### SWING BEDS

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
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</table>
| 11.00.00 Condition of Participation: Special Requirements for Hospital Providers of Long-Term Care Services ("Swing-Beds.") | The swing-bed concept allows a CAH to use their beds interchangeably for either acute-care or post-acute care.  
- A “swing bed” is a change in reimbursement status.  
- The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement. | **DOCUMENT REVIEW & INTERVIEW**  
Verify the facility:  
1. Meets the requirements and has received approvals for swing beds.  
2. Have a letter from CMS and a provider number for the swing beds. | |
Discharge Orders
There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the same facility or transfers to another facility.

If the patient does not change facilities, the same chart can be utilized but the swing-bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents.

Length of Stay
- There is no length of stay restriction for any CAH swing-bed patient.

- There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.

3-Day Qualifying Stay
- Medicare reimbursement requires a 3-day qualifying stay in any CAH or CAH prior to admission to a swing-bed.
- The swing-bed stay must fall within the same spell of illness as the qualifying stay. This requirement does not apply to patients who are not receiving Medicare reimbursement.

- There is no requirement for a CAH to use the admission.
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<table>
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<tbody>
<tr>
<td>MDS form for recording the patient assessment or for nursing care planning.</td>
<td>Self-explanatory.</td>
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<td>Reimbursement</td>
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<tr>
<td>• Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however swing-bed patients are not SNF patients.</td>
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<td>• Swing-bed patients in CAHs are considered to be patients of the CAH.</td>
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#### 11.00.01 Eligibility.
A CAH must meet the following eligibility requirements:

(1) **The facility has been certified as a CAH by CMS under 42 CFR §485.606(b); and**

(2) **The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under 42 CFR §485.645(a).**

§485.645(a) §485.645(a)(1) §485.645(a)(2)

#### DOCUMENT REVIEW & INTERVIEW
Verify the facility:
1. Meets the requirements and has received approvals for swing beds.
2. Has a designation letter from CMS and a provider number for the swing beds.
3. Count the number of beds available for patient occupancy in an inpatient, observation or swing bed status.
   - The number of beds must not exceed 25 beds.

1 = Compliant 2 = Not Compliant
11.00.02 Skilled Nursing Facility Services. The facility must be in substantial compliance with the following skilled nursing facility requirements which are scored individually.

1. Resident rights (42 CFR §483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), (e)(4), (f)(4)(ii), (f)(4)(iii), (f)(9), (g)(8), (g)(17), (g)(18) introductory text, and (h) §483.10(b)(3) through (b)(6), (d), (e), (h), (i), (j)(1)(vii) and (viii), (j), and (m)).

2. Admission, transfer, and discharge rights (§483.5 definition of transfer & discharge, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) 42 CFR §483.12(a)).

3. Freedom from abuse, neglect, and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) (c) Resident behavior and facility practices (§483.13),

4. Patient activities (§483.24(c) §483.15 (c), except that the services may be directed either by

**DOCUMENT REVIEW**

Swing-bed standards within this chapter are applicable to only those acute care hospitals and critical access hospitals (CAH) that have a Medicare provider agreement for Swing-beds. Scoring deferred.

This: These standard requirements is are scored, as applicable, individually throughout the chapter.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
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<th>SCORE</th>
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<tbody>
<tr>
<td>a qualified professional meeting the requirements of §483.24(c)(2), 42 CFR §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.</td>
<td>(4)(5)</td>
<td>Social services (§483.40(d) and 483.70(p)(§483.15(g)),</td>
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<tr>
<td>(5)(6)</td>
<td>Comprehensive assessment, comprehensive care plan, and discharge planning (42 CFR §483.20(b), §483.21(b) and (c)(2) (k), and (l)), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under 42 CFR §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in 42 CFR §413.343(b)).</td>
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<tr>
<td>(6)(7)</td>
<td>Specialized rehabilitative services (§483.65)(§483.45),</td>
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### SWING BEDS

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<tr>
<td>Dental services (§483.55)</td>
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<td>Nutrition (42 CFR §483.25(g)(1) and (g)(2) §483.25(i))</td>
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§485.645(d); §485.645(d)(1);
§485.645(d)(2); §485.645(d)(3);
§485.645(d)(4); §485.645(d)(5);
§485.645(d)(6); §485.645(d)(7);
§485.645(d)(8); §485.645(d)(9)

### 11.00.03 Formerly 11.0.02 Facilities Participating as Rural Primary Care Hospitals.

These facilities must meet the following requirements:

(1) Notwithstanding 42 CFR 485.645(a), a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted.

### DOCUMENT REVIEW & INTERVIEW

Verify the facility:
- Has a letter granting swing bed approval as a rural primary care hospital.

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<tr>
<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
<th>N/A</th>
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This standard is not met as evidenced by:
A CAH that was granted swing-bed approval under 42 CFR §485.645(b)(1) (above) may request that its application to be a CAH and swing-bed provider be reevaluated under 42 CFR §485.645(a) (above).

If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under 42 CFR §485.645(b)(1) and may not request reinstatement under 42 CFR §485.645(b)(1).

§485.645(b)(2)

11.00.04  (Formerly 11.00.03)  Payment.
Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in 42 CFR §485.645(a) (see above) is made in accordance with 42 CFR §413.70.

