge is necessary for any of the following reasons listed below, the transfer or discharge documentation in the patient's medical record will be completed by the patient's primary care provider.

1. When the transfer or discharge is necessary for the patient's welfare, and the patient's needs cannot be met in the facility.

2. When the transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility.

B. When a facility-initiated transfer or discharge is necessary for any of the following reasons listed below, the transfer or discharge documentation in the patient's medical record will be completed by a physician on staff at the facility. The physician does not have to be the patient's primary physician.

    1. When the safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient

    2. When the health of individuals in the facility would otherwise be endangered

C. When a facility-initiated transfer or discharge is necessary for the reasons outlined in B, physician documentation in the medical record will include:

    1. The reason for the transfer

    2. The specific patient needs that cannot be met

    3. Facility attempts to meet the patient's needs

    4. Services available at the receiving facility to meet the needs

D. Before a patient is transferred or discharged, the care manager, or designee, will:

    1. Notify the patient and the patient's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner that the patient can understand. (Attachment 1) The notice will include:
        a. The reason for transfer or discharge
        b. The effective date of transfer or discharge
        *c*. The location to which the patient is transferred or discharged
        d. A statement of the patient'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
        e. The name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman
        f. For patients 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 Act of 2000

g. For patients with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

E. The Notice of Medicare Non-Coverage (NOMNC) will be provided at least thirty (30) days before a Medicare patient is transferred or discharged, or as soon as practical under the following circumstances:

1. When the safety of individuals in the facility is endangered

2. The health of individuals in the facility would otherwise be endangered

3. When the transfer or discharge is necessary for the patient's welfare, and the patient's needs cannot be met in the facility

4. The patient's health has improved sufficiently to allow a more immediate transfer or discharge

5. An immediate transfer or discharge is required by the patient's urgent medical needs

6. The patient has not resided in the facility for thirty (30) days

F. The care manager, or designee, will deliver the NOMNC to Medicare patients no later than two (2) days before termination of services, except when the beneficiary transfers to another provider at the same level of care.

1. The notice must be validly delivered, which means the patient must be able to understand the purpose and contents of the notice to sign for receipt of it, including the right to appeal the termination decision. If the patient is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.

2. A copy of the signed NOMNC will be given to the patient.

3. The original signed NOMNC will be placed in the patient's medical record.

G. If the patient exercises their right to appeal the discharge or transfer, and the appeal is pending, the patient will not be transferred or discharged unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility. If

the patient is transferred while the appeal is in process, the care manager, or designee, and the provider will document the danger that failure to transfer or discharge would pose.

H. The care manager or designee will ensure that the reasons for the transfer or discharge are documented in the medical record.

I. A copy of the discharge notice will be sent to a representative of the Office of the State Long-Term Care Ombudsman by the care manager or designee.

J. If the patient is being discharged to a post-acute-care setting or will be using in-home services, the care manager will assist patients, their families, or the patient's representative in selecting a provider by using and sharing post-acute care data on quality measures and resource use measures. The data must be relevant and applicable to the patient's goals of care and treatment preferences. The information provided and the patient's choice will be documented in the medical record.

K. The care manager or RN will provide and document sufficient preparation and orientation for the patient to ensure safe and orderly transfer or discharge. The orientation will be provided in a form and manner that the patient can understand. The orientation and preparation will take into consideration factors that may affect the patient's ability to understand, such as educational level, language, and/or communication barriers, as well as physical and mental impairments. This orientation will be documented in the patient's medical record, including their understanding of the transfer or discharge.

L. When the facility anticipates discharge, a discharge is planned and not due to the patient's death or an emergency, a discharge summary will be completed that is available for release to authorized persons and agencies, with the consent of the patient or the patient's representative, that includes, but is not limited to, the following:

    1. 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, including any pending lab results

    2. A final summary of the patient's status at the time of discharge. This will include the items from the patient's most recent comprehensive assessment that accurately describe the patient's current clinical status, or a final summary of patient goals, including whether goals were met or not, and, if not, the reason.

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

a. An RN or provider will compare the medications listed in the discharge summary to medications the patient was taking while in swing bed. Any discrepancies identified during the reconciliation will be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes made.
b. Discharge instructions and accompanying prescriptions provided to the patient will accurately reflect the reconciled medication list in the discharge summary

4. A post-discharge plan of care that is developed with the participation of the Interdisciplinary team and the patient and, with the patient's consent, the patient representative(s), which will assist the patient to adjust to their new living environment

5. The post-discharge plan of care will indicate where the individual intends to reside, any arrangements made for the patient's follow-up care, and any post-discharge medical and non-medical services
    a. The post-discharge plan of care will detail the arrangements that staff have made to address the patient's needs after discharge, and include instructions given to the patient and their representative, if applicable
    b. The post-discharge plan of care will show what arrangements have been made, including:
        i. Where the patient will live after leaving the facility
        ii. Follow-up care the patient will receive from other providers, and that provider's contact information
        iii. Needed medical and non-medical services (including medical equipment
        iv. Community care and support services, if needed, and
        v. When and how to contact the continuing care provider

M. At the time the patient leaves the facility, the discharge summary will be furnished to the receiving provider, assuming responsibility for the patient's care after discharge. If there is no continuing care provider (e.g., the patient has no primary care physician in the community), efforts to assist the patient in locating one will be documented in the medical record.

N. The medical record will contain the discharge summary information and identify to whom the information has been provided.
O. The care manager will provide, at a minimum, the following information to the receiving provider:

1. Contact information of the practitioner responsible for the care of the patient
2. Patient representative information, including contact information
3. Advance Directive information
4. All special instructions or precautions for ongoing care, as appropriate
5. Comprehensive care plan goals
6. All other necessary information, including a copy of the patient's discharge summary and any other documentation, as applicable, to ensure a safe and effective transition of care

P. For patients discharged home, the medical record will document that written discharge instructions were provided to the patient and, if applicable, the patient's representative. These instructions will be discussed with the patient and patient representative and conveyed in a language and manner they can understand.

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1610 §485.645(d)(2); C-1620 §485.645(d)(5)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F627 §483.15(c); F628 §483.15(c)(2)

Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Table of Contents (Rev. 12934, Issued: 10-31-24) 260.3

***NOTES ABOUT THIS POLICY***

At the time of discharge, all interdisciplinary goals should be reviewed, along with documentation indicating whether the patient met or did not meet the goals, and if not, the reason.

## Attachment 1
## Swing Bed Notice of Transfer or Discharge

***NOTES***
***NOTICE OF TRANSFER OR DISCHARGE***

*There is an online form that can be used as a template, although it is specifically for long-term care patients.*

*Swing Bed Transfer or Discharge Notice*
*DSHS 10-237*
*https://www.dshs.wa.gov/sites/default/files/forms/pdf/10-237.pdf*

Patient Name:
Date Notice Issued:
Facility Name & Address:

Transfer or Discharge Effective Date:

You are being transferred to:

- ☐ Another nursing facility
- ☐ Another health facility
- ☐ A private residence (including home)
- ☐ Other (Please specify)

Name & Address of facility being transferred to:

The reason for your ☐ Discharge or ☐ Transfer is:

- ☐ Your health has improved sufficiently so that you no longer need the services provided in Swing Bed
- ☐ Your Discharge or Transfer is necessary for your welfare, and your needs cannot be met in this facility
- ☐ The safety of others in the facility is endangered
- ☐ The health of others in the facility would otherwise be endangered
- ☐ You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility
- ☐ The facility has ceased to operate

**Appeal Rights**

You have the right to appeal this discharge or transfer by requesting a hearing to the Office of Administrative Hearings. Your request for a hearing may be made any time up to 90 days from the date you receive this notice.

If you decide to appeal, you may request a hearing in person, by telephone/voicemail, or in writing.

You have the right to remain in the facility until the appeal is decided, if the hearing request is received on or before the proposed date of transfer/discharge, or the day you are actually transferred/discharged. If, however, discharging or transferring you from the facility would endanger your health or safety, or the health or safety of other individuals in the facility, you may be discharged or transferred while the appeal is pending.

The proposed discharge/transfer date is on the front page of this notice.

If you do not appeal, the facility may proceed with your transfer or discharge.

If the decision at the hearing supports the facility's decision (you lose the appeal), the facility may proceed with your transfer or discharge thirty (30) days after a final order is entered that upholds the decision.

If the discharge/transfer is not upheld (you win the appeal), and you are no longer in the facility, you have the right to readmission to the facility immediately upon the first available bed in a semi-private room, provided you require and are eligible for the services provided by the facility.

**Contact Information to File an Appeal**

***PLEASE REVIEW TO ENSURE THIS IS CURRENT AND ACCURATE***

| | |
|---|---|
| Office of Administrative Hearings<br>PO Box 42489<br>Olympia, Wa.<br>Telephone: 1-800-583.8271 | Acentra Health<br>Phone: 1-888-305-6759<br>TTY: 1-855-843-4776\<br><br>Mail<br>5201 West Kennedy Blvd., Suite 900<br>Tampa, Florida 33609 |
| Long-Term Care Ombudsman:<br>Phone: 1-800-562-6028<br>Fax: 253-815-8173<br>Email: ltcop@mschelps.org<br><br>PO Box 23699<br>Federal Way, Wa<br>98093-0699 | |

I have received and understand this notice.

Patient/Representative signature:

Time
Date

Witness

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# SECTION 2

# NON-CERTIFIED SWING BED POLICIES AND PROCEDURES

# INTRODUCTION

Policies and procedures for non-certified swing beds are included on the following pages. Please note that policies in Section 1, Swing Bed, may also apply as stated under Scope.

The policies were developed from the State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities, Washington RCW for Long Term Care, and other sources of long-term care policies.

Non-certified swing bed patients do not fall under the long-term care regulations, except to the extent there are references in Appendix W for Appendix PP. Although adherence to long-term regulations is not required, they do represent best practices for patients who may be in your facility for years and many for the rest of their lives.

The policy examples are designed to help you develop processes that enhance your residents' quality of life.

At the end of some policies, there are notes. You may want to review the additional notes before deciding whether the policy applies to your program.

# Administrative

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# Annual Program Assessment

**PURPOSE**

Outline the steps to complete an annual assessment.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

At least annually, a comprehensive assessment will be conducted to determine the resources needed to care for residents during day-to-day operations (including nights and weekends) and emergencies.

The assessment will be reviewed and updated, as necessary, whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

**PROCEDURE**

A. Organization leadership, including at a minimum the chief nursing officer (CNO) and the quality leader, will complete the annual assessment with input from providers and staff who care for non-certified swing bed patients.

B. The facility assessment will address or include:

    1. The facility's resident population, including, but not limited to:
        a. The number of residents and the facility's resident capacity
        b. The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments
        c. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population
        d. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population
        e. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food

2. The facility's resources, including but not limited to the following, will be assessed:
    a. All buildings and/or other physical structures and vehicles
    b. Equipment (medical and non-medical)
    c. Services provided, such as nutrition, pharmacy, behavioral health, and rehabilitation therapies
    d. All personnel, including managers, nursing and other direct care staff, including contract staff, and volunteers
    e. Education and/or training and any competencies related to resident care
    f. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies
    g. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations

3. A facility and community-based risk assessment, utilizing an all-hazards approach, will be completed, including:
    a. Active involvement of the following participants in the process:
        i. Leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the chief nursing officer (CNO)
        ii. Direct care staff, including but not limited to RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable
        iii. The facility must also solicit and consider input received from residents, resident representatives, and family members

4. The facility will use this facility assessment to:
    a. Inform staffing decisions to ensure that there is a sufficient number of staff with the appropriate competencies and skill sets necessary to care for residents' needs as identified through resident assessments and plans of care, as required
    b. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population
    c. Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population

d. Develop and maintain a plan to maximize recruitment and retention of direct care staff
e. Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care

**REFERENCE**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F838 §483.71

***NOTES ABOUT THIS POLICY***

1. The annual assessment was a new requirement for nursing homes in 2024. It is **not** required for non-certified swing bed. However, you may want to use some elements of the assessment to ensure you have the appropriate resources to care for the population you serve. You could also use some of the elements to help identify performance improvement goals.

2. Some of the requirements listed in B.3. may be in the emergency operations plan.

# Education and Training

**PURPOSE**

Outline the requirements for education and training.

**SCOPE: Non-Certified Swing Bed**

**DEFINITIONS**

**Staff:** Facility staff (direct and indirect care functions), contract staff, and volunteers,

**POLICY**

All staff, including staff who provide both direct and indirect care, contract staff, and volunteers involved in the provision of care or interacting with residents, will receive education and training appropriate to their role.

For direct care staff, the training will include evidence of competency if applicable.

**PROCEDURE**

A. The education coordinator, quality leader, or the chief nursing officer (CNO) will develop an annual education calendar that includes education topics, when the education will be offered, and applicable staff. It will also include the instructional method and whether competency is required.

B. Education and training will be provided at the time of hire and annually to all staff, contract staff, and volunteers, including:

    1. Swing Bed Program

    2. Resident Rights

    3. Abuse, Neglect, Exploitation, and Misappropriation of Property, including Recognition and Reporting

C. The following additional topics will be used as a draft outline to plan education, but will be modified if needed, as agreed to by the chief nursing officer (CNO), quality leader, and education leader.

| Staff Education | | |
|---|---|---|
| **Topic** | **Who** | **When** |
| Interpersonal communication that promotes mental and psychosocial well-being | All | At hire<br>Annual |
| Person-centered care and services that reflect the resident's goals for care | All | At hire<br>Annual |
| Culturally Competent Trauma-Informed Care | All | At hire<br>Annual |
| Care specific to residents with:<br>• Aphasia<br>• Behavioral Health diagnosis<br>• Dementia<br>• Vision impairment<br>• Hearing impairment | All | At hire<br>Annual |
| Care of the combative resident | All | At hire<br>Annual |
| Activities | All | At hire<br>Annual |
| Non-pharmacological approaches to care | All | At hire<br>Annual |
| Behavior log | Direct Care | At hire<br>Annual |
| Change in Condition | Direct Care | At hire<br>Annual |
| Skin and Wound Care | Direct Care | At hire<br>Annual |
| Bowel and Bladder Retraining | Direct Care | At Hire<br>As Needed |
| Medication Management | Licensed Staff | At hire<br>Annual |
| Pain Management | Direct Care | At hire<br>Annual |
| Restorative Care | Direct Care | At hire<br>Annual |

*All: Any clinical staff, non-clinical staff, or volunteers who interact with residents*

*Licensed Staff: Staff who are licensed to administer medications*

**D. Nurse Aide Training**

1. The facility will complete a performance review of every nurse aide at least once every 12 months.

2. The facility will provide regular in-service education based on the outcome of these reviews.

3. Training will include, at a minimum:
    a. Dementia management
    b. Resident abuse prevention
    c. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment
    d. Special needs of residents, including providing care for the cognitively impaired

4. In addition, nurse aides will also receive training as applicable to their position, as defined under C. staff education.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F726 §483.35; F730 §483.35(d)(7); F741 §483.40(a); F801 §483.60(a); F895 §483.85; F940 §483.95; F941 §483.95; F942 §483.95; F943 §483.95(c); F944 §483.95(d); F945 §483.95(e); F947; §483.95; F949 §483.95

WAC 388-97-1040 (Long Term Care)

***NOTES ABOUT THIS POLICY***

1. Although you are not required to meet all of the training requirements, many are essential for providing person-centered care and ensuring staff have the appropriate skills.

**2.** Review the recommended education and determine which applies to your population.

# Medical Director Responsibilities

**PURPOSE**

Define the role of the medical director.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

The facility will designate a physician to serve as medical director.

A. The medical director will have the following roles and responsibilities:

1. Assist facility staff in developing, reviewing, and evaluating administrative and resident care policies that address the resident's total medical and psychosocial needs, including, but not limited to, admission, transfer, discharge planning, the range of services available, emergency procedures, resident rights, and the frequency of physician visits

2. Participate as an active member of the quality committee

3. Act as a liaison between the attending physicians and other health professionals caring for residents

4. Assume temporary responsibility for the care of a resident if the resident's physician or the designated alternate physician is unavailable in the event of an emergency

5. Assist in the development and/or review of appropriate clinical practices and medical care policies that help ensure that each resident's medical regimen is incorporated appropriately into the care plan

6. Review recommendations and reports of drug regimen reviews and quality assurance activities, and assist with follow-up if needed, to the extent that the attending physician does not do this

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F841 §483.70(g), §483.70(g)(1), §483.70(g)(2)

WAC 388-97-1700 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

A medical director is **not** required for non-certified swing bed, but you may want to identify a provider on staff who can advise and be involved with the program.

# Physician and Provider Responsibilities

**PURPOSE**

Describe the requirements for physician and provider responsibilities.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A physician will admit all residents.

All residents will remain under the care of a physician during their stay.

Physician visits will occur at the frequency outlined in the procedure.

**DEFINITIONS**

**Physician Services:** Those services provided by physicians responsible for the care of individual patients in the facility.

**Advanced Practice Professional (APP):** Nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).

**Attending Physician:** Primary physician who is responsible for managing the resident's medical care. This does not include other physicians whom the resident may see periodically, such as specialists.

**PROCEDURE**

**A. Physician Choice**

1. All residents admitted or accepted for care will be under the care of a physician selected by the resident or the resident's authorized representative.

**B. Admission**

1. A physician must personally approve in writing a recommendation that an individual be admitted.

2. A physician's personal approval of an admission recommendation must be in written form. This may be accomplished through a hospital transfer summary written by a physician, paperwork completed by the resident's physician in the community, or other written form. If a physician does not provide a written recommendation that the resident be admitted prior to the admission, the physician's admission orders for the resident's immediate care will be accepted as "*personal approval*" of the admission if the orders are provided by a physician.

3. Admission orders in lieu of a physician's written recommendation for admission to the facility cannot be provided by an APP.

**C. Care by a Physician**

1. Each resident must remain under the care of a physician.

2. The facility will ensure that the medical care of each resident is provided or supervised by a physician.

3. Physician services will include, but not be limited to:
    a. Resident evaluation, including a written report of a physical examination, within 5 days before admission or within 72 hours following admission
    b. An evaluation of the resident and review of orders for care and treatment when the attending physician changes
    c. Advice, treatment, and determination of the appropriate level of care needed for each resident
    d. Written and signed orders for diet, care, diagnostic tests, and treatment of the resident
    e. Progress notes and other appropriate entries in the resident's health records
    f. Provision for alternate physician coverage in the event the attending physician is not available

**D. Frequency of Visits**

1. The timing of physician visits is based on the admission date. The first physician visit (including the initial comprehensive visit) must be conducted within the first thirty (30) days after admission, and then at 30 (thirty) day intervals up to ninety (90) days after the admission date.

2. After the first ninety (90) days, visits must be conducted at least once every 60 days. Permitting up to ten (10) days' slippage of a due date will not affect the next due date.

3. Although the physician may not delegate the responsibility for conducting the initial visit, an APP may perform other medically necessary visits before and after the physician's initial visit.

4. After the initial physician visit, an APP may make every other required visit. These alternate visits, as well as medically necessary visits, may be performed and signed by the APP, with a physician co-signature.

5. At each visit, the physician or APP will:
    a. Review the resident's total program of care, including medications and treatment
    b. Write, sign, and date progress notes
    c. Sign and date all orders except influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy

6. Alternate schedules of visits by an APP will be documented in the patient's health record with a medical justification by the attending physician.

**E. Medication Review**

1. The attending physician will review any drug regimen review irregularities identified by the pharmacist.

2. The attending physician will 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 must document their rationale in the resident's medical record.

3. The documentation must occur within thirty (30) days of receiving the report from the pharmacist.

**F. Physician Availability**

1. Physician services will be available 24 hours a day, in case of emergency.

**RELATED POLICIES**

Choice of Physician

Drug Regimen Review

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F710 §483.30; Facilities F711 §483.30(b); F712 §483.30(c); F713 483.30(d); F841 §483.70(g)(2)

WAC 388-97-1260 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

This policy is included only in the section for non-certified swing bed, since it outlines ongoing visits by a physician or APP. Typically, in a certified swing bed, patients are seen at least once a week, or more often if needed.

# Quality Assurance Performance Improvement

**PURPOSE**

Describe the quality assurance performance improvement (QAPI) program.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. To ensure the proper delivery of services and maintain and improve quality, a QAPI committee will meet at least quarterly.