Payment for post-hospital SNF-level of care services is made in accordance with 42 CFR §413.70.

This standard serves as a statement of payment and is not scored by surveyors.

Not Scored
### STANDARDS / ELEMENTS

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<tr>
<th>Standard / Element</th>
<th>Explanation</th>
<th>Scoring Procedure</th>
<th>Score</th>
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<tbody>
<tr>
<td>11.01.01 (Formerly 11.01.00)</td>
<td>The resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility.</td>
<td>Long-term residents have rights guaranteed to them under federal and state law.</td>
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<td>STANDARD / ELEMENT</td>
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<td>treatment (§483.10(c)(1));</td>
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<td>resources are available for interpretation.</td>
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<tr>
<td>4. To be fully informed, in advance, of changes to the plan of treatment (§483.10(c)(1));</td>
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<td>5. To be fully informed in language of his or her total health status, including his or her medical condition (§483.10(c)(1));</td>
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<tr>
<td>6. To personal privacy, confidentiality, and security of his or her personal and medical records (§483.10(h));</td>
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<td>7. To refuse the release of personal and medical records, except per 483.70(i)(2) and federal or state laws (§483.10(h));</td>
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<td>8. To choose to or refuse to perform services for the facility (§483.10(f)(9));</td>
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<td>9. To send and receive mail, packages and other materials delivered to the facility for the resident through a means other than the postal services (§483.10(g)(8));</td>
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<tr>
<td>10. To have privacy of communications (§483.10(h));</td>
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<td>11. To have access to stationery, postage, and writing implements at the resident’s own expense (§483.10(g)(8));</td>
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<td>12. To have immediate access to the resident’s immediate family and other relatives, subject to the resident’s right to deny or withdraw consent at any time (§483.10(f));</td>
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<tr>
<td>13. To retain and use personal possessions, including furnishings, clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents (§483.10(e)(2));</td>
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<tr>
<td>14. To share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement (§483.10(f)(4); and</td>
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<tr>
<td>15. To be free from abuse, neglect, misappropriation of property, and exploitation (§483.12).</td>
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</table>
A facility must protect and promote the rights of each resident, including each of the following rights.

11.01.02  **(Formerly 11.01.03)** Right to Request, Refuse, and/or Discontinue Treatment.
The resident has the right to:

- Request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

“Treatment” is defined as care provided for purposes of maintaining / restoring health, improving functional level, or relieving symptoms.

“Experimental research” is defined as development and testing of clinical treatments, such as an investigational drug or therapy that involves treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research.

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining resident permission.

“Advance directive” means a written instruction, such as living will or durable power of attorney for health care, recognized under state law, relating to the provisions of health care when the individual is incapacitated.

<table>
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<tr>
<th>DOCUMENT REVIEW, CHART REVIEW AND INTERVIEW</th>
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<tbody>
<tr>
<td>1. Review the facility’s policies on refusal of care and advance directives to determine the requirement is met.</td>
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<tr>
<td>2. Verify that the advance directive is being enforced, included in the plan of care, and does not preclude the provision of supportive care delivery.</td>
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<tr>
<td>3. Review medical records to determine that advance directives were requested on all patients and copies are available.</td>
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<tr>
<td>4. Review the records of sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.</td>
</tr>
<tr>
<td>5. Determine to what extent the facility provides education to the community regarding individual rights under State law to formulate advance directives.</td>
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<tr>
<td>STANDARD / ELEMENT</td>
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<tr>
<td>A resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes.</td>
</tr>
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</table>

This provision applies to residents admitted on or after December 1, 1991. The regulation at 42 CFR §489.102 specifies that at the time of admission of an adult resident, the facility must:

- Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care;

- Provide written information concerning his or her rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;

- Document in the resident’s medical record whether or not the individual has executed an advance directive;

- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

- Ensure compliance with requirements of State

6. Is there evidence in the medical record that the patient was informed of his rights, including the right to accept or refuse medical or surgical treatment?

**INTERVIEW**

If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols?

The requirement at §483.75(c) “Relationship to Other HHC Regulations may apply,” see 45 CFR Part 46, Protection of Human Subjects of Research. “Although these regulations at §483.75(c) are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.”
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<td><strong>EXPLANATION</strong></td>
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<td>law regarding advance directives;</td>
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<td>• Provide for educating staff regarding the facility’s policies and procedures on advance directives; and</td>
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<td></td>
<td>• Provide for community education regarding issues concerning advance directives.</td>
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<td>The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is also not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive, and state law allows the provider to conscientiously object.</td>
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<td>The sum total of the community education efforts must include a summary of the state law, the rights of residents to formulate advance directives, and the facility’s implementation policies regarding advance directives.</td>
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<td>Video and audio tapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience.</td>
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<tr>
<td>11.01.03 (Formerly 11.01.06) Choice of Attending Personal Physician.</td>
<td>The resident has the right to choose his or her personal attending physician.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong>&lt;br&gt;1. Review the facility’s policies to determine the requirement is met.&lt;br&gt;2. Interview patients to verify they were given the opportunity to select their own personal physician.</td>
<td>1 = Compliant&lt;br&gt;2 = Not Compliant&lt;br&gt;This standard is not met as evidenced by:</td>
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<tr>
<td>(1) The physician must be licensed to practice, and</td>
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<tr>
<td>(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in 42 CFR 483.15(d)(4) paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.</td>
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<td>(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.</td>
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<td>(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks</td>
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</table>

A resident in a swing-bed of a general acute care hospital can choose his/her own physician, unless the hospital requires that physicians of residents in hospital swing-beds have hospital admitting privileges. If this is so, the resident can choose his/her own physician from those with appropriate privileges.