B. As an alternative, the committee may be integrated into the facility's QAPI program.

C. The QAPI program must:

1. Be ongoing and comprehensive

2. Address the full range of care and services provided, including:
    a. All systems of care and management practices, clinical care, quality of life, and resident choice
    b. Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents

3. Reflect the complexities, unique care, and services that the facility provides

4. Define, implement, and address identified priorities

5. Identify and prioritize problems and opportunities that reflect process, functions, and services provided to residents based on performance data, resident and staff input, and other information

6. Develop corrective actions to address gaps in systems, and evaluate for effectiveness

7. Set expectations related to safety, quality, rights, choice, and respect

**DEFINITIONS**

**Indicators:** Measurement(s) of performance related to a particular care area or service.

**Quality Assurance Performance Improvement (QAPI):** Coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem-solving.

**Quality Assurance (QA):** Specification of standards for quality of service and outcomes, and systems throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is ongoing, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

**Performance Improvement (PI) (Also called Quality Improvement - QI):** Continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

**POLICY**

**A. QAPI Committee**

1. The QAPI committee will include:
    a. The chief nursing officer (CNO) or the leader for swing bed services, and
    b. A physician designated by the facility, and
    c. Three other members from the staff of the facility

2. The QAPI committee will meet quarterly to identify issues that may adversely affect the quality of care and services to residents and to develop and implement plans of action to correct identified quality concerns or deficiencies.

3. The QAPI committee will, at least annually, develop goals for improvement, including targets and interventions.

**B. Quality Plan**

1. The QAPI plan will describe the process for identifying and correcting quality deficiencies, including:
    a. Tracking and measuring performance
    b. Establishing goals and thresholds for performance measurement
    c. Identifying and prioritizing quality deficiencies
    d. Systematically analyzing underlying causes of systemic quality deficiencies;
    e. Developing and implementing corrective action or performance improvement activities
    f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed

**C. Quality Metrics**

1. The QAPI committee will determine quality metrics to be monitored and tracked. The following will be considered:
    a. Patient Safety Measures:
        i. Number of low-risk, long-stay residents with pressure ulcers
        ii. Number and percentage of residents who experienced a urinary tract infection

    b. Effectiveness Measures
        i. Number of residents who experienced moderate weight loss
        ii. Number of residents who experienced severe weight loss
        iii. Number of residents whose need for help with daily activities has increased
        iv. Number of residents who experienced a change in condition

    c. Patient-Centeredness Measures
        i. Number of residents who experienced worsening of a depressed or anxious mood
        ii. Number of residents who experienced a decline in functional status
        iii. Number of residents receiving psychotropics
        iv. Number of residents who receive gradual dose reduction (GDR)
        v. Resident satisfaction with care and environment

    d. Timeliness Measures
        i. Number of residents who were assessed and given the pneumococcal vaccine

ii. Average resident rating of how quickly the staff come when they call for help

e. Process Measures
   i. Percentage of monthly interdisciplinary assessments completed
   ii. Percentage of monthly pharmacist reviews completed
   iii. Percentage of quarterly resident assessments completed
   iv. Documentation of activities
   v. Documentation of restorative activities

**RESOURCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F865 §483.75(a)

RCW 74.42.640 (Long Term Care)

WAC 388-97-160 (Long Term Care)

***NOTES ABOUT THIS POLICY***

Organizations are already required to have a quality committee. There is no requirement for a separate committee for non-certified swing bed.

However, you may want to consider a sub-committee of your quality committee to address the needs of this population.

# Resident Financial Affairs and Trust Account

**PURPOSE**

The purpose of this policy is to maintain safeguards and accurate records of resident funds and valuables entrusted to the facility's care.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. Residents or their representative have the right to manage their own financial affairs.

B. The facility shall keep a current, written financial record for each resident. The record shall include written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or for the resident.

C. The resident or guardian, and if designated, the resident's family, shall have access to the financial records and will receive quarterly statements upon request.

D. Residents have the right to personal privacy and confidentiality of his or her personal and medical records, including fund accounts. Monies held in accounts, including cash on-site, will not be disclosed to any resident or staff member who is not responsible for managing resident funds.

E. The facility will not require residents to deposit personal funds.

F. If a resident chooses to deposit personal funds, the facility will 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.

G. The facility will 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.

H. There will be no charges imposed on residents from their trust accounts for any item or service for which payment is made under Medicare or Medicaid or for any bank service.

I. There must be sufficient cash on hand to honor residents' requests.

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

    1. The same day for amounts less than $100.00 ($50.00 for Medicaid residents)

    2. Three banking days for amounts in excess of $100.00 ($50.00 for Medicaid residents)

K. Residents may request that the facility temporarily place their funds in a safe location, without authorizing the facility to manage those funds. The facility will document the date, time, amount, and from whom or to whom the funds were received or dispersed.

L. The facility may not charge residents for managing residents' funds.

**PLEASE NOTE: M-X below ARE NOT specifically included in Appendix PP or RCW. They are included to provide additional information for managing resident funds or trust accounts.**

M. The facility will maintain a resident's personal funds that do not exceed $100 ($50.00 for Medicaid residents) in a non-interest-bearing account, interest-bearing account, or petty cash fund. There must be sufficient cash on hand to honor the resident's request.

N. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within thirty (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.

O. Within thirty (30) days following the death of a resident, except in a coroner or medical examiner case, all money and valuables of that resident which have been entrusted to the licensee shall be surrendered to the person responsible for the resident or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a resident without known heirs dies, the facility shall provide written notice to the county public administrator within five working days, and a copy of this notice shall be available at the facility for review by the Department.

P. The facility shall make reasonable efforts to safeguard residents' property and valuables in their possession.

Q. Not mingle resident funds or valuables with that of the facility. Residents' monies and valuables shall be maintained separately, intact, and free from any liability that the organization incurs in the use of the licensee's or the facility's funds.

R. Maintain safeguards and accurate records of resident funds and valuables entrusted to the licensee's care, including the maintenance of a detailed inventory and at least a quarterly accounting of financial transactions made on the resident's behalf.

S. Records of residents' monies, which are maintained as a drawing account, shall include a control account for all receipts and expenditures, supporting vouchers and receipts for all expenditures of monies and valuables entrusted to the licensee, an account for each resident, and supporting vouchers filed in chronological order. Each account shall be kept current with columns for debits, credits, and balance. All of these records shall be maintained at the facility for a minimum of three years from the date of the transaction. At no time may the balance in a resident's drawing account be negative.

T. Records of residents' monies and other valuables entrusted to the facility for safekeeping shall include a copy of the receipt furnished to the resident or to the resident's authorized representative. Each item of resident property entrusted to the licensee shall be clearly identified as belonging to that resident.

U. Residents' monies not kept in the facility shall be deposited in a demand trust account in a local bank, the deposits of which are insured by the Federal Deposit Insurance Corporation, or in a federally insured bank or savings and loan association. If a facility is operated by a county, such funds may be deposited with the county treasurer. If a facility is operated by the State, such funds may be deposited with the state treasurer. All banking records related to these funds, including but not limited to deposit slips, checks, cancelled checks, statements, and check registers, shall be maintained in the facility for a minimum of three years from the date of the transaction. Identification as a resident trust fund account shall be clearly printed on each resident's trust account checks and bank statements.

V. A separate list shall be maintained for all checks from resident funds that are, or have been, outstanding for 45 days or more as reflected on the most recent bank statement. Bank statements shall be reconciled monthly, with copies of the reconciliation maintained by the facility. Any checks on such accounts that are written off or uncashed shall be added to the appropriate resident's account.

W. Expenditures, for a particular resident, from the resident fund account may not exceed the drawing right that the resident has in the account. Expenditures from the resident fund account shall only be for the immediate benefit of that particular resident. No more than one month's advance payment for care may be received from a resident's account.

X. For all residents receiving Medicaid benefits, accounting will notify the resident's representative in writing when the trust account reaches $2,000, less the amount due for the monthly share of cost.

**DEFINITIONS**

**Hold, Safeguard, Manage, and Account For: The facility must act as a fiduciary of the resident's funds and report, at least quarterly,** on the status of these funds in a clear and understandable manner. Managing the resident's financial affairs includes funds that an individual gives to the facility to pay for a non-covered service. In these instances, the facility will provide a receipt to the gift giver and retain a copy.

**Interest-Bearing:** A rate of return equal to or above the rate at local banking institutions in the area. If pooled accounts are used, interest must be prorated to each resident based on actual earnings or the end-of-quarter balance.

**Surety Bond:** Agreement between the principal (the facility), the surety (the insurance company), and the obligee (depending on state law, either the resident or the state acting on behalf of the resident), wherein the facility and the insurance company agree to compensate the resident (or the state on behalf of the resident) for any loss of residents' funds that the facility holds, safeguards, manages, and accounts.

**PROCEDURE**

**A. Resident Trust Account**

1. The facility will maintain a separate trust account for residents. The funds in this account will not be combined/commingled with any other funds of the facility.

2. The accounting department will:
    a. Reconcile the resident bank account each month
    b. Complete a quarterly audit of financial transactions and provide it to each resident or their legally authorized representative. This will include funds held in the facility available for resident use.

3. When the accounting department receives a check from a conservator trust account, a family member, legal representative, or resident, they will write a receipt and make two copies of the check. The accounting department will deposit the check in the Resident Trust account. The accounting department will send a

copy of the check, the original receipt, a copy of the deposit slip, and a work paper showing the current bank balance to the CNO and the care manager.

The accounting department will maintain the paperwork supporting each resident's bank balances and will retain a copy of the check, the receipt, and the original bank deposit slip.

**B. Withdrawal of Funds from Trust Account**

1. When the resident or legal representative requests to withdraw money from the trust account, accounting will be notified.

2. Accounting will issue a check to the authorized representative within three (3) banking days of the request.

3. Both parties will sign a receipt that funds were received, the Accounting Department and the authorized representative.

4. A copy of the receipt will be given to the representative. The copy of the check and the original receipt will be maintained in the Accounting Department.

5. If the money from the trust account is requested to be available for resident use as part of the cash available onsite, accounting will obtain the required two signatures, withdraw the money from the trust account, and place it in petty cash.

6. A copy of the receipt given to the resident or authorized representative for moneys received shall be kept with trust account records (the resident's folder) maintained by the accounting department.

**B. Cash Resources On Site**

1. Cash resources kept on site will include a folder for each resident who has provided funds to be kept at the facility. The folder will contain:
    a. A ledger sheet to record transactions for the resident
    b. An envelope to hold cash on hand
    c. Pages to supplement receipts for money received and disbursed, and sales receipts for items purchased

2. The folder, ledger, and cash will be kept in a locked drawer.

**D. Distribution of Cash**

1. The social worker or RN will provide funds to residents kept in petty cash the same day as requested.

2. When cash is distributed from petty cash at the request of the resident, the social worker or RN will:
    a. Document the resident's name
    b. Document the amount of cash withdrawn
    c. Document the balance of funds remaining
    d. Have the resident sign for cash received
    e. Provide a receipt for the cash withdrawn to the resident

3. The social worker or the RN will complete a daily audit of the beginning and ending balance. If there are any discrepancies, the CNO or the CFO will be notified.

**C. Discharge, Eviction, or Death**

1. Upon discharge of a resident, all money and valuables which have been entrusted to the facility and kept within the facility shall be surrendered to the resident or authorized representative in exchange for a signed receipt.

2. The social worker or an RN will be responsible for returning money and valuables kept at the facility. This will include a detailed list of personal property and a current copy of the resident's debits and credits for funds held at the facility.

3. The accounting department will be responsible for returning any monies held in a bank account or with the county treasurer within three banking days. This will include the debits and credits to the resident's funds.

4. Within thirty (30) days following the death of a resident, except in a coroner or medical examiner case, the accounting department will make all money and valuables of that resident available to the person responsible for the resident or to the executor or the administrator of the estate in exchange for a signed receipt.

5. Whenever a resident without known heirs dies, the accounting department will provide a written notice within five working days to the public administrator of the county, and a copy of said notice shall be available in the facility for review by the Department of Health.

**RESOURCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F568 §483.10(f)(10)(iii); F569 §483.10(f)(10)(iv); F570 §483.10(f)(10)(vi)

RCW 74.42.060; RCW 74.42.130 (Long-Term Care)

## *NOTES ABOUT THIS POLICY*

1. Some portions of the policy are from a state with more detailed regulations about managing trust accounts.

2. Each facility will need to determine how it handles cash on hand and trust accounts.

# Resident Council

**PURPOSE**

To define the function of a Resident Council.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The facility will facilitate a resident council.

B. Any resident may organize and participate in the resident council.

C. The resident council will serve as a vehicle for patients to participate in decision-making, voice grievances, and resolve differences.

**PROCEDURE**

A. Residents will be provided with a private space for council meetings.

B. Members may elect a president and other officers. Elections shall be held as deemed by the members.

C. Meetings will be scheduled monthly or more often if the members choose. The meetings will be posted on the activity calendar.

D. The activity director is designated to serve as liaison to the Resident Council and will provide support services at the Resident Council's discretion. The Resident Council may meet without a staff member present.

E. Staff and visitors may only attend at the group's invitation.

F. Concerns, suggestions, and comments raised during the resident council meeting will be noted in the meeting minutes and on a resident council response form.

G. The activity director will deliver the resident council response form to the department manager, who is best able to address the concern. The department manager will address the Resident Council Response form in writing and submit

the response to the activity director.

H. The meeting minutes and completed resident council response forms will be submitted to the administrator forreview.

I. The reviewed meeting minutes and resident council response forms will be returned to the activity director for review at the next resident council meeting.

J. The resident council meeting minutes and resident council response forms will be maintained in the activity office.

K. Strict confidentiality of meeting content will be maintained. Only those who need to know will receive information about the meeting content to address the resident council's concerns and recommendations.

L. Resident council permission will be obtained before releasing resident council meeting minutes and responses to any person or entity.

**RESOURCE**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F565 §483.10(f)(5)

## *NOTES ABOUT THIS POLICY*

There is no requirement for a resident council. However, many LTC facilities have resident councils to enhance residents' quality of life and provide a structured environment for feedback.

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# Pre-Admission
# Admission

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# Admission Criteria

**PURPOSE**

Provide guidelines to ensure that all residents are admitted in accordance with state and federal regulations.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The facility will accept patients in a manner that is fair, non-discriminatory, and compliant with all applicable federal and state regulations.

B. The organization will only accept patients whose care needs can be met.

C. The following types of care needs cannot be accepted:
    1. Dialysis
    2. Significant mental illness or intellectual disability that is beyond the capability of the SNF, as determined by the chief nursing officer (CNO) and medical director
    3. History of violence towards other residents or staff
    4. Permanent tracheostomy
    5. Paraplegic or quadriplegic

D. No Medicaid or Medicaid pending resident will be admitted unless they have had a PASRR Level 1 completed, and if indicated, a PASRR Level 2.

E. No patient shall be denied admission based on sex, race, religion, ancestry, national origin, age, handicap, or sexual orientation, as long as the organization has the resources to meet the resident's needs.

**DEFINITIONS**

**Preadmission Screening and Resident Review (PASARR):** Federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.

**PROCEDURE**

A. The care manager will screen all residents before admission for:

1. Evidence of a negative TB test within the last twelve (12) months

2. PASARR Level 1

3. PASARR Level 2 if the Level 1 screening indicates that an individual may have a serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or a related condition (RC)

4. Review of resident care needs and whether they can be met

5. Review of financial sources for payment, including private pay, Medicaid, or supplemental insurance

6. Identification of a resident representative if the resident is unable to make decisions

B. If there are any questions about a potential admission, they will be discussed with the chief nursing officer (CNO) and the medical director before a decision to admit the resident is made.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F644 §483.20(e), (e(1), (e)(2)

RCW 74.42.056 (Long Term Care)

WAC 388-97-1915 (Long Term Care)

## COMMENTS ABOUT THIS POLICY

1. The admission criteria will be specific to your facility.

2. Review state regulations regarding completion of the PASARR for Medicaid patients.

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# Assessment and Care Planning

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# Baseline, Quarterly, and Annual Assessments

**PURPOSE**

Outline the process for completing a baseline, comprehensive, and quarterly assessment.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The licensed nurse will complete an initial assessment within twenty-four (24) hours of admission. The assessment will be utilized to complete an initial baseline care plan within forty-eight (48) hours of admission.

B. The interdisciplinary team will complete a comprehensive assessment within fourteen(14) days of admission and annually thereafter.

C. A focused assessment, based on the resident's individualized needs and the current plan of care, will be completed every three months except in the quarter when the annual assessment is completed.

D. Assessments will include direct observation and communication with the patient, as well as communication with both licensed and non-licensed direct care staff on all shifts.

**DEFINITIONS**

**Interdisciplinary Team:**

- Attending physician or provider
- Registered nurse with responsibility for the patient
- Nurse aide with responsibility for the patient
- Member of the food and nutrition services staff
- To the extent practical, the patient and the patient's representative(s). An explanation must be included in a patient's medical record if the participation of the patient and their patient representative is determined not to be practicable for the development of the patient's care plan
- Other appropriate staff or professionals as determined by the patient's needs or as requested by the patient

**Significant Change:** A major decline in a patient's status that will not normally resolve itself without intervention by staff or the implementation of standard disease-related clinical

interventions, which has an impact on more than one area of the patient's health status and requires interdisciplinary review and/or revision of the care plan, or both.

**PROCEDURE**

**A. Initial Baseline Assessment and Care Plan**

1. The nursing assessment will be completed within twenty-four (24) hours of admission.

2. The assessment will include, at a minimum:
    a. Resident's goal for admission
    b. Review of orders and/or assessments from the physician, dietary, therapy, and care management, and PASARR recommendations if applicable
    c. Physical and Cognitive assessment
        i. Head-to-Toe physical assessment
        ii. Cognition
        iii. Speech and Hearing
        iv. Mobility
        v. Weight
    d. Bowel and Bladder continence
    e. Medications
    f. Risk Assessments
        i. Risk for falls
        ii. Risk for skin breakdown
        iii. Risk for inadequate nutrition and/or hydration

3. The RN completing the assessment will include input from the patient as well as communication with both licensed and non-licensed direct care staff on all shifts.

4. The assessment will be utilized to develop the baseline plan of care within 48 hours of admission.

5. The baseline plan of care will be revised by the licensed nurse, based on additional input and assessments from other disciplines.

**B. Comprehensive and Annual Assessment**

1. The initial interdisciplinary comprehensive assessment will be completed within fourteen (14) days of admission, and annually thereafter. The assessment will include, but not be limited to:
    a. Identification and demographic information
    b. Customary routine
    c. Cognitive patterns
    d. Communication
    e. Vision
    f. Mood and behavior patterns
    g. Psychosocial well-being, including a history of traumatic events
    h. Physical functioning and structural problems
    i. Continence - Bladder and bowel
    j. Active diagnoses
    k. Health conditions
    l. Dental
    m. Swallowing and Nutritional Status
    n. Skin condition
    o. Activity pursuit
    p. Medications
    q. Special treatments, procedures, and programs
    r. Restraints and alarms
    s. Participation in assessment and goal setting

2. The individuals identified in Attachment 1 will be responsible for completing their portion of the assessment.

3. The assessment will be documented in the medical record by the assigned discipline.

**C. Monthly Assessment**

1. The care plan will be reviewed by an RN and updated at a minimum of monthly.

2. The RN will solicit input from all shifts and all caregivers.

**D. Quarterly Assessment**

1. A focused assessment, based on the resident's individualized needs and the current plan of care, will be completed every three months except in the quarter when the

annual assessment is completed. The RN or care manager will facilitate the assessment by the appropriate discipline.

**RELATED POLICIES**

Change of Condition

Comprehensive Care Plan (Non-Certified)

**REFERENCES**

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
C-1620 §485.645(d)(5)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F636 §483.20; F637 §483.20(b)(2)(ii); F638 §483.20(c); F639 §483.20(d); F641 §483.20(g); F644 §483.20(e); F655 §483.21; F656 §483.21(b); F657 §483.21(b);

MDS Item Matrix for October 2025
https://www.cms.gov/files/document/draftmds-30-item-matrix-v1201october2025.pdf

WAC 388-97-1000 (Long-Term Care)

WAC 388-97-1020 (Long-Term Care)

***NOTES ABOUT THIS POLICY***

1. Appendix PP requires a baseline care plan within forty-eight (48) hours, a comprehensive assessment within fourteen (14) days of admission, and a comprehensive plan of care within seven (7) days after completion of the comprehensive assessment (twenty-one days from admission). This is intended to allow the various disciplines time to complete an accurate and comprehensive evaluation and the team time to develop the plan of care.

2. Attachment 1 includes suggested responsibilities for each assessment element. However, responsibilities will depend on your assessment process.

3. Attachment 1 also includes suggested assessment elements for each category. However, the specific elements are not required by regulation and are provided as a suggestion. Long-Term Care facilities, of course, use the MDS to guide their assessment process.

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|

## Attachment 1
## Comprehensive Assessment

| | | | |
|---|---|---|---|
| Customary Routine | ❑ Time wake up<br>❑ Time to go to sleep<br>❑ Naps<br>❑ Time eat meals (Bkf / Lunch / Dinner)<br>❑ Other | Activities<br>Nursing | |
| Cognitive Patterns | ❑ What is your name?<br>❑ Where are you right now?<br>❑ What day is it today?<br>❑ What is the current year? | Provider | Nursing |
| Communication | ❑ Ability to express ideas and wants, considering both verbal and non-verbal expressions<br>❑ Understood<br>❑ Usually understood. Difficulty communicating some words or finishing thoughts, but is able if prompted or given time<br>❑ Sometimes understood. Ability is limited to making concrete requests<br>❑ Rarely/never understood. | Nursing | Provider |
| Vision | ❑ Corrective Lenses<br>❑ Cataracts<br>❑ Blind | Nursing | |
| Mood | ❑ Little interest or pleasure in doing things<br>❑ Feeling down, depressed, or hopeless<br>❑ Trouble falling or staying asleep, or sleeping too much<br>❑ Feeling tired or having little energy<br>❑ Poor appetite or overeating<br>❑ Feeling bad about yourself, or that you are a failure, or have let yourself or your family down<br>❑ Trouble concentrating on things such as reading the newspaper or watching television | Social Work or Nursing | |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| | ❑ 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<br>❑ Thoughts that you would be better off dead, or of hurting yourself in some way | | |
| Behavior | ❑ Hallucinations<br>❑ Delusions<br>❑ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others)<br>❑ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing)<br>❑ 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) | Nursing | Provider |
| 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?<br>❑ Have you experienced the loss of a close friend, relative, or pet that you loved recently?<br>❑ Have you had any past trauma in your life that we should know about so we can better care for you?<br>❑ If you have experienced some type of trauma, is there something that helps you feel better<br>❑ Is there anything we can do to help while you are in the hospital? | Social Work | Nursing |
| Culture | ❑ Ask if any cultural beliefs/customs will impact care that the hospital needs to know about | Social Work | Nursing |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| PASARR | ❑ If the patient has a PASRR (usually completed if the patient was a resident of LTC), review the PASRR | Social Work | Nursing |
| Physical functioning and structural problems | ❑ Independent<br>❑ Set-up or Clean-up Assistance<br>❑ Supervision or touching assistance<br>❑ Partial/moderate assistance<br>❑ Substantial/maximal assistance<br>❑ Dependent | PT | Nursing |
| Continence, bladder, and bowel | ❑ Urinary incontinence<br>❑ Bowel incontinence | Nursing | |
| Active diagnosis | | Provider | |
| Health conditions | | Provider | |
| Dental | ❑ Dentures (fitting/loose)<br>❑ Broken Teeth<br>❑ Overall dentation | Nursing | Dietician |
| Swallowing | ❑ Loss of liquids/solids from the mouth when eating or drinking<br>❑ Holding food in the mouth/cheeks or residual food in the mouth after meals<br>❑ Coughing or choking during meals or when swallowing medications<br>❑ Complaints of difficulty or pain with swallowing | Nursing | Dietician |
| Nutrition | ❑ Nutrition Risk Assessment<br>❑ Loss of 5% or more in the last month or loss of 10% or more within the previous six (6) months | Nursing | |
| | ❑ Dietitian Nutrition Assessment | Dietitian | |
| Skin condition | ❑ Braden Scale<br>❑ If pressure ulcers or skin breakdown, describe them in the nursing notes | Nursing | |

| Assessment Area | Questions | Primary | Secondary |
|---|---|---|---|
| Activity pursuit | What do you like to do?<br>❑ Reading – print or audiobooks<br>❑ Puzzles<br>❑ Word games<br>❑ Watching TV<br>❑ Knitting / Crocheting<br>❑ Visiting with friends<br>❑ Other | Activities or Nursing | |
| Medications | ❑ Medication Reconciliation | Nursing | Pharmacy |
| Special treatments and procedures | | Provider Orders | |
| Restraints and alarms | | Nursing | |

# Comprehensive Care Plan

**PURPOSE**

To provide guidelines for the development and implementation of an individualized, comprehensive care plan for each resident at the time of admission, quarterly, and annually.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

All residents will be assessed upon admission, monthly, quarterly, and annually to identify their care needs. Based on the assessment, a comprehensive care plan will be developed or updated, consistent with resident rights, which include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the assessment.

**DEFINITIONS**

**Person-Centered Care:** Focus on the resident and supporting them in making their own choices and having control over their daily lives.

**Culture:** A Conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

**Cultural Competency:** A Developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

**Interventions:** Actions, treatments, procedures, or activities designed to achieve a specific objective.

**Measurable:** Ability to be evaluated or quantified.

**Objective:** Statement describing the results to be achieved to meet the resident's goals.

**Person-Centered Care:** Focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

**Resident's Goal:** Resident's desired outcomes and preferences for admission, which guide decision-making during care planning.

**Trauma-Informed Care:** Approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization.

**PROCEDURE**

**A. Baseline Care Plan**

1. A licensed nurse will develop an initial baseline care plan to address each resident's immediate needs within 48 hours of admission.

2. A copy of the care plan will be provided to the patient and/or representative.

**B. Comprehensive Initial and Annual Care Plan**

1. A comprehensive, individualized care plan will be developed and implemented within fourteen (14) days after completion of the comprehensive assessment (twenty-one days after admission), and annually thereafter. A care manager, or RN, will coordinate the development of the care plan, including notifying the resident or their representative of the time and place of any care plan meetings.

2. When developing the comprehensive care plan, the comprehensive assessment will be utilized.

3. The comprehensive care plan will be 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 the food and nutrition services staff
    e. Pharmacist
    f. Rehabilitation or restorative aide
    g. Individual responsible for activities
    h. Social work or the care manager

i. 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 involvement of the resident and their resident representative is determined not to be practicable for the development of the resident's care plan
j. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident

4. The comprehensive care plan will describe the following:
    a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

    b. Any services that would otherwise be required under, but are not provided due to the resident's exercise of rights, including the right to refuse treatment

    c. 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

    d. In consultation with the resident and the resident's representative(s):
        i. The resident's goals for admission and desired outcomes
        ii. The resident's preference and potential for future discharge. Documentation of whether the resident desires to return to the community was assessed, and any referrals to local contact agencies and/or other appropriate entities were made
        iii. Discharge plans as appropriate

5. The comprehensive care plan will:
    a. Include data collected from the resident's assessment and integrate those findings into the care planning process
    b. Provide treatment and services that include reasonable and measurable resident care goals
    c. Be continuously monitored for effectiveness
    d. Be reviewed regularly and updated at least every thirty (30) days
    e. Individualized to meet the resident's needs, with measurable objectives describing the steps toward achieving the resident's goals that can be measured, quantified, and/or verified
    f. Include input from other interdisciplinary team members, as appropriate

g. Continuously evaluated based on the resident's clinical condition, diagnostic test results, care goals, and treatment, care, and services plan
h. Revised as needed to meet the resident's changing condition

6. A summary of the interdisciplinary care plan will be provided to the resident and their representative after each care plan update.

7. The services provided or arranged by the facility, as outlined by the comprehensive care plan, must be culturally-competent and trauma–informed.

**C. Monthly Care Plan Review**

1. Monthly or more frequently if needed, an RN will update the care plan based on input from staff on all shifts and the resident or resident representative.

2. A summary of any changes will be provided to the resident and their representative after each care plan update.

**D. Quarterly Care Plan Review**

1. A focused assessment, based on the resident's individualized needs and the current plan of care, will be completed every three months except in the quarter when the annual assessment is completed.

2. The RN or care manager will schedule an interdisciplinary care plan meeting to review the assessment and update the plan of care. The patient or family will be invited to attend.

3. A summary of any changes will be provided to the resident and their representative after each care plan update.

**ATTACHMENT**

Care Plan Example

**RELATED POLICIES**

Baseline, Quarterly, and Annual Assessment

Change of Condition

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F656 §483.21(b)(1); F657 §483.21(b)(2)

RCW.388-97-1020 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

1. Depending on the time after admission when you complete the comprehensive plan of care, you may not need a baseline care plan.

2. The care plan must be reviewed and updated at a minimum of monthly by the RN and quarterly by the interdisciplinary team.

3. A new comprehensive assessment must be completed annually, and the care plan must be modified as needed.

4. Several disciplines have been added to the interdisciplinary team, which are not specifically included in the CoPs, including: pharmacist, rehabilitation or restorative aide, individual responsible for activities, and social work or care management.

5. An example of a very simple care plan is included in Attachment 1. You may choose to write the care plan in the first person.

# Attachment 1
# Care Plan Example

**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 | Care Manager | By Jan. 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<br><br>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<br><br>The nurse aide will deliver the newspaper to the patient daily | Daily |
| I will be safe and free from falls | The Hendrich Fall Risk assessment will be completed quarterly | Occupational Therapy | By Oct 1 |
| | The interventions identified as part of the Hendrich Fall Risk assessment will be implemented and included in the plan of care | Licensed Nurse<br><br>All Staff | Ongoing |
| | Please do not relocate items in my room without my consent | All staff | Daily and ongoing |
| | Please remind me to wear my glasses | All staff | Daily and ongoing |

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# Continuing Care

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# Activities

**PURPOSE**

Outline the provision of activities.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

The organization will have an activities program designed to encourage each resident to maintain normal activity and help each resident return to self-care.

A staff member qualified by experience or training in directing group activities will be responsible for the activities program.

The organization will provide adequate recreation areas with sufficient equipment and materials to support the program.

**DEFINITIONS**

**Activities:** 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.

**One-to-One Programming:** Programming provided to residents who are unable or cannot effectively plan their own activity pursuits, or who require specialized or extended programs to enhance their overall daily routine and activity pursuits.

**Designated Activities Coordinator:** An Individual qualified by experience or training in directing group activities.

**PROCEDURE**

A. An initial and annual activities assessment will be completed for each resident by the designated activities coordinator. The activity assessment will include:
    1. Social History
    2. Interests and Hobbies
    3. Clubs and Organizations
    4. Spiritual Preferences
    5. Support System Relationships
    6. Cognitive/Behavioral
    7. Mood
    8. Communication
    9. Physical
    10. Physician Orders
    11. Customary Routine
    12. Activity Preferences / Choices

B. The assessment will identify if and when residents would like to pursue independent activities.

C. Information used to complete the activity assessment may be obtained from the resident, relatives, friends, legal representatives, the patient's physician, the medical record, activity documents/notes, social history, staff members, by observation, and activity documents/notes.

D. The activities plan will be included in the interdisciplinary plan of care.

E. The designated activities coordinator or the individual providing the activities will document participation.

F. Activities will be available daily.

G. Equipment and supplies for both independent and group activities and for patients having special needs will be available.

H. Staff with appropriate training and experience will provide activities which may include occupational therapy assistant, physical therapy assistant, and nursing.

I. Activity programs will be provided for residents confined to their rooms in accordance with their physical and mental status and lifelong interests. Provisions will be made for independent activities as appropriate.

J. A variety of activities will be provided that include, but are not limited to:
    1. Social and group activities
    2. Indoor and outdoor activities
    3. Activities away from the facility
    4. Religious or cultural programs
    5. Creative and expressive programs
    6. Educational programs
    7. Exercise program
    8. Seasonal and special events
    9. Activities that appeal to men and women

K. A monthly activities calendar will be posted in a prominent place visible to residents.

**ATTACHMENTS**

Attachment 1: Resident Self-Assessment

Attachment 2: Activities Assessment

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F561 §483.10(f) §483.10(f)(1); §483.10(f)(3); §483.10(f)(8) ; F679 §483.24(c); F680 §483.24(c)(2)

RCW 74.42.190 (Long Term Care)

***NOTES ABOUT THIS POLICY***

Activities are also appropriate for certified swing bed patients and should be identified during the initial comprehensive assessment.

## Attachment 1
## Activities Self-Assessment

**How can we HELP you fulfill your day?**

**Would you like to do any of these activities?**

☐ Puzzle Books ☐ Jigsaw Puzzles ☐ Card Games ☐ Sewing / Needlework ☐ Journaling

☐ Board games ☐ Write Letters ☐ Arts / Crafts ☐ Other

☐ Reading ☐ Books ☐ Newspapers ☐ Magazines ☐ Comic Books

☐ Music – What Type

☐ Watch movies – What Type

☐ Watch TV – What shows

**Would you like to participate in exercise activities?**

| Walk in the hallway | Wheelchair in the hallway | Other |
|---|---|---|
| | | |

**Would you like to participate in any religious activities?**

**Do you have any other activities you enjoy?**

## Attachment 2
## Activities Assessment

**Diagnosis:**

**Religion:** **Religious/Church Participation:**

**Children:** **Grandchildren:**

**Diet?** **Hearing?** **Eyesight?**

**Visitors:**

**Past Occupation:**

**Hand dominance:** **Communication Issues**

**Patient is:** **Ambulatory** **Walker** **Wheelchair** **Bedrest**

**Assistance:** **When ambulating** **With Wheelchair** **With Walker**

**Degree of Alertness**

**INTERESTS:**

**(P - Present PI - Past Interest SI - Slightly Interested Not Interested**

| | | |
|---|---|---|
| ☐ **Sewing/Needlework** | ☐ **Cards** | ☐ **Books** |
| ☐ **Checkers** | ☐ **Arts and Crafts** | ☐ **Organizations** |
| ☐ **Music** | ☐ **Movies/TV** | ☐ **Table Games** |

**Other**

- ☐ **Newspapers/Magazines/Newsletters:**
- ☐ **Types of movies**
- ☐ **Plays Instrument / Types of Music**
- ☐ **Patients' requests for programs**

**Room/Visit program**

**Patient has their own work in room**

**Consult with Occupational Therapy or the Care Manager**

**Patient needs contact with others**

**Reality Orientation Program**

**Restorative Program Involvement**

**Activities Program Precautions**

**SUMMARY AND PLAN**

**Signature**

**Date**

# Bowel and Bladder Program

**PURPOSE**

Outline the processes for assessing bowel and bladder continence and for developing interventions, as appropriate to the resident's needs.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

The facility will ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence, unless their clinical condition is such that continence cannot be maintained.

An indwelling catheter will not be used unless there is a valid medical indication.

A resident who enters the facility with an indwelling catheter, or who subsequently receives one, will be assessed for catheter removal as soon as possible, unless the resident's clinical condition indicates that catheterization is necessary. Interventions will be implemented to restore or improve normal bladder function to the extent possible after the removal of an indwelling catheter.

Care involving elimination will be carried out in a manner that respects the resident's privacy and maintains the resident's dignity.

**DEFINITIONS**

**Bristol Stool Chart:** A diagnostic tool that classifies human feces into seven categories based on their shape and consistency. It is used to assess and communicate about bowel habits.

**Continence:** Any void that occurs voluntarily, or as the result of prompted, assisted, or scheduled use of the bathroom.

**Fecal Seepage:** Undesired leakage of stool, often after a bowel movement with otherwise normal continence and evacuation.

**Passive Incontinence:** Involuntary discharge of fecal matter or flatus without any awareness.

**Urge Incontinence:** Discharge of fecal matter or flatus in spite of active attempts to retain these contents.

**Urinary Retention:** Inability to completely empty the urinary bladder by micturition.

**Urinary Tract Infection (UTI):** A clinically detectable condition associated with invasion by disease-causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (ureteritis), and/or kidney (pyelonephritis). An infection of the urethra or bladder is classified as a lower tract UTI, and an infection involving the ureter or kidney is classified as an upper tract UTI.

**PROCEDURE**

**A. Orientation/Education**

1. All nursing staff will be oriented to procedures related to eliminatory function as soon as possible after hire and periodically thereafter as needed.

B. **Indwelling Catheters**

1. A resident who enters the facility with an indwelling catheter will have an assessment by a licensed nurse and provider for the potential removal of the catheter and participation in a bladder retraining program or other treatment to restore bladder function as soon as possible after admission, unless the resident's clinical condition demonstrates that the catheter is necessary.

2. The following conditions may require the use of a urinary catheter per a provider's order:
    a. Urinary retention that causes persistent incontinence, symptomatic infections, and/or renal dysfunction that cannot be corrected surgically or managed by intermittent catheterization
    b. Residents with skin wounds, pressure sores, or irritations that would be contaminated by incontinent urine and adversely affect healing
    c. Residents who are terminally ill and/or severely impaired to the extent that frequent bed and/or clothing changes would be uncomfortable or disruptive.
    d. The need for urinary output to be measured for a specific amount of time

3. All residents with an indwelling urinary catheter will be assessed at least weekly by the licensed nurse for signs and symptoms of a urinary tract infection (UTI), such as

change in sensorium, pelvic, flank, or lower back pain, elevated temperature, or cloudy and/or foul-smelling urine.

4. All residents with an indwelling urinary catheter will be offered fluids frequently unless contraindicated by condition or physician's orders, including:
    a. Intake and Output
    b. Fluid intake of 1500-2000 ml. per day
    c. Fruit juices such as orange or cranberry are offered to maintain acidic urine and decrease the chance of a UTI

5. After the removal of an indwelling urinary catheter, licensed staff will initiate a bladder retraining program or other treatments to restore as much normal bladder function as possible.

6. All nursing staff will use universal precautions and approved infection control practices when providing catheter care and when emptying a urinary catheter bag.

**C. Assessment of Urinary Continence**

1. The licensed nurse, and other disciplines as appropriate, including a pharmacist, dietitian, or provider, will complete an assessment as part of the comprehensive admission assessment and when a resident develops urinary incontinence. The evaluation will be completed within two (2) weeks of admission, quarterly, and whenever the resident develops urinary incontinence.

2. The assessment will include the following:
    a. Prior urinary incontinence, including onset, duration, and characteristics, precipitants of urinary incontinence, associated symptoms (e.g., dysuria, polyuria, hesitancy), and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI
    b. Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days
    c. Medication review, particularly those that might affect continence, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedative/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention)

d. Patterns of fluid intake, such as amounts, time of day, alterations, and potential complications, such as decreased or increased urine output
e. Signs and symptoms of dehydration
f. Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake)
g. Pelvic and rectal examination to identify physical features that may directly affect urinary continence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, distended bladder, or bladder spasms
h. Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence, such as impaired cognitive function or dementia, impaired mobility, decreased manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, reduced vision, and pain with movement
i. Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc., and the types of prompting needed to encourage urination
j. Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders (e.g., Multiple Sclerosis, Parkinson's Disease, or tumors) that could affect the urinary tract or its function
k. If a catheter is in place, the underlying factors which support the clinical indication for the initiation and continuing need for catheter use, determination of which factors can be modified or reversed (or rationale for why those factors should not be modified), and the development of a plan for removal Identification of and/or potential of developing complications such as skin irritation or breakdown
l. Tests or studies indicated to identify the type(s) of urinary incontinence (e.g., post-void residual(s) for residents who have, or are at risk of, urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs
m. Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, and availability of urinals, use of bed rails or restraints, or fear of falling)

**D. Interventions for Urinary Incontinence**

1. The following interventions will be considered for residents who experience urinary incontinence, and those determined to be appropriate for the resident will be included in the plan of care:

a. Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, or neurological impairments
b. Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode, or reducing the distance to the toilet)
c. Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion)
d. Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction
e. Implementing a fluid and/or bowel management program to meet the assessed need
f. Bladder Rehabilitation/Bladder Retraining
g. Pelvic Floor Muscle Rehabilitation
h. Cognitively intact residents identified as having stress or urge incontinence will be instructed in Kegel exercises and reminded to perform them regularly (Appendix 1)
i. Prompted Voiding
j. Habit Training/Scheduled Voiding
k. Medication therapy
l. Intermittent catheterization (if ordered by the provider)
m. Signs and symptoms of Urinary Tract Infection (UTI), which may include any unexplained change in sensorium, pelvic or lower back pain, or elevated temperature
n. Limiting fluid intake to one hundred and fifty (150) ml after the evening meal to prevent incontinence at night

2. Skin care will be provided for all residents with incontinence, including careful cleaning with soap and water, rinsing, and drying immediately after an incontinence event or as soon as possible. Barrier skin ointments will be used as determined by the licensed nurse. No powders will be used.