- The right to choose a personal physician does not mean that the physician must serve the resident.

- If the physician of the resident’s choosing fails to fulfill a given requirement, such as frequency of physician visits, the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment.

A facility may not place barriers in the way of residents choosing their own physician. If a resident does not have a physician, or if the resident’s physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his/her choice in finding another physician.

A resident can choose his/her own physician, but cannot have a physician who does not have swing bed admitting privileges.

The requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges.
### SWING BEDS

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<th>SCORE</th>
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**alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options.**

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

§483.10(d)
§483.10(d)(1)
§483.10(d)(2)
§483.10(d)(3)
§483.10(d)(4)
§483.10(d)(5)

11.01.04 (Formerly 11.01.02) Planning and Implementing Care Participation in Care. The resident has the right to: be informed of, and participate in, his or her treatment, including:

- Participates in planning care and treatment,” means

**DOCUMENT REVIEW, CHART REVIEW, AND INTERVIEW**

1. Look for on-going efforts on the part of facility staff to keep residents informed.
2. Look for evidence that information is communicated in a manner that is

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<table>
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<tr>
<td><strong>The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</strong></td>
<td>that the resident is afforded the opportunity to select from alternative treatments, to the level of his ability to understand.</td>
<td><strong>understandable to residents.</strong></td>
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<tr>
<td>Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.</td>
<td>This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment.</td>
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<tr>
<td>§483.10(c) §483.10(c)(1) §483.10(d)(3)</td>
<td>Information on health status must be presented in language that the resident can understand. Communicating with the resident in language that the resident can understand includes minimizing the use of technical words, providing interpreters for non-English speaking residents, using sign language when needed, or other interventions, as appropriate.</td>
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<td>“Total health status” includes;</td>
<td>“Total health status” includes;</td>
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<td>• functional status,</td>
<td>• functional status,</td>
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<td>• medical care,</td>
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<td>• nursing care,</td>
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<td>• nutritional status,</td>
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<td>• rehabilitation and restorative potential,</td>
<td>• rehabilitation and restorative potential,</td>
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<td>• activities potential,</td>
<td>• activities potential,</td>
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<td>• cognitive status.</td>
<td>• cognitive status.</td>
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<tr>
<td>3. Is information available when it is most useful to the residents such as when they are expressing concerns, raising questions, and on an on-going basis?</td>
<td>Is information available when it is most useful to the residents such as when they are expressing concerns, raising questions, and on an on-going basis?</td>
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<tr>
<td>4. Review medical records for evidence that the resident has participated in planning and treatment care changes. There should be a notation in the multidisciplinary care meetings of patient participation.</td>
<td>Review medical records for evidence that the resident has participated in planning and treatment care changes. There should be a notation in the multidisciplinary care meetings of patient participation.</td>
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<tr>
<td>5. Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes.</td>
<td>Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes.</td>
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<tr>
<td>6. If there appears to be a conflict between a resident’s right and the resident’s health or safety, determine if the facility attempted to accommodate both the exercise of the resident’s rights and the resident’s health, including exploration of care alternatives through a thorough care planning process in which the resident may participate.</td>
<td>If there appears to be a conflict between a resident’s right and the resident’s health or safety, determine if the facility attempted to accommodate both the exercise of the resident’s rights and the resident’s health, including exploration of care alternatives through a thorough care planning process in which the resident may participate.</td>
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<tr>
<td>7. If a resident whose ability to make decisions about care and treatment is impaired, was he kept informed and consulted on personal preferences to the level of his ability to understand?</td>
<td>If a resident whose ability to make decisions about care and treatment is impaired, was he kept informed and consulted on personal preferences to the level of his ability to understand?</td>
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11.01.05  [Formerly 11.01.07]  
**Informed of Care and Treatment.**  
The resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

- The right to be fully informed, in advance, of changes to the plan of care and treatment and of any changes in that care or treatment that may affect the resident’s well-being.

§483.10(c)(2)(iii)  
§483.10(d)(2)

“**Informed in advance,**” means that the resident receives information necessary to make a health care decision.

The information should include his/her medical condition, changes in his/her medical condition, the benefits and reasonable risks of the recommended treatment, and reasonable alternatives.

If there are any financial costs to the resident in the treatment options, they should be disclosed in advance and in writing to the resident prior to his/her decision.

CHART REVIEW AND INTERVIEW

1. Interview the person responsible for the Swing-bed services to determine how the standards are met.

2. Review medical records for evidence that the resident has been notified in advance of care and treatment and changes in care.