**E. Assessment of Bowel Incontinence**

1. The licensed nurse, and other disciplines as appropriate, including a pharmacist, dietitian, or provider, will complete an assessment as part of the comprehensive admission assessment, and when a resident develops bowel incontinence not related to an acute illness in which diarrhea is expected. The evaluation will be completed within two (2) weeks of admission, quarterly, and whenever the resident develops bowel incontinence.

2. The assessment will include:
    a. Type of incontinence
        i. Passive incontinence
        ii. Urge incontinence
        iii. Fecal seepage
    b. Frequency and stool consistency, as well as the onset, duration, and severity of symptoms, to understand the type of fecal incontinence
    c. Timing of fecal incontinence (e.g., post-defecation or during the night) to evaluate if fecal incontinence is associated with a bowel movement.
    d. Dietary history, to rule out possible underlying causes
    e. Medications, to evaluate the effect on fecal incontinence
    f. Co-morbid conditions, to determine possible underlying causes
    g. Obstetric history, to rule out fecal incontinence associated with the use of forceps, birth weight greater than 4 kg, or a fourth-degree tear
    h. Previous surgeries (e.g., anal fissure surgery or fistula surgery), pelvic radiation, or other pelvic floor problems (e.g., urinary incontinence or pelvic organ prolapse) that may contribute to fecal incontinence
    i. Impact of fecal incontinence on quality of life

**F. Interventions for Bowel Incontinence**

1. The following interventions will be considered for residents who experience bowel incontinence, and those determined to be appropriate will be included in the plan of care:
    a. Encourage adequate fiber intake
    b. Encourage adequate fluid intake
    c. Avoid foods that may trigger symptoms
    d. Establish a regular toileting schedule
    e. Medications as ordered by the provider

2. Skin care will be provided for all residents with incontinence, including careful cleaning with soap and water, rinsing, and drying immediately after an incontinence event or as soon as possible. Barrier skin ointments will be used as determined by the licensed nurse. No powders will be used.

**G. Assessment of Constipation**

1. The licensed nurse, and other disciplines as appropriate, including a pharmacist, dietitian, or provider, will complete an assessment as part of the comprehensive

admission assessment and when a resident develops constipation. The evaluation will be completed within two (2) weeks of admission, quarterly, and whenever the resident develops constipation.

2. The assessment will include:
    a. Baseline history of bowel pattern: type and quantity of stool, frequency and timing of bowel movements, and any straining with bowel movements
    b. Assessment of stool consistency using a Bristol Stool Chart or similar tool
    c. Seven-day diet history of daily fluid and fiber intake
    d. Review of medications to evaluate their effect on constipation
    e. Review of co-morbid conditions that may cause or contribute to constipation
    f. Individual's functional and cognitive status
    g. If there is a concern of a fecal impaction, the licensed nurse will perform a digital rectal examination

**H. Interventions and Documentation for Constipation**

1. The following interventions will be considered for residents who experience constipation, and any interventions included in the plan of care:
    a. Encourage low-intensity physical activity for about 30-60 minutes (as tolerated) at least three times a week
    b. Encourage adequate fiber intake
    c. Encourage adequate fluid intake
    d. Establish a regular toileting schedule based on the resident's typical schedule
    e. Place the resident in a sitting position on the toilet or commode if possible.
    f. Ensure proper positioning during toileting, such as using a footstool to elevate the knees
    g. Insertion of glycerin suppository at least 5 cm (2 ½ inches) into the rectum half an hour before defecation time if ordered by the physician.
    i. Implement a bowel protocol per provider order if no bowel movement by day two (2) (Appendix 2)

2. No resident will have an impaction manually removed until other measures have failed, unless by the order of a physician. If a nurse feels that this is the only way to remove stool from the rectum at the time, a physician must be notified and an order received.

3. Documentation
    a. A daily record of each resident's bowel pattern will be recorded and maintained by the licensed staff and the certified nursing assistants (C.N.A).

b. Each shift is responsible for documenting:
    i. Bowel movements (BM) and a numerical number used to state how many days have gone by since the resident had a BM
    ii. The BM will be charted using the Bristol Stool Chart or similar tool on the flow sheet and will also be entered in the narrative note on the back of the activities of daily living (ADL) flow sheet. A zero will be used for no BM in the shift. Each day will represent one full day, meaning that if a resident has a bowel movement on day two (2), the following day will start the count over again at day 1.

c. The night shift charge nurse will be responsible for reviewing the bowel flow sheet every night.

I. The licensed nurse will complete a weekly written evaluation in the progress notes of the patient's performance in the bowel and/or bladder management program.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F690 §483.25(e)

Registered Nurses' Association of Ontario (RNAO). A proactive approach to bladder and bowel management in adults. 4th ed. Toronto (ON): RNAO; 2020

Lewis SJ. Heaton KW. Stool form scale as a useful guide to intestinal transit time. *Scandinavian Journal of Gastroenterology 1997; 32(9): 920-4*

***NOTES ABOUT THIS POLICY***

1. This policy is VERY detailed, and you may have a nursing resource manual that has much of the same information.

2. A bowel protocol should be in place for all residents.

3. The Bristol Stool Chart can be found online.

## Attachment 1
## Kegel Exercises

1. Tighten pelvic muscles around the anus while sitting or standing; identify muscles by stopping the flow of urine. Muscles in the abdomen, thigh, and buttocks should remain relaxed during Kegel exercises.

2. Instruct the resident to tighten and relax pelvic muscles three (3) sessions each day. Each session should have ten (10) tightening of three (3) seconds each.

3. In addition, contract and release pelvic muscles rapidly – trying to do one hundred (100) contractions in one (1) minute. Repeat this exercise three (3) times a day as well.

4. Both exercises can be done during free time or while waiting for meals, activities, etc.

## Attachment 2
## Healthy Bowel Protocol

Resident name:

| # days with no BM | Dietary Intervention (BID) | Stimulant Laxative (oral) | Dulcolax Suppository | Fleet Enema | Assess bowl sounds | Consult with MD |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

**Stimulant laxative to be given on day two (2) of no BM**
Senekot 8.6 mg 2 tabs by mouth once daily at supper _____ or bed time _____
Bisacodyl 5 mg 1 tab once daily at supper _____or bed time _____

**Implement dietary intervention to be given each day with no BM**

- Prunes
- Prune juice
- Extra flax/fiber
- Banana
- Apple slices
- Apple sauce

**Dulcolax suppository: insert one suppository per rectum once daily on day three (3) if no BM**

**Fleet enema to be administered per rectum once daily on day four (4) if no BM**

**DO NOT initiate bowel protocol if:**
a) bowel sounds are not heard
b) abdominal mass is palpated that is of unknown origin
c) significant change in the resident's level of consciousness or mental status
d) resident complains (or shows signs of) severe abdominal pain

If the bowel protocol is used twice in a four (4) week period, refer to the dietitian to review dietary interventions.

Physician signature: _____ Date: _____

# Fall Risk Assessment and Prevention

**PURPOSE**

Outline the processes for assessing fall risk, implementing interventions to prevent falls, and follow-up after a fall.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. All staff are responsible for reducing fall risks and ensuring a safe environment free from hazards.

B. All clinical and non-clinical staff will be aware of high-fall risk residents and will work within their scope of practice to prevent patient falls.

C. Staff will work as a cohesive team to eliminate environmental hazards by involving environmental services and engineering as appropriate.

D. Basic safety precautions will be addressed for all residents. For those identified as having a higher level of risk, more in-depth interventions will be implemented.

E. Any staff member, licensed healthcare provider, resident's legal representative, or family member may request that a patient be placed on fall precautions.

**DEFINITIONS**

**Fall:** An unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury. All types of falls are included, whether they result from physiological or environmental reasons.

**Intentional Rounding:** Routine, standardized patient rounding is performed regularly by clinical staff. Purposes of the rounds include, but are not limited to, meeting residents' physical needs (i.e., eyeglasses, hearing aids, water that are within the patient's reach), and completing a visual safety check.

**Hendrich II Fall Risk Model**: A Fall risk tool for use in older adults.

**PROCEDURE**

**A. Fall Prevention**

1. All staff will be aware of and utilize the **HEAR ME** method for preventing falls as appropriate to their role.
    a. **H**azards in the environment should be noticed and eliminated. An environment free from hazards includes, but is not limited to:
        i. Monitor cords, equipment, and uneven surfaces to eliminate trip hazards
        ii. Immediately clean up spills and place caution signs if the floors are wet
        iii. Ensure patients' immediate physical safety while notifying appropriate clinical staff if unsafe patient activity is observed
        iv. All resident care areas will have an environmental audit quarterly by the individual responsible for safety. The audit will be reported to the Safety Committee or the Quality Committee.
        v. Any significant environmental concerns will be corrected immediately

    b. **E**ducate residents about how to accomplish their activities in a safe way.

    c. **A**nticipate the needs of residents. Understand/learn routines and habits, and the times they will need your help.

    d. **R**ound frequently to learn residents' needs. Rounding—going from patient to patient to see how they are doing—is the activity that allows you to "keep an eye" on each resident and accommodate their needs in a timely manner.

    e. **M**aterials and equipment should be in good working order and used correctly.

    f. **E**xercise and ambulation with residents is vital to maintaining their fitness and preventing falls.

**AHRQ**
**HEAR ME**

- **H**azards in the environment.
- **E**ducate residents.
- **A**nticipate residents' needs.
- **R**ound frequently.
- **M**aterials and equipment.
- **E**xercises and ambulation

2. All staff are responsible for:
    a. Ensuring interventions in the care plan are implemented

    b. Checking for sensory deficits

    c. Communication across the interdisciplinary teams and with patients, relatives, and caregivers, including the handover of residents who are at high risk of falls between shifts or between departments

3. Medical staff are responsible for:
    a. Reviewing medications that may increase the risk of falls, especially sedatives, antipsychotics, antihypertensives, and antidysrhythmic medications

    b. Examining the patient/resident after a fall with injury

4. Nursing staff are responsible for:
    a. Ensuring a fall risk assessment is completed for each resident at admission and periodically thereafter

    b. Implementing interventions as defined in the plan of care

    c. Evaluating the interventions in place as outlined in the plan of care for each resident

**B. Fall Risk Assessment**

1. Within forty-eight (48) hours of admission, quarterly, and with any change of condition, the licensed nurse, in collaboration with other disciplines as needed, will assess fall risk using the Henrich II Fall Risk Model.

2. Individualized Fall Intervention Plan

a. Interventions to reduce the risk of a resident falling will be documented in the resident care plan for all residents identified as being at risk of falling. Strategies to prevent falls will include discussions with the patient/resident and direct caregivers.

b. When a resident is identified at risk of falls, written and oral information about fall prevention will be provided to them or their representative. The education will be recorded in the medical record.

**C. Assessment and Management of a Resident Who Falls**

1. If a resident falls, an immediate assessment will be carried out by a licensed nurse before moving the patient, if at all possible.
    a. The resident will be assessed for signs of serious injury, for example, obvious fractures, including neck of femur and cervical spine, head injury, significant soft tissue injuries, and any change in neurological status.
    b. The resident's airway, breathing, circulation, and Glasgow Coma Scale (GCS) will be assessed and documented.
    c. It is important that the safe retrieval of the patient who has fallen is managed correctly. Staff must know how to access and operate lifting equipment and have the expertise to manage suspected cervical injuries and hip fractures requiring immobilization or flat-lifting. Hoist and fabric slings are not to be used for patients with suspected cervical injuries or suspected / clinically indicated hip fractures. Ensure pain relief is given before moving the patient if appropriate.

2. If no serious injury is visible, reported, or suspected, then the resident can be assisted in getting up or assisted into bed using appropriate supervision and manual handling aids.

3. For serious injury, the RN will notify the attending physician or emergency provider as soon as possible.

4. The RN will notify the attending physician of all falls, regardless of whether there is an injury or not. This may be done by leaving a telephone message and documenting in the medical record that a message was left.

5. A set of observations must be completed and documented to detect any new harm that occurred from the fall, including:

a. Temperature, pulse, respiratory rate, blood pressure, neurological signs, and blood glucose for residents with diabetes every hour X4, every 4 hours X4, and daily X4, or more frequently if ordered by the provider

6. Hemodynamically stable patients without severe injury must be reviewed within twenty-four (24) hours by the attending physician.

**D. Management of a Patient with Visible, Reported, or Suspected Severe Injury Following a Fall**

1. Severe injury may include, but not be limited to:
   a. Possible cervical/spinal injury. Injury to the cervical spine may be indicated by: neck pain, neurological deficit in limbs, position/height of fall
   b. Possible hip fracture
   c. Signs of other bony deformity
   d. Suspected or known head injury
   e. Change in neurologic status
   f. Significant soft tissue injury
   g. Abnormality in normal vital signs

2. For severe injury, notify the attending physician or emergency physician on duty.

3. If there is evidence of a cervical spine injury, the patient's head must be held still until a provider arrives.

4. Do not move the patient.

5. The attending physician must review orders, including the risks and benefits of continuing anticoagulant therapy or other medications after a fall has occurred.

**E. Post-Fall Assessment**

1. Following a resident fall, with or without injury, a comprehensive post-fall assessment will be completed within four (4) hours by the licensed nurse.

2. Within three (3) days, an interdisciplinary team that includes at a minimum the licensed nurse, CNA, pharmacist, activities, and representative from rehabilitation will review the fall to identify the cause and any strategies to prevent future falls.

3. The attending physician will be called after the meeting, if they cannot attend, to review the team's discussion and recommendations.

4. If an environmental hazard has caused or contributed to a significant injury, the safety and risk managers will be notified.

5. Once the team reaches a conclusion about the cause(s) of the resident's fall, the licensed nurse will add individualized interventions to the resident's care plan.

6. The care plan interventions will be monitored to make sure they are effective in preventing future falls.

**F. Reporting Falls**

1. All the details of the fall and potential causes must be documented in the nursing and medical record, and an incident report completed in the electronic reporting system.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F867 §483.75(e)(1)

AHRQ Falls Prevention and Management at https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod3sess2.html

Hendrich Fall Risk
https://hendrichfallriskmodel.com/
*PLEASE NOTE THE TOOL IS COPYRIGHTED AND THERE IS A FEE TO USE*

## *NOTES ABOUT THIS POLICY*

Your organization likely has a fall policy. However, it may not be specific to an older population. It is highly recommended that a review and revision of your current policy, or a new policy, be developed that is specific to the non-certified swing bed population. The Hendrich Fall Risk has been validated and is evidence-based for older adults. Although there is a licensing fee, you may want to consider purchasing it. You do not have to purchase all the services offered to license the fall risk assessment.

# Nutrition And Hydration

**PURPOSE**

Outline the facility's responsibility to assist residents in maintaining acceptable nutrition and hydration and to identify when changes occur.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The facility will serve three (3) meals, or their equivalent, daily at regular times with not more than fourteen hours between a substantial evening meal and breakfast on the following day, and not less than ten hours between breakfast and a substantial evening meal on the same day.

B. Substantial food will be available for a late admission or late return from a procedure when the resident did not eat a meal and is now hungry.

C. Food of an appropriate quantity and at a proper temperature will be served in a form consistent with the needs of the resident.

D. Special eating equipment and utensils will be provided for residents who need them.

E. Food served, and uneaten, will be discarded.

F. The facility will ensure that the resident 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 the resident's preferences indicate otherwise.

G. Residents will be offered sufficient fluid intake to maintain proper hydration.

H. Residents will be offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet.

I. Each resident requiring assistance with eating will be provided with help and will receive training or adaptive equipment, as needed, based on patient assessment, to promote independence in eating.

J. A resident who is able to eat alone or with assistance will not be fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding is clinically indicated and consented to by the resident.

K. A resident who is fed by enteral means will receive the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding.

**SCOPE: Non-Certified Swing Bed**

**DEFINITIONS**

**Acceptable Parameters of Nutritional Status:** Factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values.

**Artificial Nutrition and Hydration:** Medical treatments and nutrition that are provided through routes other than the usual oral route, typically by placing a tube directly into the stomach, the intestine, or a vein.

**Bolus Reeding:** Administration of a limited volume of enteral formula over brief periods of time.

**Clinically Significant:** Effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

**Continuous Feeding:** Uninterrupted administration of enteral formula over extended periods of time.

**Dietary Supplements:** Herbal and alternative products that are not regulated by the Food and Drug Administration, and their composition is not standardized. Dietary supplements must be labeled as such and must not be represented for use as a conventional food or as the sole item of a meal or the diet.

**Enteral Feeding** (also referred to as tube feeding): Delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum.

**Feeding Tube:** Medical device used to provide liquid nourishment, fluids, and medications by bypassing oral intake.

**Naso-Gastric Feeding Tube (NG tube):** Tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach.

**Nutritional Status:** Includes both nutrition and hydration status.

**Nutritional Supplements**: Products that are used to complement a resident's dietary needs (e.g., calorie or nutrient dense drinks, total parenteral products, enteral products, and meal replacement products).

**Therapeutic Diet:** A diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

**PROCEDURE**

**A. Nutritional Assessment**

1. A comprehensive nutritional assessment will be completed as part of the admission comprehensive assessment, quarterly, or at any time a resident is identified as being at risk for unplanned weight loss/gain or compromised nutritional or hydration status.

2. The dietitian is responsible for completing the nutritional assessment and may utilize existing information such as assessments from other disciplines, the existing medical record, observation, staff interviews, and resident and family interviews.

3. The dietitian assessment will identify factors that place the resident at risk for inadequate nutrition/hydration. The assessment will include:
    a. General appearance
    b. Height
    c. Weight
    d. Food and fluid intake
    e. Fluid loss or retention
    f. Altered nutrient intake, absorption, and utilization
    g. Review of laboratory results
    h. Review of medications
    i. Other assessments as appropriate
    j. Ability to eat independently
    k. Need for adaptive equipment

## B. Plan of Care

1. Based on the assessment, an individualized care plan to address the resident's specific nutritional concerns and preferences will be developed. The care plan will address to the extent possible:
    a. Identified causes of impaired nutritional status
    b. Reflect the resident's personal goals and preferences
    c. Identify resident-specific interventions, a time frame, and parameters for monitoring
    d. Need for feeding assistance
    e. Need for adaptive equipment

2. The care plan will be updated as needed by the licensed nurse or dietitian when the resident's condition changes, goals are met, interventions are determined to be ineffective, or new causes of nutrition-related problems are identified.

3. If nutritional goals are not achieved, the care-plan interventions will be reevaluated for effectiveness and modified as appropriate.

## C. Weight

1. The interdisciplinary team will establish a weight goal based on a resident's usual body weight or desired body weight.

2. The CNA caring for the resident will be responsible for weighing the resident at admission, readmission, monthly, when there is a significant change in condition, when food intake has declined and persisted (e.g., for more than a week), or when there is other evidence of altered nutritional status or fluid and electrolyte imbalance.

3. If there is significant or severe weight loss, the dietitian will be contacted to complete an assessment. If there is severe weight loss, the licensed nurse will contact the provider.

| Interval | Significant Loss | Severe Loss |
|---|---|---|
| 1 month | 5% | Greater than 5% |
| 3 months | 7.5% | Greater than 7.5% |
| 6 months | 10% | Greater than 10% |

4. A consistent method of weighing a resident will be in place to ensure accurate weights (e.g., using the same scale, wearing the same or similar clothes, weighing at the same time of day, or adjusting for use of a prosthetic).

**C. Assistance with Eating and Adaptive Equipment**

1. The CNA will assist residents with eating if needed. The CNA will not feed a resident if the resident can feed themselves.

2. Residents will be provided with adaptive equipment to encourage independence if needed.

**D. Monitoring Food and Fluid Intake**

1. The CNA will monitor food and fluid intake and record on the flow sheet for all residents identified at nutritional risk.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F692 §483.25(g); F693 §483.25(g)

RCW 74.420.290; RCW 74.42.300 (Long Term Care)

***NOTES ABOUT THIS POLICY***

The policy may also apply to certified swing beds.

# Immunizations

**PURPOSE**

Describe the process of offering influenza, pneumococcal, and COVID-19 immunizations.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. Physician-approved policies for orders of influenza and pneumococcal vaccines will be developed.

B. Residents will be offered influenza vaccination from October 1 through March 31 annually.

C. Residents will be offered the pneumococcal vaccination at the time of admission unless they have received the pneumococcal vaccine within the last 12 months.

D. Residents will be offered the COVID-19 vaccine in the fall and spring or as recommended by the CDC.

**PROCEDURE**

A. A licensed nurse will review all resident vaccination records and attempt to procure a current vaccination status on admission.

B. All residents will be offered the influenza, pneumococcal, and COVID-19 vaccines unless they are medically contraindicated or the resident has already received them during the current vaccination period.

C. Before administering influenza, pneumococcal, or COVID-19, the licensed nurse will:

1. Review the resident's record of vaccination and immunization status, including assessment for potential medical contraindications

2. Provide pertinent information and education to residents or their representatives about the benefits, risks, and potential side effects of the influenza, pneumococcal, and COVID-19 vaccines

3. Obtain resident or representative consent

D. All education provided to residents or their legal representative and vaccine administration information will be documented in the resident's medical record.

E. Declinations or medical contraindications of any vaccinations offered will be noted in the resident's medical record by the licensed nurse.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F883 §483.80(d)

RCW 74.42.285 (Long Term Care)

***NOTES ABOUT THIS POLICY***

1. Immunizations may be covered in your Infection Prevention policies.

2. This policy may also apply to certified swing beds.

# Pain Assessment and Reassessment

**PURPOSE**

To establish a method to assess and effectively manage pain experienced by residents.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. Pain management will be provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

B. To help a resident attain or maintain their highest practicable level of well-being and to prevent or manage pain, the staff will:

1. Recognize when the resident is experiencing pain and identify circumstances when pain can be anticipated

2. Evaluate the existing pain and the cause(s)

3. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences

**DEFINITIONS**

**Acute Pain:** Pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery.

**Adjuvant Medication:** Any medication with a primary indication other than pain management but with analgesic properties in some painful conditions.

**Adverse Consequence:** An unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in a resident's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease).

**Chronic Pain:** Pain that typically lasts for more than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause.

**Medication Assisted Treatment (MAT):** Use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

**Opioid Use Disorder (OUD):** Problematic pattern of opioid use leading to clinically significant impairment or distress. Additional criteria for assessing and diagnosing OUD are found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

**Subacute Pain:** Pain that has been present for 1–3 months.

**PROCEDURE**

A. At the time of admission and at least annually, a comprehensive pain assessment will be completed and include, to the extent possible:

1. History of pain and its treatment (including non-pharmacological and pharmacological treatment and whether or not each treatment has been effective)

2. History of addiction, past and/or ongoing and related treatment for opioid use disorder (OUD)

3. Characteristics of pain, such as: (intensity, pattern, location, frequency, and duration

4. Impact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood)

5. Factors such as activities, care, or treatment that precipitate or exacerbate pain, as well as those that reduce or eliminate the pain

6. Additional symptoms associated with pain (e.g., nausea, anxiety)

7. Physical and psychosocial issues (physical examination of the site of the pain, movement, or activity that causes the pain, as well as any discussion with the resident about any psychological or psychosocial concerns that may be causing or exacerbating the pain)

8. Current medical conditions and medications, including medication-assisted treatment for OUD.

9. The resident's goals for pain management and their satisfaction with the current level of pain control

B. The licensed nurse performing the assessment will include pain management strategies in the interdisciplinary plan of care as appropriate.

C. A certified nursing assistant or licensed nurse will assess each resident for pain at least once per shift and after every pain management intervention.

D. Pain interventions may include, but are not limited to:

1. Administration of pain medications or medication for the control or relief of anxiety by a licensed nurse

2. Altering the environment for comfort (such as adjusting room temperature, tightening and smoothing linens, using pressure redistributing mattresses and positioning, comfortable seating, and assistive devices)

3. Physical modalities, such as ice packs or cold compresses (to reduce swelling and lessen sensation), mid-heat (to decrease joint stiffness and increase blood flow to an area), neutral body alignment and repositioning, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture/acupressure, chiropractic, or rehabilitation therapy

4. Exercises to address stiffness and prevent contractures, as well as restorative nursing programs to maintain joint mobility

5. Cognitive/Behavioral interventions (e.g., relaxation techniques, reminiscing, diversions, activities, music therapy, offering spiritual support and comfort, as well as teaching the resident coping techniques and education about pain)

E. The licensed nurse will reassess the resident within one hour after the administration of a pharmacologic pain relief intervention, and once per shift for other non-pharmacological interventions to determine the effectiveness of pain relief. The licensed nurse will document the pain intervention and its effectiveness in the medical record.

F. Pain management and effective strategies for pain relief will be discussed at each interdisciplinary care planning conference and included in the resident's care plan as needed.

G. If a resident is experiencing pain, the resident, family, or significant other will be provided education regarding pain management. Education will include, but not be limited to:

    1. Types of pain the resident is experiencing

    2. Pain control mechanisms available to the resident or staff

    3. Potential limitations of pain management and treatment

    4. Potential and/or actual side effects of pain management and treatment

    5. Determination of the resident's acceptable level of pain

H. Pain will be assessed by a method appropriate for the resident, including but not limited to:

    1. Numbers Scale 1- 10

    2. Wong-Baker FACES

    3. FLACC Pain Scale

    4. Pain Assessment in Advanced Dementia (PAINAD) Scale

    5. Defense and Veterans Pain Rating Scale

    6. Other expressions of verbal and non-verbal pain, including:
        a. A resident may avoid the use of the term "pain." Other words used to report or describe pain may differ by culture, language, and/or region of the country. Examples of descriptions may include: heaviness or pressure, stabbing, throbbing, hurting, aching, gnawing, cramping, burning, numbness, tingling, shooting or radiating, spasms, soreness, tenderness, discomfort, pins and needles, feeling "rough," tearing or ripping.
        b. Nonverbal indicators that may represent pain need to be viewed in the entire clinical context, with consideration given to pain as well as other clinically pertinent explanations. Examples of possible indicators of pain include, but are

not limited to: negative verbalizations and vocalizations (e.g., groaning, crying/whimpering, or screaming); facial expressions (e.g., grimacing, frowning, fright, or clenching of the jaw); changes in gait (e.g., limping), skin color, vital signs (e.g., increased heart rate, respirations and/or blood pressure), perspiration; behavior such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities; loss of function or inability to perform activities of daily living (ADLs) (e.g., rubbing a specific location of the body, or guarding a limb or other body parts); difficulty eating or loss of appetite; difficulty sleeping (insomnia).

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F697 §483.25(k)

Pain Assessment in Advanced Dementia (PAINAD)
https://geriatrictoolkit.missouri.edu/cog/painad.pdf

Defense and Veterans Pain Rating Scale
https://www.va.gov/PAINMANAGEMENT/docs/DVPRS_2slides_and_references.pdf

***NOTES ABOUT THIS POLICY***

1. This policy is intended to be an adjunct to the pain policy you utilize for other patients. It is more specific to identifying and treating pain in the non-certified population, including patients with cognitive deficits.

2. The policy may also apply to certified swing bed patients.

# Pharmacist Monthly Medication Review

**PURPOSE**

To outline the process for quarterly medication review by a licensed pharmacist.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. This review must include a review of the resident's medical chart and the review documented in the medical record.

B. If the anticipated length of stay is less than thirty (30) days, the pharmacist will not be required to complete a drug regimen review, unless requested by the chief nursing officer (CNO), medical director, or the attending physician.

C. The pharmacist must report any irregularities to the attending physician, the medical director, and the chief nursing officer (CNO). The report will include Irregularities, including but not limited to any drug that meets the criteria for an unnecessary drug.

D. 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 must document their rationale in the resident's medical record.

**DEFINITIONS**

**Adverse Consequence:** Broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease.

**Adverse Drug Reaction (ADR):** A form of adverse consequence. It may be either a secondary effect of a medication, usually undesirable and distinct from its therapeutic and helpful effects, or a response to a medication that is noxious and unintended and occurs at doses used for prophylaxis, diagnosis, or therapy. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories. The others are hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not rise to the level of being an adverse consequence.

**Clinically Significant:** Effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

**Dose:** Total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a twenty-four (24) hour period may be referred to as the daily dose.

**Irregularity:** Use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy.

**Medication Interaction:** Impact of another substance (such as another medication, herbal product, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may reduce the effectiveness of the medication or increase the risk of adverse effects.

**Medication Regimen Review (MRR) or Drug Regimen Review:** Thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes reviewing medical records to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities. The MRR also involves collaborating with other members of the IDT, including the resident, their family, and/or resident representative.

**PROCEDURE**

A. The licensed pharmacist will complete a monthly medication regimen review for all residents.

B. The review will be documented in each resident's medical record.

C. Any irregularities noted by the pharmacist during the review will be documented on a separate, written report that is sent to the attending physician, facility's medical director, and chief nursing officer (CNO). The report will list, at a minimum, the resident's name, the relevant drug, and the irregularity identified by the pharmacist. The report will be forwarded within one week of the review.

D. The licensed pharmacist will notify the chief nursing officer (CNO) and the physician or licensed practitioner responsible for the patient immediately if any irregularity is identified that requires urgent action to protect the resident. A follow-up report will be provided to the medical director.

E. 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 must document their rationale in the resident's medical record. The documentation must occur within thirty (30) days of receiving the report from the pharmacist.

F. The medical record must show documentation that the attending physician reviewed any irregularities identified by the pharmacist. For issues that require physician intervention, the attending physician either accepts and acts on the report and recommendations or rejects all or part of the report, documenting their rationale for the rejection in the resident's medical record. It is not acceptable for an attending physician to document only that they disagree with the report, without providing a clinical basis for their disagreement. The documentation must occur within thirty (30) days of receiving the report from the pharmacist.

G. The pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation unless warranted by a change in the resident's condition or other circumstances.

H. The pharmacist will complete a drug regimen review within twenty-four (24) hours or sooner if requested for any resident who experiences an acute change of condition and for whom an immediate MRR is requested after appropriate staff have been notified, including the resident's physician, the medical director, and the chief nursing officer (CNO).

I. As part of the review, the pharmacist's review will consider factors such as:

    1. Whether the physician and staff have documented objective findings, diagnoses, symptoms, and/or resident goals and preferences to support indications for use

    2. Whether the physician and staff have identified and acted upon, or should be notified about, the resident's allergies and/or potential side effects and significant medication interactions

    3. Whether the medication dose, frequency, route of administration, and duration are consistent with the resident's condition, manufacturer's recommendations, and applicable standards of practice

4. Whether the physician and staff have documented progress towards, decline from, or maintenance of the resident's goal(s) for the medication therapy

5. Whether the physician and staff have documented any attempts for gradual dose reduction (GDR) or added any non-pharmacological approaches, in an effort to reduce or discontinue a drug

6. Whether the physician and staff have obtained and acted upon laboratory results, diagnostic studies, or other measurements (such as bowel function, intake, and output) as applicable

7. Whether medication errors exist or circumstances exist that make them likely to occur

8. Whether the physician and staff have noted and acted upon possible medication-related causes of recent or persistent changes in the resident's condition, such as worsening of an existing problem or the emergence of new signs or symptoms

J. The pharmacist may identify and report irregularities in one or more of the following categories:

1. The use of a medication without identifiable evidence of adequate indications for use, such as the use of a medication to treat a clinical condition without identifiable evidence that safer alternatives or more clinically appropriate medications have been considered

2. The use of homeopathic or herbal options (e.g., St. John's Wort) that may interfere with the effectiveness of clinically appropriate medications

3. The use of an appropriate medication that is not helping attain the intended treatment or the resident's goals because of timing of administration, dosing intervals, sufficiency of dose, techniques of administration, or other reasons

4. The use of a medication in an excessive dose (including duplicate therapy) or for excessive duration, thereby placing the resident at greater risk for adverse consequences or causing existing adverse consequences

5. The presence of an adverse consequence associated with the resident's current medication regimen

6. The use of a medication without evidence of adequate monitoring; i.e., either inadequate monitoring of the response to a medication or an inadequate response to the findings

7. Presence of medication errors or the risk for such errors

8. Presence of a clinical condition that might warrant initiation of medication therapy

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents (Rev. 232; Issued: 07-23-25)
F756 §483.45(g)

RCW 74.42.210 (Long Term Care)

## *NOTES ABOUT THIS POLICY*

Although not required in Appendix W, a monthly medication review by a pharmacist is highly recommended to ensure the resident's medication regimen is current and appropriate.

# Psychotropic Drug Review and Gradual Dose Reduction

**PURPOSE**

To outline the appropriate use of anti-psychotic and psychotropic medications and to outline the process for gradual dose reduction (GDR).

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. Based on the residents' comprehensive assessment, the facility will ensure that 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.

B. The attending physician or prescribing practitioner will review the risk versus benefit of using the medication, including any black box warnings or off-label uses, and discuss the implications for prescribing the medication with the resident and/or the resident's legal representative.

C. The physician or prescribing practitioner will obtain informed consent before ordering a psychotropic or anti-psychotic medication, except in an emergency, in which informed consent must be obtained as soon as possible. Informed consent will include discussion of:

    1. The reason for the treatment and the nature and seriousness of the patient's illness

    2. The nature of the procedures to be used in the proposed treatment, including their probable frequency and duration

    3. The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment

    4. The nature, degree, duration, and probability of the side effects and significant risks, commonly known by the health professions

    5. The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment

    6. That the patient has the right to accept or refuse the proposed treatment, and if they consent, has the right to revoke their consent for any reason at any time

D. Residents will 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. PRN orders for psychotropic drugs are limited to fourteen (14)days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond fourteen (14) days, they will document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to fourteen (14) days. They cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

E. Residents who use psychotropic drugs will receive gradual dose reduction (GDR), unless clinically contraindicated, in an effort to discontinue these drugs. For any resident who is receiving a psychotropic medication, the SNF will show evidence that a GDR has been attempted unless clinically contraindicated. The time frames and duration of attempts to taper any medication will be consistent with accepted standards of practice and depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence.

F. For any resident who is receiving a psychotropic drugs, the facility must show evidence that a GDR has been attempted unless clinically contraindicated.

**DEFINITIONS**

A. **Adequate Indications for Use**: Identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with the manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

B. **Adverse Consequence:** Unwanted, unintended, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease). Adapted from The Merck Manual Professional Version: http://www.merckmanuals.com/professional/clinical pharmacology/adverse-drug-reactions/adverse-drug-reactions

C. **Anticholinergic Side Effect:** The effect of a medication that opposes or inhibits the activity of the parasympathetic (cholinergic) nervous system to the point of causing symptoms such as dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium, hallucinations, flushing, and increased blood pressure. Types of medications that may produce anticholinergic side effects include: • Antihistamines, antidepressants, anti-psychotics, antiemetics, muscle relaxants; and • Certain medications used to treat cardiovascular conditions, Parkinson's disease, urinary incontinence, gastrointestinal issues, and vertigo.

D. **Antipsychotics:** Also known as a neuroleptic, antipsychotics are drugs primarily used to treat the symptoms of psychosis.

E. **Behavioral Interventions:** Individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical, or psychosocial well-being.

F. **Chemical Restraint:** Any drug used for discipline or that makes it more convenient (i.e., less effort) for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms; however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety. In these instances, a medication would be deemed unnecessary to treat a resident's symptoms, and a safer alternative should be used. For example, if a nonpharmacological intervention should be used or attempted and is not clinically contraindicated, but a medication is administered and has the effect consistent with the definition of convenience (defined below), the medication would be classified as a chemical restraint.

G. **Expressions or Indications of Distress:** A person's attempt to communicate unmet needs, discomfort, or thoughts that they may not be able to articulate. The expressions may present as crying, apathy, or withdrawal, or as verbal or physical actions such as pacing, cursing, hitting, kicking, pushing, scratching, tearing things, or grabbing others.

H. **Extrapyramidal Symptoms (EPS):** Neurological side effects that can occur at any time from the first few days of treatment with antipsychotic medication to years later. EPS includes various syndromes such as:
    - Akathisia, which refers to a distressing feeling of internal restlessness that may appear as constant motion, the inability to sit still, fidgeting, pacing, or rocking
    - Medication-induced Parkinsonism, which refers to a syndrome of Parkinson-like symptoms, including tremors, shuffling gait, slowness of movement, expressionless face, drooling, postural unsteadiness, and rigidity of muscles in the limbs, neck, and trunk

I. **Dystonia:** An acute, painful, spastic contraction of muscle groups (commonly the neck, eyes, and trunk) that often occurs soon after initiating treatment and is more common in younger individuals.

J. **Gradual Dose Reduction (GDR):** Stepwise tapering of a dose to determine if a lower dose can manage symptoms, conditions, or risks, or if the dose or medication can be discontinued.

K. **Neuroleptic Malignant Syndrome (NMS):** Syndrome related to the use of medications, mainly antipsychotics, that typically presents with a sudden onset of diffuse muscle rigidity, high fever, labile blood pressure, tremor, and notable cognitive dysfunction. It is potentially fatal if not treated immediately, including stopping the offending medications.

L. **Psychotropic Drug:** 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.

M. **Serotonin Syndrome:** Potentially serious clinical condition resulting from overstimulation of serotonin receptors. It is commonly related to the use of multiple serotonin-stimulating medications (e.g., SSRIs, SNRIs, triptans, and certain antibiotics). Symptoms may include restlessness, hallucinations, confusion, loss of coordination, fast heartbeat, rapid changes in blood pressure, increased body temperature, overactive reflexes, nausea, vomiting, and diarrhea.

N. **Tardive Dyskinesia:** Abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the trunk or other parts of the body may also be affected.

O. **Unnecessary Drugs:** Any drug when used— (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons above.

**PROCEDURE**

A. All residents receiving psychotropics or antipsychotics, whether prescribed routinely or PRN, will have behaviors documented in a behavior log.

B. PRN Psychotropics and PRN antipsychotics will only be renewed as outlined in the following table:

| Type of PRN Order | Time Limitations | Exception | Required Action |
|---|---|---|---|
| Psychotropic medications, **excluding antipsychotics** | 14 days | The order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order. | The attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration |
| Antipsychotic medications | 14 days | None | If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, the attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate |

C. The attending physician or prescribing practitioner must complete the required evaluation of a resident before writing a new PRN order for an antipsychotic. Evaluation includes directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner will, at a minimum, determine and document the following in the resident's medical record:
    1. Is the antipsychotic medication still needed on a PRN basis?
    2. What is the benefit of the medication to the resident?
    3. Have the resident's expressions or indications of distress improved because of the PRN medication?
    4. Rationale and diagnosis for target symptoms

D. The attending physician or prescribing practitioner will review the risk versus benefit of using the medication, including any black box warnings or off-label uses, and discuss the implications for prescribing the medicines with the resident and/or the resident's legal representative. The physician or prescribing practitioner will obtain informed consent before ordering a psychotropic or anti-psychotic medication, except in an emergency, in which informed consent must be obtained as soon as possible.

E. Orders for psychotropic medication will only be written for the treatment of specific medical and/ or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches. The physician or prescribing practitioner will document the evaluation and the rationale for the use of psychotropic or antipsychotic drugs.

F. The use of non-pharmacological approaches must be attempted, unless clinically contraindicated.

G. The physician or prescribing practitioner will monitor the resident for lack of drug efficacy clinically and in discussions with the interdisciplinary team within one month of initiating and during routine visits.

**H. Gradual Dose Reduction**

1. The time frames and duration of attempts to taper any medication will be consistent with accepted standards of practice and depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. Dose reductions will occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence.

2. A gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications will be implemented after no more than three (3) months after admission, unless clinically contraindicated. Gradual dose reduction must be attempted for two (2) separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants.

3. Medical record documentation will reflect the date of the GDR attempt, the outcome of the dose reduction attempt, and the plan regarding future GDR attempts.

4. Nursing will maintain a daily behavior log for all patients with a GDR regimen.

5. The monthly pharmacist review of medications will include recommendations for GDR if clinically indicated and whether the physician and staff have documented any attempts for gradual dose reduction or added any non-pharmacological approaches, in an effort to reduce or discontinue a drug.

**I. Contraindication for GDR**

1. For any individual who is receiving a psychotropic medication, a GDR may be considered clinically contraindicated for reasons that include, but are not limited to, the following:
    a. The continued use is in accordance with relevant current standards of practice, and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or

b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility, and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function, exacerbate an underlying medical or psychiatric disorder, or increase distressed behavior.