1 = Compliant  
2 = Not Compliant

**This standard is not met as evidenced by:**

11.01.06  [Formerly 11.01.09]  
**Personal Privacy & Confidentiality.**  
The resident has the right to personal privacy and confidentiality of his/her personal and clinical records.

“**Right to privacy**” means the resident has the right to privacy with whomever the resident wishes to be private and this privacy should include full visual, and to the extent desired, for visits and other activities, auditory privacy.  

**Private space may be created flexibly and need not be dedicated solely for**

INTERVIEW AND OBSERVATION

1. Interview a select sample of residents to determine that they understand they have the right to personal privacy in their care and treatment, and of their clinical records.

1 = Compliant  
2 = Not Compliant

**This standard is not met as evidenced by:**

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Healthcare Facilities Accreditation Program (HFAP)  
Accreditation Requirements for Critical Access Hospitals  
© 2018 HFAP
### SWING BEDS

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<th>STANDARD / ELEMENT</th>
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<th>SCORING PROCEDURE</th>
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<td>(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups but this does not require the facility to provide a private room for each resident.</td>
<td>- For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility’s administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents. Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual’s need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual’s consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.</td>
<td>1. Interview residents to determine if the staff respect the resident’s privacy relating to communication, mail, and packages. 2. Observe the area to assure there is knocking on the door before entering a resident’s room and that there are privacy curtains pulled when a treatment is given. Look for breaches of visual and audible privacy as well as security of the medical record. 3-2 Document any instances where you observe a resident’s privacy being violated. Completely document how the resident’s privacy was violated. Example: Resident #12 left without gown or bed covers and unattended on 2B Corridor at 3:30 p.m. February 25, 2001. Identify the responsible party, if possible.</td>
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</table>
§483.70(i)(2) or other applicable federal or state laws.

(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident’s medical, social, and administrative records in accordance with State law.

Except as provided in paragraph (e)(3) of 42 CFR 483.10,

The resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident’s right to refuse release of personal and clinical records does not apply when—

1. The resident is transferred to another healthcare institution.

2. Record release is required by law.

§483.10(h)
§483.10(h)(1)
## SWING BEDS

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<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
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<td>§483.10(e)(3)(ii)</td>
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### 11.01.07 [Formerly 11.01.10] Work.
The resident has the right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility.

The resident may perform services for the facility, if he or she chooses, when—

(i) The facility has documented the resident’s need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary

All resident work, whether of a voluntary or paid nature, shall be part of the plan of care.

A resident’s desire for work is subject to medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident.

The resident also has the right to refuse such treatment at any time that he or she wishes.

At the time of development or review of the plan, voluntary or paid work can be negotiated.

The “prevailing rate” is the wage paid to workers in the community surrounding the facility for the same type, quality, and quantity of work requiring comparable skills.

### INTERVIEW AND CHART REVIEW
Interview the person responsible for the Swing bed unit to determine how the requirement was met.

1. Are residents engaged in work (e.g., doing housekeeping, doing laundry, preparing meals)?
   - Pay special attention to the possible work activities of residents with intellectual disabilities or mental illness.

2. If a resident is performing work, determine whether it is voluntary, and whether it is described in the plan of care. Is the work mutually agreed upon between the resident and the treatment team?

This standard is not met as evidenced by:
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<th>EXPLANATION</th>
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<td>or paid;</td>
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<td>(iii) Compensation for paid services is at or above prevailing rates.</td>
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<td>(iv) The resident agrees to the work arrangement described in the plan of care.</td>
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<td>(1) Refuse to perform services for the facility.</td>
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<td>§483.10(h)(2)(iv)</td>
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3. Review a select sample of residents’ records to determine that the required documentation was in the chart— inclusion in the plan of care, consent of the patient, and whether the patient is compensated and at what rate.

1. Interview the person responsible for the Swing bed unit to determine how the requirement was met.

2. Interview a resident to determine that the requirement was met.

INTERVIEW

"Promptly" means delivery of mail or other materials to the resident 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 of regularly scheduled postal delivery and pickup service.

1 = Compliant
2 = Not Compliant

This standard is not met as evidenced by:
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A postal service, including the right to:
The resident has the right to:
(i) Privacy of such written communications, including the right to:

Send and promptly receive mail that is unopened.

(ii) Have access to stationery, postage, and writing implements at the resident’s own expense.

§483.10(g)(8)
§483.10(g)(8)(i)
§483.10(g)(8)(ii)
§483.10(i)
§483.10(i)(1)
§483.10(i)(2)

The resident has the right and the facility must provide immediate access to any resident by the following:
The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

The facility may set reasonable hours for visitation.

If it would violate the rights of a roommate to have visitors in the resident’s room, the facility must establish alternate areas in the facility for visiting. These areas could include the chapel, a suitable office area, a dining room, or a porch or patio area.

**DOCUMENT REVIEW AND INTERVIEW**

1. Review the policy or process for visitation in the facility to ensure that reasonable guidelines are in place and that there is a clear patient consent process for visitors defined.

2. Interview patients to determine the process is in force.
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<th>EXPLANATION</th>
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<td>(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;</td>
<td></td>
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<tr>
<td>(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;</td>
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- Subject to the resident’s right to deny or withdraw consent at any time, immediate family or other relatives of the resident.

- Subject to reasonable restrictions and the resident’s right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

§483.10(f)
§483.10(f)(4)(ii)
§483.10(f)(4)(iii)
§483.10(j)
§483.10(j)(4)
§483.10(j)(1)(vii)

11.01.10  (Formerly 11.01.13)

Personal Property.
The resident has a right to be treated with respect and dignity, including:

• The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits.

All residents’ possessions must be treated with respect and safeguarded.

The facility has the right to limit personal property due to space limitations in the facility or for safety considerations.

11.01.11  (Formerly 11.01.14)

Married Couples.
The resident has a right to be treated with respect and dignity, including:

• The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

The requirement means that when a room is available for a married couple to share, the facility must permit them to share it, if they choose.

§483.10(e)(4)

DOCUMENT REVIEW AND OBSERVATION
1. Review the facility’s policies to determine that the requirement is met.

2. Observe the patient rooms to determine that residents have personal possessions. If residents’ rooms have few personal possessions, ask residents and families if:
   - They are encouraged to have and to use personal items;
   - Their personal property is safe in the facility.

This standard is not met as evidenced by:

1 = Compliant
2 = Not Compliant

11.01.12

§483.10(l)

The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits.

All residents’ possessions must be treated with respect and safeguarded.

The facility has the right to limit personal property due to space limitations in the facility or for safety considerations.

DOCUMENT REVIEW AND OBSERVATION
1. Review the facility’s policies to determine that the requirement is met.

2. Observe the patient rooms to determine that residents have personal possessions. If residents’ rooms have few personal possessions, ask residents and families if:
   - They are encouraged to have and to use personal items;
   - Their personal property is safe in the facility.

This standard is not met as evidenced by:
§483.10(m)

11.02.01 (Formerly 11.01.04)  
Medicaid & Medicare Notification.  
The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

If Medicare or Medicaid does not make payment for services, the provider must fully inform the resident of any related charges both at the time of admission and prior to the time that changes will occur in their bills.

Listed below are general categories and examples of items and services that the facility may charge to resident funds, if they are requested and agreed to by a resident.

- Telephone
- Television / radio for personal use
- Personal comfort items including smoking materials, notions, novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a resident
- Flowers and plants
- Social events and entertainment offered

1. Review facility policies, documents, and patient medical records. Verify that notification of covered services and charges is enforced.
2. Ask the resident about out of pocket expenses for items and services.
   - Who handles payments?
   - How do they know the cost of items and services?
   - Do they receive an explanation of charges in their bill?

This standard is not met as evidenced by:
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<tr>
<td>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in 42 CFR 483.10(g)(17)(i)(A) and (B).</td>
<td>outside the scope of the activities program</td>
<td>DOCUMENT REVIEW AND CHART REVIEW</td>
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<td>§483.10(g)(18)</td>
<td>Non-covered special care services such as privately hired nurses or aides</td>
<td>1. Review facility policies to verify all required elements are met.</td>
<td>1 = Compliant</td>
</tr>
<tr>
<td>§483.10(g)(17)</td>
<td>Private room, except when therapeutically required for example, isolation for infection control</td>
<td>2. Review the medical record of at least one patient adjudged incompetent by a court to determine these requirements are met.</td>
<td>2 = Not Compliant</td>
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<td>§483.10(g)(17)(i)</td>
<td>Specially prepared or alternative food requested</td>
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<td>§483.10(g)(17)(i)(A)</td>
<td>The facility has written policies that depict the process for ensuring the representative of the incompetent resident acts on behalf of the resident.</td>
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<td>§483.10(g)(17)(i)(B)</td>
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11.02.02 (Formerly 11.01.08) Resident Adjudged Incompetent. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights. This standard is not met as evidenced by: | | | |
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<th>EXPLANATION</th>
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<td>rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.</td>
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<td>(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.</td>
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<td>(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.</td>
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<td>(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.</td>
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§483.10(b)(7)
§483.10(b)(7)(i)
§483.10(b)(7)(ii)
§483.10(b)(7)(iii)
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<th>EXPLANATION</th>
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<td>11.03.01 Facility Prohibits and Prevents Abuse.</td>
<td>The facility has written policies that address: 1. Abuse, neglect, and exploitation of residents and their property are prohibited. 2. Processes to investigate allegations of abuse, neglect, and exploitation of residents and their property.</td>
<td>OBSERVATION AND CHART REVIEW 1. Review the facility’s policies to determine all elements of the requirement are met. 2. Interview the person responsible for the Swing bed unit to determine how the requirement was met. 3. Interview a resident to determine that the requirement was met.</td>
</tr>
<tr>
<td>11.03.01 Facility Prohibits and Prevents Abuse. The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. (2) Establish processes and guidelines to investigate any such allegations.</td>
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<td>1 = Compliant 2 = Not Compliant</td>
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This standard is not met as evidenced by:

The intent of this requirement is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, during the resident’s stay, and when the facility’s rules change.

A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits.