2. Physician documentation will include the rationale for why GDR attempts are clinically contraindicated.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F605 §483.12; F756 §483.45(c)

Behavior Log developed by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS)
https://quality.allianthealth.org/media_library/behavior-monthly-tracking-log/

Briggs Healthcare Behavior Log (There is a fee to use)
https://www.briggshealthcare.com/Behavior-Monitoring-Form

***NOTES ABOUT THIS POLICY***

1. Although not required in Appendix W, review of psychotropics and GDR, when applicable, is a standard of care for long-term care patients.

2. Two behavior logs are included in the reference section above. The first, provided under contract with CMS by Alliant Health Solutions, allows caregivers to monitor and track behaviors, location, interventions, and outcomes. The tool is an Excel spreadsheet and allows behaviors to be graphed over time.

# Range of Motion and Restorative Program

**PURPOSE**

Outline the processes for maintaining or improving a resident's highest level of mobility.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The facility will provide the services, care, and equipment to ensure that:

    1. A resident maintains, and/or improves to his/her highest level of range of motion (ROM) and mobility, unless a reduction is clinically unavoidable; and

    2. A resident with a limited range of motion and mobility maintains or improves function unless a reduced range of motion (ROM) is unavoidable based on the resident's clinical condition

B. The comprehensive assessment will identify the current range of motion (ROM) and mobility capabilities of the resident, which will be used to develop targeted interventions.

C. The resident's care plan will include specific interventions, exercises, and/or therapy to maintain or improve ROM and mobility, or to prevent, to the extent possible, declines or further declines in ROM or mobility.

D. The resident or resident's representative will be included in the development of the restorative/rehabilitative care plan and provided with the risks and benefits of the treatments.

E. The decision on what type of treatments will include an evaluation of the cognitive ability of the resident to be able to independently participate, whether the resident requires assistance due to a medical condition, cognitive impairments, or loss of ability to follow treatment instructions.

F. Care plan interventions may be delivered through the facility's restorative program or as ordered by the attending practitioner through specialized rehabilitative services.

**PROCEDURE**

**A. Physical Therapist or Occupational Therapist Comprehensive Assessment**

1. A physical therapist or occupational therapist will complete a comprehensive assessment within two weeks of admission, quarterly, and when there is a significant change in the resident's activities of daily living or mobility.

2. The comprehensive assessment will identify:
    a. Current status of the resident's ROM and mobility capabilities
    b. Evaluation to determine if the resident can independently participate, and whether the resident requires assistance due to a medical condition, cognitive impairment, or loss of ability to follow treatment instructions

3. Based upon the comprehensive assessment, the physical therapist or occupational therapist will develop a restorative plan for the resident, if appropriate, that will include:
    a. Type of treatments, frequency, duration, and measurable objectives and resident goals
    b. The measurable objective to describe what the resident is expected to achieve, such as mobility goals, and/or range of motion (ROM) within a specific timeframe
    c. Increasing and/or promoting independence to the extent clinically possible for the resident in the areas of both ROM and mobility
    d. Provision of necessary equipment
    e. Restorative services
    f. Adapting the environment to meet the needs of the resident
    g. Use of equipment for mobility, including walkers, canes, splints, braces, or other rehabilitative equipment
    h. Resident risks for complications and interventions to mitigate, to the extent possible, the potential complications

**B. Resident Involvement**

1. The physical therapist or occupational therapist will discuss the recommendations with the resident or resident representative, including the risks and benefits.

2. Documentation will be included in the medical record.

**C. Care Plan**

1. The resident's care plan will include specific interventions, exercises, and/or therapy to maintain or improve ROM and mobility, or to prevent, to the extent possible, declines or further declines in the resident's ROM or mobility.

2. The care plan will include measurable goals and timeframes for achieving ROM or restorative goals.

3. The care plan will address the presence of any contractures and interventions required, and any dependence or decline in mobility and ROM.

**D. Restorative Program**

1. Care Plan interventions may be delivered through the restorative program or as ordered by the attending practitioner through specialized rehabilitative services.

2. The RA will work under the direct supervision of a physical therapist and receive regular instruction and consultation from physical therapy staff.

3. The physical therapist will review the restorative plan with restorative aides, including the type of interventions, frequency of interventions, and measurable goals at least quarterly.

4. Services provided by the RA will include, but are not limited to, the following:
    a. Assisted ambulation
    b. Range of motion
    c. General strengthening exercises
    d. Placement of restorative devices or equipment, such as braces, splints, and prostheses.
    e. Assisted positioning
    f. Activities of daily living
    g. Restorative feeding program

**E. Documentation**

1. RAs will document any restorative interventions and the resident's response in the medical record.

2. Documentation will reflect the attempts to implement the care plan and revision of interventions to address the changing needs of the resident.

**F. Competency**

1. RAs will demonstrate competency to provide restorative services.

2. A physical therapist or occupational therapist will determine the competency of RAs.

**REFERENCE**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F675 §483.24; F676 §483.24; F677 §483.24(a)(2); F688 §483.25(c)(1)

***NOTES ABOUT THIS POLICY***

1. Development of a restorative program, overseen by OT or PT, is highly recommended.

2. If a CNA or restorative aide is responsible for implementing the program, there must be documented competency.

# Resident Behavior, New or Worsening

**PURPOSE**

This policy provides guidelines for staff to ensure the identification, monitoring, and care planning of newly identified or worsening behaviors in a resident.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

Staff will monitor residents with newly identified or worsening behaviors. These behaviors will be documented and observed for a minimum of seventy-two (72) hours, and the care plan will be modified to address possible causes and interventions.

**PROCEDURE**

A. The licensed nurse will:

    1. Notify the chief nursing officer (CNO)

    2. Inform the resident's attending physician of the behavior and document the notification in the medical record

    3. Implement physician orders

    4. Notify the resident's responsible party and/or legal representative and document notification in the medical record

    5. Implement behavior observation monitoring

B. The physician or Advanced Practice Provider (APP) will assess the patient within twenty-four (24) hours or sooner if possible, depending on the severity of the symptoms.

C. A seventy-two (72) hour observation period will be initiated when:

    1. A resident demonstrates new, escalating, or concerning behaviors (e.g., aggression, withdrawal, verbal outbursts, wandering)

    2. An incident such as attempted elopement, inappropriate touching, or self-harm

    3. Staff, physician, or family expresses concern regarding behavioral changes

D. Behavior observation monitoring will include documentation in the behavior monitoring log for a period of at least seventy-two (72) hours. The following will be documented at least once per shift or more frequently, if indicated:
    1. Time and description of behaviors
    2. Precipitating events
    3. Staff interventions
    4. Resident Response
    5. Environmental or situational context
    6. Medication administration

E. The interdisciplinary team will meet within three (3) days after a behavior change. The team will include the chief nursing officer (CNO) or charge nurse, a licensed nurse, a CNA, a pharmacist, a care manager, and the physician, if available.

F. The interdisciplinary team will:
    1. Assess the effectiveness of the interventions already put in place
    2. Identify additional or new interventions
    3. Determine if ongoing behavior observation monitoring is needed
    4. Assess the need for psychiatric or behavioral health referrals
    5. Update the care plan

G. If the physician or APP is unable to attend the meeting, the licensed nurse or care manager will relay the recommendations of the team to the physician.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F740 §483.40

Behavior Log developed by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS)
https://quality.allianthealth.org/media_library/behavior-monthly-tracking-log/

Briggs Healthcare Behavior Log (There is a fee to use)
https://www.briggshealthcare.com/Behavior-Monitoring-Form

# Safe, Clean, Comfortable, Home-Like Environment

**PURPOSE**

Describe the resident's right to a safe, clean, comfortable, and home-like environment.

**SCOPE: Non-Certified Swing-Bed**

**POLICY**

A. The resident has the right to a safe, clean, comfortable, and homelike environment, including, but not limited to, receiving treatment and support for activities of daily living.

B. The facility will:

1. Provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible

2. Exercise reasonable care for the protection of the resident's property from loss or theft

3. Ensure that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk

4. Provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior

5. Provide clean bed and bath linens that are in good condition

6. Provide private closet space in each resident's room

7. Provide adequate and comfortable lighting levels in all areas

8. Provide comfortable and safe temperature levels

**DEFINITIONS**

**Adequate Lighting:** Levels of illumination suitable for tasks the resident chooses to perform or the facility staff must perform.

**Comfortable Lighting:** Lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning.

**Comfortable and Safe Temperature Levels:** Ambient temperature should be within a relatively narrow range that minimizes residents' susceptibility to heat loss and the risk of hypothermia or hyperthermia, and is comfortable for residents.

**Comfortable Sound Levels**: Sound that does not interfere with the resident's hearing and enhances privacy when privacy is desired, and encourages interaction when social participation is desired. Of particular concern to comfortable sound levels is the resident's control over unwanted noise.

**Environment:** Any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas.

**Homelike Environment:** De-emphasizes the institutional character of the setting to the extent possible and allows the resident to use personal belongings that support a homelike environment. A determination of "homelike" should include the resident's opinion of the living environment.

**Orderly:** Uncluttered physical environment that is neat and well-kept.

**Sanitary:** Includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used to complete activities of daily living.

**PROCEDURE**

A. All direct and indirect care staff and providers, as well as other staff, including but not limited to facilities and environmental services, will be aware of and facilitate the residents' right to a safe, clean, comfortable, and homelike environment.

B. All staff who identify any issues related to the environment will report the issue directly to the licensed nurse and to facilities or environmental services as appropriate.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F584 §483.10(i)

# Safety Measures with Combative Residents

**PURPOSE**

Provide guidelines for staff to follow when caring for residents who are aggressive or combative, to promote a safe environment for both residents and staff.

**SCOPE: Non-Certified Swing-Bed**

**POLICY**

A. All staff with patient care contact will receive education at hire and annually regarding the care of aggressive and combative residents.

B. Combative or aggressive residents will be treated in a manner that ensures the safety, dignity, and rights of all residents, including the combative or aggressive resident and staff.

**DEFINITIONS**

Aggressive or combative behavior includes:

1. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating

2. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, and throwing objects

3. Sexually aggressive behavior, such as saying sexual things, inappropriate touching/grabbing

4. Taking, touching, or rummaging through others' property

5. Wandering into others' rooms/spaces

**PROCEDURE**

A. The chief nursing officer (CNO), in collaboration with the education department, will develop training modules to prevent and respond to aggressive or combative behaviors for all staff, including contract staff, who may come in contact with the resident. Training will include verbal de-escalation techniques, environmental modifications to reduce combative behaviors, emergency response for acute aggression, trauma-informed care, and behavioral interventions. The training will also include observing physical, verbal, and behavioral warning signs of potential aggressive behavior.

B. Training will be provided at the time of hire or onboarding for contract staff, and annually thereafter.

C. At the time of admission, residents will be assessed to identify any history of combative behavior, including the type of behavior, triggers, and potential underlying medical or psychological conditions.

D. A behavior log will be implemented for residents with aggressive or combative behavior.

E. The interdisciplinary care plan for residents with aggressive or combative behaviors will be comprehensive and individualized. Specific interventions that address behaviors will be included. Interventions may include, but are not limited to:

    1. Establishing trust, maintaining eye contact, and speaking calmly

    2. Promoting security and avoiding confrontation

    3. Learn what makes the resident angry or frightened and empathize with their concerns

    4. Reinforcing/praising positive behaviors

    5. Avoiding assertive verbal communication

F. If a resident begins to exhibit aggressive or combative behaviors or shows an increase in aggressive or combative behaviors, the licensed nurse will :

    1. Contact the resident's physician about the behavioral symptoms

    2. Contact the resident's designated representative

    3. Provide necessary supervision to protect the resident and other residents

G. Physical interventions should be utilized only as a last resort when residents endanger themselves or others.

**RESOURCES**

Behavior Log developed by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS)
https://quality.allianthealth.org/media_library/behavior-monthly-tracking-log/

Briggs Healthcare Behavior Log (There is a fee to use)
https://www.briggshealthcare.com/Behavior-Monitoring-Form

# Skin Assessment

**PURPOSE**

Define the process for monitoring the resident's skin status and to initiate skin care management to improve outcomes when appropriate.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

Each resident's skin will be assessed on an ongoing basis.

**PROCEDURE**

A. The certified nursing assistant (CNA) will check and document the skin status of non-ambulatory residents every shift and twice weekly for ambulatory residents. The assessment will include identification of any skin abnormalities, including but not limited to:
    1. Bruising
    2. Skin tears
    3. Rashes
    4. Swelling
    5. Dryness
    6. Soft heel lesions
    7. Decubitus
    8. Blisters
    9. Scratches
    10. Abnormal color
    11. Abnormal skin
    12. Abnormal skin temperature (h-hot/c-cold)
    13. Hardened skin (orange peel texture)

B. Any sign of skin abnormalities or worsening of skin condition identified by the CNA will be reported to the licensed nurse for follow-up as soon as they are identified.

C. The licensed nurse will assess the skin abnormalities reported by the CNA and document the findings.

D. The licensed nurse will perform a weekly skin check on all non-ambulatory residents and a monthly check of all ambulatory residents. The findings will be documented in the medical record. The assessment will include identifying any skin abnormalities or worsening of a skin condition.

E. The licensed nurse will notify the physician of any new or abnormal findings, including when there is a need to discontinue an existing form of treatment or commence a new form of therapy.

F. The care plan will be updated for any changes in skin status, including appropriate interventions.

### *NOTES ABOUT THIS POLICY*

Skin assessment is a crucial aspect of resident care. Any skin issues or potential skin issues should be identified as soon as possible, and appropriate interventions should be put in place.

# Unintended Weight Change

**PURPOSE**

Guidelines for staff to manage residents' unintended weight changes.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. Each resident will maintain 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 the resident's preferences indicate otherwise.

B. Each resident will be offered sufficient fluid intake to maintain proper hydration and health.

C. Each resident will be offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet.

D. Individualized interventions will be implemented, if needed, to ensure that residents' nutritional needs are met.

E. Residents who require assistance with eating will be provided with support during meals and will receive training or adaptive equipment, as needed, based on their assessment, to promote independence in eating.

F. Staff will identify and monitor unintended weight changes among residents and implement interventions ordered by the physician, recommended by the dietitian, and any interventions included in the resident's plan of care.

**DEFINITIONS**

**Acceptable Parameters of Nutritional Status:** Factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values.

**Clinically Significant:** Effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

**Dietary Supplements:** Herbal and alternative products that are not regulated by the Food and Drug Administration, and their composition is not standardized. Dietary supplements must be labeled as such and must not be represented for use as a conventional food or as the sole item of a meal or the diet.

**Significant Weight Loss**

- 5% change within 1 month
- 7.5% change within 3 months
- 10% change within 6 months

**Severe Weight Loss**

- >5% change within 1 month
- >7.5% change within 3 months
- >10% change within 6 months

**PROCEDURE**

A. Residents will be weighed at the time of admission or readmission, weekly for the first four weeks after admission or readmission, and at least monthly thereafter to help identify and document weight trends.

B. Any significant or severe weight changes, unless the resident is receiving comfort care, will require a second weight to corroborate.

C. The staff person taking the weight will document the weight in the medical record. If there is a change of 5 pounds more or less than the previous weight, the staff person will notify the licensed nurse on duty. (Note: This may or may not be a significant or severe weight loss.)

D. The charge nurse or licensed nurse on duty will review all resident weights the same day they are taken to determine if any significant or severe weight change has occurred.

E. The licensed nurse will notify the attending physician of any significant or severe change in weight.

F. The licensed nurse will request a consult from a registered dietitian (RD) for any significant or severe change in weight.

G. The RD will complete a comprehensive nutritional assessment on any resident with unplanned, significant, or severe weight loss within three (3) days of notification.

1. The nutritional evaluation may utilize existing information from various sources, including laboratory tests, medications, assessments, observations, interviews with direct care staff, and interviews with residents and their families.

2. The assessment should identify the factors that place the resident at risk for inadequate nutrition and hydration.

3. The nutritional assessment from the nutritional evaluation, and current dietary standards of practice will be used to develop an individualized care plan to address the resident's specific dietary concerns and preferences.

H. The resident's care plan will be updated to:

1. Address any identified causes of impaired nutritional status

2. Reflect the resident's personal goals and preferences. Examples of goals may include:
    a. Setting a target weight range
    b. Identifying a desired fluid intake
    c. The management of an underlying medical condition (e.g., diabetes, kidney disease, wound healing, heart failure, or infection)
    d. The prevention of unintended weight loss or gain

3. Identify resident-specific interventions along with a time frame and parameters for monitoring. Examples of interventions include:
    a. Fortification of foods
    b. Offering smaller, more frequent meals
    c. Providing between-meal snacks or nourishments
    d. Increasing the portion sizes of a patient/resident's favorite foods and meals
    e. Providing nutritional supplements

I. If nutritional goals are not achieved, the care-planned interventions will be reevaluated for effectiveness and modified as appropriate.

J. Following any significant or severe change in weight, weight will be taken weekly for at least four (4) weeks, or as directed by the provider or recommended by the dietitian.

**REFERENCE**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F692 §483.25(g)

### *NOTES ABOUT THIS POLICY*

Although this policy can also apply to certified swing bed patients, it is most applicable to long-term patients.

# Vision and Hearing Impaired Residents

**PURPOSE**

Provide guidelines for caring for residents with hearing or visual impairments.

**SCOPE: Non-Certified Swing Bed**

**POLICY**

A. The facility will foster a culture of respect and dignity, ensuring that residents with limited vision or hearing receive the same level of care and consideration as other residents.

B. Residents with limited vision or hearing will have an interdisciplinary plan of care with individualized strategies developed based on their degree of vision or hearing impairment.

C. Residents will receive proper treatment and assistive devices to maintain vision and hearing.

D. Residents and their representatives will be assisted in locating and utilizing any available resources for the provision of the services that may be needed. This includes making appointments and arranging transportation to obtain needed services.

E. In situations where the resident has lost a device, the resident and their representative will be assisted in locating resources, as well as in making appointments, and arranging for transportation to replace a lost device.

**DEFINITIONS**

**Assistive Devices to Maintain Vision**: Include, but are not limited to, glasses, contact lenses, magnifying lenses, or other devices that are used by the resident.

**Assistive Devices to Maintain Hearing:** Include, but are not limited to, hearing aids and amplifiers.

**PROCEDURE**

**A. Vision Impaired Residents**

1. Screening of a resident's vision will be completed at admission by the licensed nurse as part of the comprehensive assessment, or at any time when there appears to be a change in visual acuity. The screening does not replace an assessment by a practitioner specializing in the treatment of vision impairment.

2. Appointments and transportation will be arranged by care management for a comprehensive evaluation by a professional specializing in the provision of vision services or to obtain assistive devices such as glasses or contact lenses as needed.

3. The following strategies will be implemented for any resident with vision loss:
    a. Staff will identify themselves whenever entering a room or interacting with a resident
    b. Staff will speak clearly and directly to residents, using descriptive language and spatial references to help them understand
    c. If at all possible, interact at eye level, especially when the resident is seated
    d. Avoid rearranging the environment if at all possible
    e. Maintain an uncluttered environment and remove hazards
    f. Large-print and braille signs to guide residents, especially in common areas and dining rooms

4. The following strategies will be considered for residents with vision loss. Specific strategies will be included in the plan of care.
    a. Access to assistive devices, such as large-button phones, talking clocks, and magnifying glasses

    b. Written Communication Tools
        i. Reading materials in large print
        ii. Access to and training on assistive technology, including screen readers, voice recognition software, and other devices that can enhance independence.
        iii. Labels applied to frequently used items using high contrast colors

    c. Environment
        i. Sunglasses or window curtains drawn to minimize glare if appropriate
        ii. Provide verbal explanations of the location of items or food

B. Staff will receive training on the specific needs of residents with limited vision, including:
    a. How to assist with daily tasks, navigate the environment, and communicate effectively
    b. The importance of using sensory cues, such as contrasting colors and textures, to enhance residents' awareness of their surroundings

**B. Hearing Impaired Residents**

1. A screening of a resident's hearing will be completed at admission by the licensed nurse as part of the comprehensive assessment, or at any time when there appears to be a change in hearing. The screening does not replace an assessment by a practitioner specializing in the treatment of hearing impairment.

2. Appointments and transportation will be arranged by care management for a comprehensive evaluation by a professional specializing in the provision of hearing services or to obtain hearing assistive devices as needed.

3. Strategies for the care of hearing-impaired residents will be included in the plan of care and may include:
    a. Speak slowly and clearly in a low tone of voice
    b. Use familiar language: if the resident's first language is not English, try to use a few words from their native language
    c. Enunciate clearly; some residents may rely on reading lips to give form to the sounds they hear
    d. Sit on the same level when speaking
    e. Avoid using the tone of voice characteristic of independent-dependent relationships (like between a child and parent or a student and a teacher)
    f. Do not interrupt the residents while they are speaking; they may lose their train of thought
    g. Avoid contradicting or arguing with the residents
    h. If the resident does not understand a question the first time, repeat the question exactly
    i. Use both verbal and nonverbal communication
    j. Ask the resident questions to help them feel more in control

4. Staff will receive training on the specific needs of residents with limited hearing, including how to assist with daily tasks, navigate the environment, and communicate effectively.

**REFERENCES**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 232; Issued: 07-23-25)
F685 §483.25(a)

Friends Across the Ages: Top 10 Tips for Communicating with Nursing Home Residents at https://www.friendsacrosstheages.org/top-10-tips-for-communicating-with-nursing-home-residents/

Open Resources for Nursing (Open RN); Ernstmeyer K, Christman E, editors.
Eau Claire (WI): Chippewa Valley Technical College; 2021 at https://www.ncbi.nlm.nih.gov/books/NBK591813/table/ch7sensory.T.nursing_interventions_to_ad/#:~:text=Monitor%20functional%20implications%20of%20diminished,to%20the%20patient%20as%20needed.

### *NOTES ABOUT THIS POLICY*

Although this policy can also apply to certified swing bed patients, it is most applicable to long-term patients.

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# SECTION 3

# CERTIFIED SWING BED ADMISSION PACKET

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# Signature Page

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

By signing this document, you acknowledge that we have verbally reviewed the documents listed below in a language you can understand and provided you with a written copy. We have 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 (Provide separately from admission packet)*
- ☐ What Can Families Do
- ☐ Rights and Responsibilities
- ☐ **Choice of Physician*
- ☐ Physician Contact Information
- ☐ Financial Obligations
- ☐ Privacy Practices
- ☐ Abuse and Neglect
- ☐ Transfer and Discharge
- ☐ Contact information

**Separate information or signature required*

**Patient Printed Name**

**Patient Signature**

**Date**

**Name and title of the person who reviewed the information with the patient**

**Date**

# Swing Bed Information

**Welcome to the Swing Bed Program**
We hope you find the following information about our Swing Bed program helpful. Please feel free to ask questions at any time during your stay.

**About Swing Bed Care**
The Social Security Act (the Act) permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or skilled nursing facility (SNF) care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care (swing bed care) and meets certain requirements.

When your physician has determined that you have recovered from the acute phase of your illness, accident, or surgery, but you are not able to go home yet, they may recommend transfer to a swing bed. Some types of patients who may benefit from swing bed include patients who are:

- Recovering from joint replacement or other types of surgery
- Recovering from a stroke, cardiac or respiratory illness, or other medical condition
- Require management of complex wounds
- Require long-term antibiotic therapy that can't be treated in an outpatient setting
- Require assistance to learn how to manage medications

**Swing Bed Services**
The following services may be provided as part of the swing bed program:

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Intravenous Therapy
- Wound Care
- Medication Management
- Nutritional Counseling
- Patient & Family Education

**Financial Obligations**
Your costs will depend on your insurance coverage. You will receive separate information about financial obligations.

**Doctor Visits**
Similar to your acute care stay, you will receive around-the-clock nursing care, and your doctor will oversee your care. However, since you are no longer in acute care, your physician may not make daily rounds but will visit with you at least once every week. Nursing staff will communicate any concerns or questions with your physician, or you may contact your physician directly.

**Planning your Care**
Your Care Team, including your physician, nursing staff, dietitian, and therapists, will work with you to set personalized treatment goals and will share your progress with you throughout your stay.

During the day, you will receive treatments based on your condition and recovery goals. As a swing bed patient, you will be encouraged to do as much for yourself as possible.

You have the right to be fully informed in advance about care and treatment, and of any changes in that care or treatment. You also have the right to participate in planning your care and treatment and any changes in care and treatment, including planning for discharge.

There will be a care planning meeting at least once each week. We encourage you or your family to attend. This is the opportunity to ask questions and provide input to your care team. If you can't or choose not to participate, someone will meet with you after the conference to discuss your care team's recommendations.

**Family / Support Person**
Your family or support person(s) are encouraged to play an active role in your recovery. They can help by providing emotional support and encouragement, as well as by participating in any education that will help you care for yourself after discharge.

**Clothing**
While you are a patient in a swing bed, we want you to be as comfortable as possible, so we expect you to wear your own clothes every day. Please have your family or friend bring loose-fitting clothes and a pair of comfortable, supportive shoes.

**Length of Stay**
Your length of stay will depend on your progress toward the goals set by you and by the care team.

If you have original Medicare, you may remain in a swing bed as long as you are making progress toward your goals. Other insurance companies may have different limits on how long you can stay.

A member of the Care Team will meet with you to discuss discharge plans and options, which may include discharge home, assisted living, or other options. The Care Team will be actively involved in this process and may provide recommendations and alternatives for future care when necessary.

At least two (2) days before your discharge or transfer, we will provide you with a notice that includes the discharge date and the location of your discharge. You have the right to appeal this decision if you feel you are being discharged too soon.

**Questions**

The care manager can answer any questions you have regarding swing bed care. You can also talk to your nurse or your doctor.

**Contact Information for Care Manager**

# What Can Families Do

Because we understand that it is difficult for families to be apart and patients often feel more secure when their family is near, we want families to feel welcome to participate.

Listed below are some of the things we might suggest. You may have ideas of your own that you would like to try. Just let the nurses know if you wish to help so we can coordinate a schedule for you.

1. Bathing
2. Assist with meals and feeding
3. Assist with dressing
4. Bring books, favorite magazines, unopened mail, iPads
5. Accompany patient to recreational activities or appointments with provider permission using a temporary pass
6. Visit with the patient and provide daily support
7. Sit with patients who require close supervision
8. Assist with transferring and walking when approved by your provider and/or therapists
9. Assist with repositioning
10. Evening care to get ready for bed
11. Bring comfortable clothing changes, shoes, and launder the patient's clothes

*Adapted from Whitman Hospital & Medical Clinics*

# Your Rights as a Swing Bed Patient

**REPRESENTATIVE**

1. If you are judged incompetent under the laws of a state by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under state law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law.

2. Your wishes and preferences must be considered in the exercise of rights by your representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process.

3. In the case of a patient representative whose decision-making authority is limited by state law or court appointment, you retain the right to make decisions outside the representative's authority.

**EXERCISE OF RIGHTS**

4. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights. You have the right to be supported by the facility in the exercise of your rights.

5. You have the right to participate in or refuse to participate in experimental research.

6. You have the right to formulate an advance directive.

**QUALITY OF LIFE**

7. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

8. You have the right to retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other residents.

9. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

**YOUR CARE**

10. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

11. You have the right to be informed, in advance, of changes to your plan of care.

12. You have the right to request, refuse, and/or discontinue treatment.

**FREEDOM FROM ABUSE**

13. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.

**PRIVACY AND COMMUNICATION**

14. You have the right to personal privacy, including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each resident.

15. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

16. You have the right to access stationery, postage, and writing implements at your own expense.

**CHOICE OF PHYSICIAN / PROVIDER**

17. You have the right to choose an attending physician. You have the right to be informed if the physician you have selected is unable or unwilling to be your attending physician, and to choose an alternative physician if you request.

18. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

**VISITORS**

19. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.

20. You have the right to immediate access by others who are visiting with your consent, subject to reasonable clinical and safety restrictions, and your right to deny or withdraw consent at any time.

**FINANCIAL OBLIGATIONS**

21. If you are entitled to Medicaid benefits, you will be informed of:
    d. The items and services that are included under the state plan and for which you may not be charged
    e. Those other items and services that the facility offers and for which you may be charged, and the amount of charges for those services
    f. When changes are made to the items and services

22. You will be informed, regardless of payor source, before or at the time of admission, and periodically during your stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or Medicaid, or by the facility's per diem rate.

**MEDICAL RECORDS**

23. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with state law.

**COMPLAINT OR GRIEVANCE**

24. You have the right to contact the Department of Health Services, the Long-Term Care Ombudsman, Adult Protective Services, or other state officials if you have a complaint or grievance. You may also let the care manager, risk manager, or administrator know if you have a complaint or grievance.

**DISCHARGE OR TRANSFER**

25. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility is endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if you do not submit the necessary paperwork for third-party payment, or after the third party, including Medicare or Medicaid, denies the claims, and you refuse to pay for your stay
    - The facility ceases to operate

26. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility.

## Your Responsibilities

1. To provide, to the best of your knowledge, accurate and complete information about your present illness, past illnesses, hospitalizations, medications, mobility, and other matters relating to your health.

2. To report unexpected changes in your condition to your physician or other members of the health care team.

3. To let us know if you clearly understand your plan of care or need further explanation.

4. To actively participate in your plan of care.

5. To follow hospital rules and regulations.

6. To be considerate of the rights of other residents and facility personnel.

7. To be respectful of the property of other residents and of the hospital.

8. To follow the smoke-free campus policy.

## Choice of Physician

Swing Bed care is typically provided by our Hospitalist group. If you agree to having this group oversee your care, please check below:

☐ _____ Name of Hospitalist Group
***Include the names of all providers (Physicians, NPs, and PAs) in the group***

If you prefer a different physician, please let us know which physician you choose. Please note that the physician must have privileges to practice in our facility and must agree to be your primary physician.

I would like to have _____ as my physician while I am in Swing Bed.

**PATIENT NAME**

**PATIENT SIGNATURE**

**DATE**

**WITNESS**

## Contact Information

We understand you may want to contact your physician or other primary care providers who are caring for you.

You may contact the physician or other providers directly by calling the numbers below.

If it is not confidential, you may ask the nurse or care manager to contact the physician or other providers on your behalf.

**Provider Name**
*Contact Info*

**Provider Name**
*Contact Info*

# Financial Obligations

The following information shows what we may charge you for and your financial obligations based on your insurance.

**Medicaid**

***Check the current information for the State Medicaid Plan.***

If you have Medicaid insurance or if you become eligible for Medicaid, we may charge you for any of the following items:

- Telephone
- Television/radio for personal use
- Personal comfort items, including notions, novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made
- Personal clothing
- Personal reading matter
- Gift purchases on behalf of a patient
- Flowers and plants
- Social events and entertainment that are offered outside the scope of the activities program
- Non-covered special care services, such as privately hired nurses or aides
- Private room, except when therapeutically required, for example, isolation for infection control
- Specially prepared or alternative food you request, not ordered by your physician

**Medicare**

If you have Medicare insurance, Medicare will cover 100% of Medicare-covered charges, as outlined below, for the first 20 days, as long as you meet swing bed criteria. You may receive a separate bill from your physician. Continued stay in a swing bed is always based on meeting the swing bed criteria for skilled care.

| | |
|---|---|
| Days 1 – 20 | $0 for each benefit period |
| Days 21 – 100 | $___ patient responsibility per day in 20__ |
| Days 100 and beyond | All costs |

Medicare-Covered Services include:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Skilled rehabilitation services
- Laboratory and radiology services as ordered by the physician

- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available in the swing bed
- Dietary counseling
- Activities

**Other Insurance**
If you have Medicare and supplemental insurance, your policy may cover the coinsurance after the first 20 days based on your plan's benefits.

The care manager will call your insurance company to verify your benefits, but it is always a good idea for you to call as well.

# Abuse and Neglect

You have the right to be free from verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and/or involuntary seclusion.

To prevent abuse, we conduct criminal background checks for all providers, employees, and contract staff. In addition, we provide education which includes:

- Patient rights
- What constitutes abuse
- Abuse prevention
- Mandatory reporting procedure
- Recognizing signs of burnout, frustration, and stress that may lead to abuse

We have zero tolerance for any behavior on the part of anyone who could encounter a patient that could be perceived to constitute verbal abuse, sexual abuse, mental abuse, physical abuse, corporal punishment, and/or involuntary seclusion.

If you or your family believes you have been subjected to abuse, please contact the individuals or agencies listed below to file a complaint or grievance. You may also file a complaint that may not include allegations of abuse.

**Internal Contacts –** ***Add your facility information for reporting***

**Washington State Department of Social and Health Services (DSHS)**
https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action
Phone: 1-800-562-6078
(TTY) 1-800-737-7931

**Adult Protective Services**
Phone: 1-877-734-6277
(TTY) 1-833-866-5595

**Washington State Ombudsman**
Info & Complaint line: 1-800-562-6028
Fax: 253-815-8173
Email: ltcop@mschelps.org
1200 S. 336th St, Federal Way, WA 98003

# Transfer or Discharge

You will be given as much advance notice as possible before you are transferred or discharged.

The reasons you may be transferred or discharged include:

1. The transfer or discharge is necessary for your welfare, and your needs cannot be met at our hospital

2. The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by our hospital

3. The health and/or safety of individuals at our hospital are endangered

4. You have failed, after reasonable and appropriate notice, to pay for your stay at our hospital, or to pay under Medicare or Medicaid

5. Our facility ceases to operate

You will be notified at least thirty (30) days before you are transferred or discharged unless one of the following occurs:

1. The health or safety of individuals is endangered

2. Your health has improved sufficiently to allow a more immediate transfer or discharge

3. An immediate transfer or discharge is required due to an urgent medical need

4. You have not been a swing bed patient for at least thirty (30) days

The notice of discharge will include:

- Date of transfer or discharge
- Reason for transfer or discharge
- The place where you will be transferred or discharged to
- Right to appeal the discharge or transfer to the state, including the State Long-Term Ombudsman

# Contact Information

**Risk Management**

**Chief Nursing Officer**

**Administrator**

**Washington State Department of Social and Health Services (DSHS)**
Online:
https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action
Phone: 1-800-562-6078
(TTY) 1-800-737-7931

**Adult Protective Services**
Phone: 1-877-734-6277
(TTY) 1-833-866-5595

**Washington State Ombudsman**
Info & Complaint line: 1-800-562-6028
Fax: 253-815-8173
Email: ltcop@mschelps.org
1200 S. 336th St, Federal Way, WA 98003

# SECTION 4

# NON-CERTIFIED SWING BED ADMISSION PACKET

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# 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 we have verbally reviewed the documents listed below in a language you can understand and provided you with a written copy. We have given you the opportunity to ask any questions you may have. You may ask any questions you have at any time during your stay.

- ☐ General Information
- ☐ **Advance Directives (Provide separately from admission packet)*
- ☐ What Can Families Do
- ☐ Rights and Responsibilities
- ☐ **Choice of Physician*
- ☐ Physician Contact Information
- ☐ Financial Obligations
- ☐ Privacy Practices
- ☐ Abuse and Neglect
- ☐ Transfer and Discharge
- ☐ Contact information

**Separate information or signature*

**Patient Printed Name**

**Patient Signature**

**Date**

**Name and title of the person who reviewed the information with the patient**

**Date**

# Information

**Welcome**
We hope you find the following information about our non-certified / long-term swing bed program helpful. Please feel free to ask questions at any time during your stay.

**About Non-Certified or Long-Term Swing Bed Care**
Non-certified or long-term swing bed care is provided when you no longer need skilled care and require long-term assistance.

We offer a wide range of services to provide ongoing medical and non-medical support for those individuals with chronic illness, disability, or the natural aging process who cannot live safely on their own.

**Swing Bed Services (Edit those you do not provide)**
The following services are provided as part of our swing bed program.

- Skilled nursing
- Medication administration
- Assistance with activities of daily living
- Activities program
- Nutritious meals that accommodate dietary restrictions or special diets
- Restorative program to help maintain optimal function
- Medical social work
- Rehabilitation, including physical therapy, occupational therapy, or speech, if ordered by a physician

**Bed Hold and Readmission**
If you must be transferred to an acute care hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving the notice to let us know whether you want us to keep your bed for you.

If Apple Health is covering your stay, they will cover up to ____ days for us to hold the bed for you. If you are not eligible for Apple Health and the daily rate is not covered by your insurance, then you are responsible for paying $___ for each day we hold the bed for you.

If you are away from the facility for more than seven days due to hospitalization or other medical treatment, we will readmit you to the first available bed in a semi-private room, provided we can offer the care you need and you wish to be readmitted.

**Photographs**
You agree that we may take photographs of you for identification and health care purposes. We will not take a picture of you for any other purpose unless you give us prior written permission to do so.

**Doctor Visits**
Your physician will oversee your care. You will have monthly visits with your physician, nurse practitioner, or physician assistant.

We will notify your physician if your condition changes or if you require anything between visits.

You may also contact your physician directly.

**Planning your Care**
Your Care Team, including your physician, nursing staff, dietitian, pharmacist, and care manager, will work with you to set up a personalized plan of care. We meet as a team monthly and as needed. We encourage you or your family to attend. This is the opportunity to ask questions and provide input to your care team. If you can't attend, we will follow up with you after the meeting.

You have the right to be fully informed in advance about care and treatment, and of any changes in that care or treatment. You also have the right to participate in planning your care and treatment and any changes in care and treatment, including planning for discharge.

**Clothing**
You will wear your own clothes every day. Please have your family or friend bring loose-fitting clothes and a pair of comfortable, supportive shoes.
***Add if the hospital or the family is responsible for laundry.***

**Questions**
The care manager can answer any questions you have regarding swing bed care. You can also talk to your nurse or your doctor.

***ADD CONTACT INFO for Care Manager***

# What Can Families Do

Because we understand that it is difficult for families to be apart and patients often feel more secure when their family is near, we want families to feel welcome to participate.

Listed below are some of the things we might suggest. You may have ideas of your own that you would like to try. Just let the nurses know if you wish to help so we can coordinate a schedule for you.

1. Bathing
2. Assist with meals and feeding
3. Assist with dressing
4. Bring books, favorite magazines, unopened mail, iPads and/or accompany the patient for recreational activities or appointments with provider permission using a Temporary Pass
5. Visit with the patient and provide daily support
6. Sit with patients who require close (1:1) supervision
7. Assist with transferring and walking when approved by your provider and/or therapists
8. Assist with repositioning
9. Evening care to get ready for bed
10. Bring comfortable clothing changes, shoes, and launder the patient's clothes

*Adapted from Whitman Hospital & Medical Clinics*

## Your Rights

**REPRESENTATIVE**

1. If you are judged incompetent under the laws of a state by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under state law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law.

2. Your wishes and preferences must be considered in the exercise of rights by your representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process.

3. In the case of a patient representative whose decision-making authority is limited by state law or court appointment, you retain the right to make decisions outside the representative's authority.

**EXERCISE OF RIGHTS**

4. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights. You have the right to be supported by the facility in the exercise of your rights.

5. You have the right to participate in or refuse to participate in experimental research.

6. You have the right to formulate an advance directive.

7. You have the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect.

**QUALITY OF LIFE**

8. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

9. You have the right to retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other residents.

10. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

11. You must be promptly notified when there is a change in room or roommate assignment.

**YOUR CARE**

12. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

13. You have the right to be informed, in advance, of changes to your plan of care.

14. You have the right to request, refuse, and/or discontinue treatment.

**FREEDOM FROM ABUSE**

15. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.

**PRIVACY AND COMMUNICATION**

16. You have the right to personal privacy, including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each resident.

17. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

18. You have the right to access stationery, postage, and writing implements at your own expense.

**CHOICE OF PHYSICIAN / PROVIDER**

19. You have the right to choose an attending physician. You have the right to be informed if the physician you have selected is unable or unwilling to be your attending physician, and to choose an alternative physician if you request.

20. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

**VISITORS**

21. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.

22. You have the right to immediate access by others who are visiting with your consent, subject to reasonable clinical and safety restrictions, and your right to deny or withdraw consent at any time.

**FINANCIAL**

23. If you are entitled to Medicaid benefits, you will be informed of:
    g. The items and services that are included under the state plan and for which you may not be charged
    h. Those other items and services that the facility offers and for which you may be charged, and the amount of charges for those services
    i. When changes are made to the items and services

24. You will be informed, regardless of payor source, before or at the time of admission, and periodically during your stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or Medicaid, or by the facility's per diem rate.