These rights include the resident’s right to:

- Be informed about what rights and responsibilities the resident has (§483.10(b)(3 through 6));
- Choose a physician (§483.10(d));
- Participate in decisions about treatment and care planning (§483.10(d));
- Have privacy and confidentiality (§483.10(e));
- Work or not work (§483.10(h));
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<th>EXPLANATION</th>
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<td>• Have privacy in sending and receiving mail (§483.10(i));</td>
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<td>• Visit and be visited by others from outside the facility (§483.10(j)(1)(vii and viii));</td>
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<td>• Retain and use personal possessions (§483.10(l));</td>
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<td>• Share a room with a spouse (§483.10(m)).</td>
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“Total health status” includes:

- functional status,
- medical care,
- nursing care,
- nutritional status,
- rehabilitation and restorative potential,
- activities potential,
- cognitive status,
- oral health status,
- psychosocial status, and
- sensory and physical impairments.

Information on health status must be presented in...
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<th>STANDARD / ELEMENT</th>
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<td>language that the resident can understand.</td>
<td><strong>Communicating with the resident in language that the resident can understand includes minimizing the use of technical words, providing interpreters for non-English speaking residents, using sign language when needed, or other interventions, as appropriate.</strong></td>
<td><strong>The facility has written policies establishing:</strong></td>
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11.03.02 *(Formerly 11.03.03)*

**Employment Restrictions and Screening of Staff.**

The facility must –

A. **Not employ or otherwise engage** individuals who:

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; or

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

(B) **Report to the State nurse aide registry or licensing authorities**

**The intent of this regulation is to prevent employment of individuals who have been convicted of abusing, neglecting, or mistreating individuals in a health care related setting.**

In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility should check all staff references and make reasonable efforts to uncover information about any past criminal prosecutions.

“**Found guilty...by a court of law**” applies to situations where the defendant pleads guilty, is found guilty, or pleads *nolo contendere.*

**DOCUMENT REVIEW AND FILE REVIEW**

1. Review human resource policies and procedures on background and reference checks prior to hire.

2. Review employee files to determine that a background and reference check has been done prior to hire for all staff.

3. Spot check employment applications for questions about convictions or mistreatment, neglect or abuse of residents, or misappropriation of their property.

   - Determine if applicants have answered these questions and if affirmative answers had resulted in rejections of employment candidates.

4. **Contact the State Nurse Aide Registry or Board of Nursing, as appropriate.**

5. **Determine if applicants with a finding concerning mistreatment, neglect, and**
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<td>any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for serve as a nurse aide or other facility staff-to-the-state nurse aide registry or licensing authorities.</td>
<td>“Finding” is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents or misappropriation of their property. Any facility staff found guilty of neglect, abuse, or mistreating residents or misappropriation of property by a court of law, must have his or her name entered into the nurse aide registry, or reported to the licensing authority, as appropriate.</td>
<td>abuse of residents or misappropriation of their property have been rejected.</td>
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### 11.03.03 (Formerly 11.03.02) Staff Treatment of Residents.

The facility must:

1. Not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion.

2. Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident’s medical symptoms. When the use of restraints is.

### The facility has written policies establishing the staff treatment of residents including unacceptable behaviors and consequences.

The intent of this regulation is to assure that the facility has in place an effective system that prevents mistreatment, neglect and abuse of residents, and misappropriation of resident’s property.

“Physical restraints” are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily and that restricts freedom of movement or normal access to one’s body.

### DOCUMENT REVIEW, CHART REVIEW & INTERVIEW

1. Interview the person responsible for the Swing bed unit to determine how the requirement was met.

2. Interview a resident to determine that the requirement was met.

1. Request a select group of accident/incident reports in the last three months to determine if there have been complaints of abuse.

2. Review charts of patients who were restrained or secluded. Look for situations
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<td>indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</td>
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<td>where predisposing factors for mistreatment may have been an issue.</td>
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<tr>
<td>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
<td></td>
<td>3. Interview patients to determine their impressions regarding safety in the facility, and mechanisms to report perceived abuse.</td>
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<tr>
<td>§483.12(a)(1)</td>
<td></td>
<td>During Sample Selection—If the team has identified a problem in mistreatment, neglect or abuse of residents or misappropriation of their property, then request—</td>
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<tr>
<td>§483.12(a)(2)</td>
<td></td>
<td>1. A copy of the facility’s policies and procedures regarding abuse prevention.</td>
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<tr>
<td>§483.13(e)</td>
<td></td>
<td>Note particularly the extent to which those policies concern the areas uncovered through complaints and/or previous survey;</td>
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<tr>
<td>§483.13(c)(1)(i)</td>
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<td>2. Reports of action(s) by a court of law against employees;</td>
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<td>3. Reports of alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident’s property;</td>
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<td></td>
<td></td>
<td>4. Reports of the results of these investigations; and</td>
<td></td>
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<td></td>
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<td>5. Records of corrective actions taken.</td>
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The resident has the right to be free from verbal, abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, and involuntary seclusion. The facility is responsible for preventing abuse, but also for those practices and omissions, neglect and misappropriation of property, which if left unchecked, lead to abuse.

Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals.

“Abuse” is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being.

This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

“Verbal abuse” is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Examples of verbal abuse include, but are not limited to: threats of harm; and saying things to frighten a resident, such as telling a resident that she will never

### DOCUMENT REVIEW, INTERVIEW, AND OBSERVATION

1. Review the policy on abuse to determine it addresses the 6 types of abuse identified in the standard.

2. Request a select group of accident / incident reports in the last three months to determine if there have been predisposing factors for abuse or neglect.

3. Interview patients to determine their impressions regarding safety in the facility, and mechanisms to report perceived abuse.

4. Observe for lack of compliance during unit tours.

5. Offsite, pre-survey review of complaints can focus the survey team’s on-site review of actual incidents and predisposing factors to abuse or neglect and misappropriation of property.

6. Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act, the nature of the abuse, and where and when it occurred. Ensure that the facility addresses that incident immediately.

7. If the survey team’s observations and resident’s responses signal the presence of
be able to see her family again.

“Sexual abuse” includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

“Physical abuse” includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment and restraints.

“Mental abuse” includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

“Involuntary seclusion” is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident’s will, or the will of the resident’s legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs.

“Misappropriation of resident’s property” is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

---

abuse, determine how the facility prevents and reports abusive behavior.

8. If a resident is being temporarily separated from other residents, for less than 24 hours, as an emergency short-term intervention, answer these questions--

a. What are the symptoms that led to the consideration of the separation?

b. Are these symptoms caused by failure to:
   - Meet individual needs;
   - Provide meaningful activities;
   - Manipulate the resident’s environment?

c. Can the cause(s) be removed?

d. If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation?

e. Does the facility use the separation for the least amount of time?

f. To what extent has the resident, surrogate or representative participated in care planning and made an informed choice about separation?

g. Does the facility monitor and adjust care to reduce negative outcomes, while
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<td>11.03.05 (Formerly 11.03.03) Reporting Allegations of Patient Mistreatment, Neglect, or Abuse. In response to allegations of abuse, neglect, exploitation, or mistreatment of a resident.</td>
<td>The facility has written policies establishing the procedure to be implemented in response to allegations of abuse, neglect, exploitation, or mistreatment of a resident.</td>
<td>INTERVIEW AND DOCUMENT REVIEW</td>
<td>1 = Compliant 2 = Not Compliant</td>
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<td>1. On interview determine if the facility has had any of the alleged violations and ask how these were handled.</td>
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<td>This standard is not met as evidenced by:</td>
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<td>2. Review the policy and procedure to determine that it meets the requirement.</td>
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- Ensure that all alleged violations continually trying to find and use less restrictive alternatives?

h. If residents are temporarily separated in secured units, staff should carry keys to these units at all times.

i. If the purpose of the unit is to provide specialized care for residents who are cognitively impaired (through a program of therapeutic activities designed to enable residents to attain and maintain the highest practicable physical, mental or psychosocial well-being) then placement in the unit is not in violation of resident rights, as long as the resident’s individual care plan indicates the need for the stated purpose and services provided in the unit and the resident, surrogate, or representative has participated in the placement decision.
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<td>involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures (including to the State survey and certification agency). §483.12(c) §483.12(c)(1) §483.13(c)(2)</td>
<td>3. Contact the State Nurse Aide Registry or Board of Nursing, as appropriate. 4. Determine if applicants with a finding concerning mistreatment, neglect, and abuse of residents or misappropriation of their property have been rejected.</td>
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**Investigation of Alleged Abuse.**

In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

- Have evidence that all alleged violations are thoroughly investigated and must
- Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(2)

§483.12(c)(3)

§483.13(c)(3)

**Reporting Allegations of Abuse.**

In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure:

- Report the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with

**DOCUMENT REVIEW**

1. Review the policy and procedure to determine it meets the requirement.

2. Verify that reported cases of abuse have been investigated by review of the documentation.

**DOCUMENT REVIEW AND INTERVIEW**

1. Review the policy and procedure to determine the requirement was met.

2. Interview the administrator to determine if there have been any allegations that have been investigated and what corrective action was taken.

3. Ask for the results of any in-house investigations of mistreatment, neglect, or abuse of residents, misappropriation of their
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<th>SCORING PROCEDURE</th>
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State law, including to the State Survey and Certification Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

§483.12(c)(4)
§483.13(c)(4)

property, or injuries of unknown sources.

a. Was the administrator notified of the incident and when?

b. Did investigations begin promptly after the report of the problem?

c. Is there a record of statements or interviews of the resident, suspect (if one is identified), any eye witnesses and any circumstantial witnesses?

d. Was relevant documentation reviewed and preserved (e.g., dated dressing which was not changed when treatment recorded change)?

e. Was the alleged victim examined promptly (if injury was suspected) and the finding documented in the report?

f. What steps were taken to protect the alleged victim from further abuse (particularly where no suspect has been identified)?

g. What actions were taken as a result of the investigation?

h. What corrective action was taken, including informing the nurse aide registry, State licensure authorities, and other agencies (e.g., long-term care...
### SWING BEDS

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<th>EXPLANATION</th>
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**11.04.01** For Future Use.

**11.04.02** *(Formerly 11.03.04)*

**Activities Program.**

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

The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is licensed or registered, if

A “recognized accreditation body” refers to those organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professional or registered occupational therapists.