25. You have the right to manage your financial affairs.

**MEDICAL RECORDS**

26. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with state law.

27. You have the right to access personal and medical records and have the resident upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and

format as agreed to by the facility and the individual within 24 hours (excluding weekends and holidays).

28. You have the right to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and with two (2) working days advance notice to the facility.

**COMPLAINT OR GRIEVANCE**

29. You have the right to contact the Department of Health Services, the Long-Term Care Ombudsman, Adult Protective Services, or other state officials if you have a complaint or grievance. You may also let the care manager, risk manager, or administrator know if you have a complaint or grievance.

**DISCHARGE OR TRANSFER**

30. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility is endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if you do not submit the necessary paperwork for third-party payment, or after the third party, including Medicare or Medicaid, denies the claims, and you refuse to pay for your stay
    - The facility ceases to operate

31. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility.

## Choice of Physician

The _____ (name of group) are the attending physicians for swing bed patients. On nights and weekends, coverage is provided by _____physicians. If you agree to having this group oversee your care, please check below:

☐ **Physician Group (NAME), and/ or ER Group (If you have a group)**

The NAME OF HOSPITAL Physician Group includes:
*Include the names of all providers (physicians, NPs, and PAs) in the group*

If you prefer a different physician, please let us know which physician you prefer. Please note that the physician must have privileges to practice at our hospital and must agree to be your primary physician.

☐ I would like _____to be my physician

## Contact Information

We understand you may want to contact your physician or other providers who are caring for you.

You may also contact them directly by calling the number(s) below:

| | |
|---|---|
| **Provider Name:** | **Provider Name:** |
| **Contact Info:** | **Contact Info:** |

If it is not confidential, you may also let the nursing staff or any member of the care team know that you would like to speak to your physician, and they will call the physician for you.

# Financial Obligations

The following information shows what we may charge you for and your financial obligations based on your insurance.

**Medicaid**

***Note: Check the State Medicaid Plan for specifics***

If you have Medicaid insurance or if you become eligible for Medicaid, we may charge you for any of the following items:

- Telephone
- Television/radio for personal use
- Personal comfort items, including notions, novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made
- Personal clothing
- Personal reading matter
- Gift purchases on behalf of a patient
- Flowers and plants
- Social events and entertainment offered outside the scope of the activities program
- Non-covered special care services, such as privately hired nurses or aides
- Private room, except when therapeutically required, for example, isolation for infection control
- Specially prepared or alternative food you request, not ordered by your physician

**Other Insurance**

If you have private long-term care insurance, the care manager will call your insurance company to see what benefits you have, but it is always a good idea for you to call as well.

**Private Pay**

If you are paying privately, the care manager will provide you with information about the costs.

# Abuse and Neglect

You have the right to be free from verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and/or involuntary seclusion.

To prevent abuse, we conduct criminal background checks for all providers, employees, and contract staff. In addition, we provide education which includes:

- Patient rights
- What constitutes abuse
- Abuse prevention
- Mandatory reporting procedure
- Recognizing signs of burnout, frustration, and stress that may lead to abuse

We have zero tolerance for any behavior on the part of anyone who could encounter a patient that could be perceived to constitute verbal abuse, sexual abuse, mental abuse, physical abuse, corporal punishment, and/or involuntary seclusion.

If you or your family believes you have been subjected to abuse, please contact the individuals or agencies listed below to file a complaint or grievance. You may also file a complaint that may not include allegations of abuse.

**Internal Contacts –** ***Add your facility information for reporting***

**Washington State Department of Social and Health Services (DSHS)**
https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action
Phone: 1-800-562-6078
(TTY) 1-800-737-7931

**Adult Protective Services**
Phone: 1-877-734-6277
(TTY) 1-833-866-5595

**Washington State Ombudsman**
Info & Complaint line: 1-800-562-6028
Fax: 253-815-8173
Email: ltcop@mschelps.org
1200 S. 336th St, Federal Way, WA 98003

# Transfer or Discharge

You will be given as much advance notice as possible before you are transferred or discharged.

The reasons you may be transferred or discharged include:

1. The transfer or discharge is necessary for your welfare, and your needs cannot be met at our hospital

2. The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by our hospital

3. The health and/or safety of individuals at our hospital are endangered

4. You have failed, after reasonable and appropriate notice, to pay for your stay at our hospital, or to pay under Medicare or Medicaid

5. Our hospital ceases to operate

You will be notified at least thirty (30) days before you are transferred or discharged unless one of the following occurs:

1. The health or safety of individuals is endangered

2. Your health has improved sufficiently to allow a more immediate transfer or discharge

3. An immediate transfer or discharge is required due to an urgent medical need

4. You have not been a swing bed patient for at least thirty (30) days

The notice of discharge will include:

- Date of transfer or discharge
- Reason for transfer or discharge
- The place where you will be transferred or discharged to
- Right to appeal the discharge or transfer to the state, including the Long-Term Ombudsman

# Contact Information

**Risk Management**

**Chief Nursing Officer**

**Administrator**

**Washington State Department of Social and Health Services (DSHS)**
Online:
https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action
Phone: 1-800-562-6078
(TTY) 1-800-737-7931

Adult Protective Services
Phone: 1-877-734-6277
(TTY) 1-833-866-5595

**Washington State Ombudsman**
Info & Complaint line: 1-800-562-6028
Fax: 253-815-8173
Email: ltcop@mschelps.org
1200 S. 336th St, Federal Way, WA 98003

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# SECTION 5

# CROSSWALK
# APPENDIX W - APPENDIX PP

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| Topic | Appendix W | Appendix PP |
|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Abuse, Neglect, Exploitation, and Misappropriation of Property** | C-1612 | | F600 | |
| **Activities** | No specific requirement other than to meet psychosocial needs | | F561 | F679 |
| **Admission Process and Disclosures** | C-1425 | | | |
| **Baseline Plan of Care** | No requirement | | F636<br>F637<br>F639 | F655<br>F656<br>F657 |
| **Choice of Physician** | C-1608 | | F555 | |
| **Culturally Competent Trauma-Informed Care** | C-1620 | | F656 | |
| **Dental Services** | C-1624 | | F790 | F791 |
| **Discharge** | C-1610 | C-1620 | F627 | F628 |
| **Education and Competency** | Specific to each discipline | | F726<br>F730<br>F741<br>F801<br>F895<br>F940<br>F941 | F942<br>F943<br>F944<br>F945<br>F947<br>F949 |
| **Financial Obligations** | C-1608 | | F582 | |
| **Initial Assessment** | C-1620 | | F636 | F637 |
| **Interdisciplinary Plan of Care** | C-1620 | | F656 | |
| **Medication Management** | All requirements in Appendix W related to medication management | | F605 | F756 |
| **Privacy and Confidentiality** | C-1608 | | F540 | |
| **Resident Rights** | C-1608<br>C-1610 | C-1612 | F550<br>F551<br>F552<br>F553<br>F554<br>F555 | F557<br>F558<br>F559<br>F560<br>F561<br>F562<br>F563 |
| **Physician Responsibilities** | | | F710<br>F711 | F712<br>F713 |
| **Rehabilitation** | C-1622 | | F825 | |

| Topic | Appendix W | Appendix PP |
|---|---|---|

| | | | |
|---|---|---|---|
| **Therapeutic Leave** | C-1620 | F625 | F626 |
| **Nutrition** | C-1626 | F692 | F693 |
| **Social Service** | C-1616 | F745 | |
| **Visitation** | C-1608 | F563 | |

# SECTION 6

# CONTINUOUS SURVEY READINESS

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| Regulatory Requirement | Regulatory Reference |
|---|---|

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. This applies primarily to certified swing beds.

| Admission | |
|---|---|
| 1. For patients in the same facility being admitted to a 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<br><br>*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-1600 |

| 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<br>• 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<br>• Will require skilled care on a daily basis, which, as a practical matter, can only be provided in an SNF on an inpatient basis<br><br>*Note:*<br>• *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*<br>• *Recertification is required at admission, 14 days, and then every 30 days thereafter* | Medicare Benefits Manual Chapter 8, 40.0<br><br>Medicare General Information, Eligibility, and Entitlement Chapter 4, 40.3 and 40.4 |
| 6. History and Physical completed within the time frame specified in the hospital bylaws<br><br>*Note: A new H&P is required for swing bed admissions -- a new record is required* | C-1102<br>C-1600 |

| Regulatory Requirement | Regulatory Reference |
|---|---|

| Admission: Patient Required Disclosures | |
|---|---|
| 7. Signature/attestation that the patient received the required disclosures | C-1608<br>C-1610<br>C-1612 |
| 8. Choice of attending physician (must be documented in the EMR) | C-1608 |
| 9. Contact Information for primary care providers, including those provided to the patient | C-1608 |
| 10. Swing bed rights and responsibilities were provided verbally and in a manner the patient could understand, and the patient was provided the opportunity to ask questions<br><br>*Notes:*<br>• *This must be specific swing bed rights. Not hospital rights or long-term care rights*<br>• *If there are any patient rights in state regulations that are not included in the CMS rights, they must be included* | C-1608<br>C-1610<br>C-1612 |
| 11. Visitation<br><br>*Note: Right to 24-hour access by visitors if requested by the patient* | C-1608 |
| 12. Advance Directives<br>• Patient was asked if they had an advance directive, and if not, if they wanted information<br>• If the patient has an advance directive, is it in the medical record?<br>• If the patient has a DNR, there is a physician's order for code status<br>• Hospital staff and practitioners who provide care in the hospital comply with these directives | C-0812 |
| 13. Financial obligations for Medicare and Medicaid, including what is covered and not covered under the state plan. Include the Medicare co-pay on day twenty-one | C-1608 |

| Abuse<br>Grievance or Complaint | |
|---|---|
| 14. Hospital responsibility for preventing abuse<br><br>*Note: Freedom from abuse is required under patient rights. However, it is recommended that a statement* | C-1612 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| *or page be included in the admission packet regarding the hospital's responsibilities for preventing abuse* | |
| 15. Information on how to file a grievance/complaint both internally and externally, including state licensing agencies and ombudsman | C-1612 |

| **Admission: Assessment** | |
|---|---|
| 16. Assessment of the patient's needs, strengths, goals, life history, and preferences was completed within 72 hours of admission<br>• Identification and demographic information<br>• Customary routine<br>• Cognitive patterns<br>• Communication<br>• Vision<br>• Mood and behavior patterns<br>• History of trauma<br>• Psychosocial well-being<br>• Physical functioning and structural problems<br>• Continence<br>• Disease diagnoses and health conditions<br>• Dental<br>• Nutritional status<br>• Skin condition<br>• Activity pursuit<br>• Medications<br>• Special treatments and procedures<br>• Discharge planning<br><br>*Note: CMS requirement of 14 days to complete the comprehensive assessment does not apply to swing bed patients. 72 hours is recommended, if necessary, to span a weekend* | C-1620 |
| 17. Assessment by PT, OT, or Speech, if ordered by the provider, within 72 hours of admission<br><br>*Note:*<br>• *72 hours is recommended if necessary to span a weekend*<br>• *There is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay* | C-1620<br>C-1622 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| 18. Assessment by a dietitian within 72 hours of admission<br><br>*Note:*<br>• *A dietitian assessment should be completed even if the patient is determined not to be at nutritional risk based on the nursing risk assessment*<br>• *There is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay* | C-1620<br>C-1626 |
| 19. Assessment of Trauma | C-1620 |
| 20. Review of PASRR (if a PASRR has been completed before admission)<br><br>*Note: Will usually have been completed if the patient has been an LTC patient* | C-1620 |

| **Admission: Plan of Care** | |
|---|---|
| 21. Interdisciplinary Plan of Care (POC) developed (first IDT meeting) within the time frame appropriate for the length of stay | C-1620 |
| 22. Plan of Care developed by an interdisciplinary team that includes, at a minimum:<br>• Attending physician<br>• Registered nurse with responsibility for the patient<br>• CNA with responsibility for the patient<br>• Member of the food and nutrition staff<br>• To the extent practicable, the participation of the patient and the patient's representative(s) (If they do not attend, sign that they are in concurrence with the plan)<br>• Other appropriate staff or professionals in disciplines as determined by the patient's needs or as requested by the patient. (If the patient is being seen by rehab, then they should attend. If there are complex medication issues, the pharmacist should attend.<br><br>*Notes:*<br>• *An explanation must be included in a patient's medical record if the participation of the patient and their patient representative is determined not* | C-1620 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| *to be practicable for the development of the plan of care*<br>• *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*<br>• *If there are no CNAs on duty, document in the care plan meeting minutes*<br>• *If the patient is receiving PT, OT, or Speech, they should be in attendance*<br>• *If the patient has a complex medication regimen, the pharmacist should attend* | |
| 23. POC includes measurable objectives and timeframes to meet the patient's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment<br><br>*Note: Goals MUST be measurable and must have timeframes for completion of each goal* | C-1620 |
| 24. 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 |
| 25. 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<br><br>*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<br>F656 |
| 26. Plan of Care updated once or twice per week with input from the interdisciplinary team and the patient<br><br>*Note: There is no specific regulatory requirement for weekly. However, with the length of stay, the POC* | C-1620 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| *should be updated at least weekly, and ideally twice per week* | |

| Continued Care | |
|---|---|
| 27. Dietitian recommendations implemented and documented<br><br>*Note: If the dietician recommends weekly weights, check and see if they were done and recorded*<br>*Note: If the dietician recommends a snack at bedtime, check and make sure the snack was offered and documented* | C-1626 |
| 28. Nutrition<br>• Food in form to meet individual needs (F-805)<br>• Drinks available to meet needs/preferences (F-807)<br>• Assistive devices-eating equipment/utensils if needed (F-810)<br>• Allergies, preferences & substitutes taken into consideration (F-804) | C-1626 |
| 29. Weight at admission and as required based on patient status<br><br>*Note: Maintaining weight and hydration are critical elements of swing bed care* | C-1626 |
| 30. Rehab, if ordered, is provided at least five days per week | Medicare Benefit Policy Manual Chapter 8 - 30.4; 30.6 |
| 31. Rehab, if ordered, is provided at the frequency determined by the assessment and provider order | C-1622 |
| 32. 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 before therapy, etc.) | C-1622 |
| 33. Evidence that nursing is supporting therapy goals (i.e., assisting the patient to walk, dress, etc.)<br>34. *Note: Nursing support of therapy goals is extremely important to maintaining functional status, especially on the weekends* | C-1620 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| 35. Therapeutic interventions, wound care, oxygen therapy, medications, etc., provided as ordered and documented in the medical record | C-1049 |
| 36. Activities are provided, as needed, based on the patient assessment<br><br>*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 |
| 37. Therapeutic Leave<br><br>*Note: Provider order, Release of liability signed, Patient or individual patient is released to receive proper instructions for care* | C1620 |
| 38. Comprehensive reassessment completed with any significant change in condition | C-1620 |

| **Transfer or Discharge** | |
|---|---|
| 39. 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 |
| 40. Patient provided with Notice of Medicare Non-Coverage two (2) days before discharge | Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, Chapter 30 §260.2 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| 41. Discharge Notice provided:<br>Contents of the notice.<br>• The reason for transfer or discharge<br>• The effective date of transfer or discharge<br>• The location to which the resident is transferred or discharged<br>• 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;<br>• The name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman<br>• 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<br>C-1620 |
| 42. Copy of the patient notice of transfer or discharge sent to the State Ombudsman | C-1610<br>C-1620 |
| 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-1610<br>C-1620 |
| 44. Reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescribed and over the counter) | C-1610<br>C-1620 |
| 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 their new living environment<br><br>The post-discharge plan of care must indicate where the individual intends 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-1610<br>C-1620 |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| 46. A final summary of the patient's status to include items in §483.20<br><br>*Note: This requires a reassessment of the same items in the original comprehensive assessment. However, most facilities will review the goals defined in the plan of care and determine whether they were met.* | C-1610<br>C-1620 |
| 47. Other information to the next provider of care:<br>• Contact information of the practitioner responsible for the care of the patient<br>• Patient representative information, including contact information<br>• Advance Directives<br>• All special instructions or precautions for ongoing care, as appropriate | C-1610<br>C-1620 |

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# SECTION 7

# CONTINUOUS SURVEY READINESS NON-CERTIFIED SWING BED

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| Regulatory Requirement | Regulatory Reference |
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The audit tool is designed to help you complete an internal audit of non-certified swing beds. Please note that this includes only those additional areas applicable to non-certified swing beds.

| Pre-Admission | | |
|---|---|---|
| 1. PASARR Level 1 completed before admission if Medicaid (Apple Care) or Medicaid eligible | F644<br>F645<br>F646 | RCW 74.42.056<br>WAC 388-97-1915 |

| Admission | | |
|---|---|---|
| 2. Resident Rights<br><br>*If you use the Resident Rights for Certified Swing Bed, recommend adding: right to vote, access to records within 24 hours, notification of resident or representative of a change in room or roommate assignment, protection of resident funds, examination of survey results* | F550 thru F555<br>F557 thru F563<br>F583 thru F584 | RCW 74.42.030<br>RCW 74.42.100<br>RCW 74.42.110<br>RCW 74.42.120<br>RCW 74.42.160 |
| 3. Trust Account if requested by resident or representative, including cash available if requested | F568 thru F570 | RCW 74.42.060<br>RCW 74.42.130 |
| 4. Financial obligations for Medicare and Medicaid, including what is covered and not covered under the state plan. Include the Medicare co-pay on day twenty-one | F582 | |

| Assessments | | |
|---|---|---|
| 5. Assessment by a physician within 5 days before admission or within 72 hours of admission | F710 | WAC 388-97-1260 |
| 6. Assessment within 24 hours of admission to develop baseline plan of care by RN | F636<br>F637<br>F638<br>F655<br>F656<br>F657 | WAC 388-97-1000<br>WAC 388-97-1020 |
| 7. Initial assessment within 14 days of admission completed by interdisciplinary team | | |
| 8. Quarterly assessments completed by interdisciplinary team | | |
| 9. Annual assessment completed by interdisciplinary team | | |

Right to vote

| Comprehensive Plan of Care | | |
|---|---|---|
| 10. Baseline plan of care within 48 hours of admission | F655<br>656<br>F657<br>F658 | RCW 388-97-1020 |
| 11. Initial comprehensive care plan within 14 days after completion of the comprehensive care plan | | |
| 12. Comprehensive care plan completed by interdisciplinary team, including patient or representative if possible | | |

| Regulatory Requirement | Regulatory Reference | |
|---|---|---|
| **Continuing Care** | | |
| 13. Physician / Provider Visits<br><br>First visit within 30 days of admission<br>Then every 30 days for 90 days<br>Then every 60 days after the first 90 days<br>APP may make every other required visit after the initial visit | F710<br>F711<br>F712<br>F713 | WAC 388-97-1260 |
| 14. Activities<br><br>Activities Assessment and Program<br>Activities documented | F679<br>F680 | RCW 74.42.190 |
| 15. Bowel and Bladder Program | F690 | |
| 16. Fall Prevention<br><br>• Comprehensive Fall Prevention Program in place<br>• Resident assessed<br>• Interventions implemented | F689 | |
| 17. Nutrition and Hydration<br><br>• Adequate nutrition and hydration<br>• 3 meals served<br>• Not more than 14 hours between evening meal and breakfast<br>• Not less than 10 hours between breakfast and evening meal<br>• Adaptive equipment if needed | F692<br>F693 | RCW 74.420.290<br>RCW 74.420.300 |
| 18. Immunizations<br><br>• Influenza<br>• Pneumococcal<br>• Covid-19 | F883 | RCW 74.42.285 |
| 19. Pain Assessment | F697 | |
| 20. Monthly pharmacist medication review and physician review | F605<br>F756 | RCW 74.420.210 |
| 21. Psychotropic Drug Review and Gradual Dose Reduction by pharmacist and physician | F605<br>F756 | |
| 22. Range of Motion and Restorative Program | F676<br>F688<br>F675 | |
| 23. Resident Behavior, New or Worsening | F637 | |

| Regulatory Requirement | Regulatory Reference |
|---|---|
| | F740<br>F757 |
| 24. Safe, Clean, Comfortable, Home-Like Environment | F584 |
| 25. Safety Measures for Combative Residents | Policy |
| 26. Behavior Log | Policy |
| 27. Skin Assessment | Policy |
| 28. Unintended Weight Change | F692<br>F693 |
| 29. Vision and Hearing Impaired Residents | F685 |