Because the activities program should occur within the context of each resident’s care plan, it should be multi-faceted and reflect each individual resident’s needs. Therefore, the activities program should provide stimulation or solace; promote physical, cognitive and/or emotional health enhance, to the extent practicable, each resident’s physical and mental status; and promote each resident’s self-respect by providing, for example activities that allow for self-expression, personal responsibility and choice.

The activities program should be multi-faceted and reflect individual resident’s needs on their care plan.

Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers, ombudsman; adult protective services; Medicaid fraud and abuse unit)?

**OBSERVATION, CHART REVIEW, AND INTERVIEW**

Observe individual, group and bedside activities.

1. Are residents who are confined or choose to remain in their rooms provided with suitable in-room activities (e.g., music, reading, visits with individuals who share their interests)? Do any facility staff members assist the resident with activities?

2. If residents sit for long periods of time with no apparently meaningful activities, is the cause-

- The resident’s choice;
- Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities;
- Lack of assistance with ambulation;
- Lack of sufficient supplies and/or staff to facilitate attendance and
applies, by the State in which practicing; and

(ii) Is
(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a patient-therapeutic activities program in a health-care setting; or

(C) Is a qualified occupational therapist or occupational therapy assistant; or

(D) Has completed a training course approved by the State.

(iii) Or, the services may be directed by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist and visitors.

participation in the activity programs;

• Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex?

3. For residents selected for review, determine to what extent the activities reflect the individual resident’s assessment.

4. Review the activity calendar for the month prior to the survey to determine if the formal activity program:
   • Reflects the schedules, choices and rights of the residents;
   • Offers activities at hours convenient to the residents (e.g., morning, afternoon, some evenings and weekends);
   • Reflects the cultural and religious interests of the resident population; and
   • Would appeal to both men and women and all age groups living in the facility.

5. Review clinical records and activity participation in the activity programs;
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<th>STANDARD / ELEMENT</th>
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<td>specialist, occupational therapist, or other professional with experience or education in recreational therapy.</td>
<td>attendance records of residents to determine if--</td>
<td>- Activities reflect individual resident history indicated by the comprehensive assessment;</td>
<td></td>
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<tr>
<td>§483.24(c)</td>
<td>§483.24(c)(1)</td>
<td>§483.24(c)(2)</td>
<td>§483.24(c)(2)(i)</td>
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<td>§483.24(c)(2)(ii)</td>
<td>§483.24(c)(2)(iii)(A)</td>
<td>§483.24(c)(2)(iii)(B)</td>
<td>§483.24(c)(2)(iii)(C)</td>
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<tr>
<td>§483.24(c)(2)(iii)(D)</td>
<td>§483.15(f)</td>
<td>§483.15(f)(1)</td>
<td>§483.15(f)(2)</td>
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6. If there are problems with provision of activities, determine if these services are provided by qualified staff.
### 11.05.01 [Formerly 11.03.05] Social Services

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

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| 11.05.01 Social Services | “Medically-related social services” means services provided by the facility’s staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services could include, for example: 1. Making arrangements for obtaining needed adaptive equipment, clothing, and personal items. 2. Maintaining contact with family (with resident’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning. 3. Assisting staff to inform residents and those they designate about the resident’s health status and health care choice. 4. Making referral and obtaining services from outside entities (e.g. talking books, absentee ballots, community wheelchair transportation). 5. Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements). 6. Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other | CHART REVIEW
Review medical records to find evidence that social service interventions successfully address resident’s needs and link social supports, physical care, and physical environment with resident’s needs and individuality. For residents selected for review— 1. How do facility staff implement social services interventions to assist the resident in meeting treatment goals? 2. How do staff that are responsible for social work monitor the resident’s progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly? 3. How does the care plan link goals to psychosocial functioning / well-being? 4. Has the staff responsible for social work established and maintained relationships with the resident’s family or legal representative? 5. What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan? |

This standard is not met as evidenced by:

1 = Compliant
2 = Not Compliant
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<td>6.</td>
<td>Look for evidence that social services interventions successfully address residents’ needs and link social supports, physical care, and physical environment with residents’ needs and individuality.</td>
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<td>7.</td>
<td>Providing or arranging provision of needed counseling services;</td>
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<td>8.</td>
<td>Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;</td>
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<td>9.</td>
<td>Finding options that meet the physical and emotional needs of each resident;</td>
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<td>10.</td>
<td>Meeting the needs of residents who are grieving; and</td>
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<td>11.</td>
<td>Assisting residents with dental/denture care, podiatric care; eye care; hearing services, and obtaining equipment for mobility or assistive eating devices.</td>
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Where needed services are not covered by the Medicaid State Plan, nursing facilities are still required to obtain these services.
### Qualifications of Social Worker

A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

A qualified social worker is an individual with:

1. Qualifications of social worker. A minimum of a bachelor’s degree in social work or a bachelor’s degree in a human services field including but not limited to sociology, gerontology, special education, rehabilitation counseling, and psychology; and

2. One year of supervised social work experience in a healthcare setting working directly with individuals.

The intent of this regulation is to assure that all facilities provide for the medically-related social services needs of each resident.

This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services.

A qualified social worker need not personally provide all of these services. It is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline.

### DOCUMENT REVIEW AND FILE REVIEW

1. Review the resume of the social worker and the job description to determine that the standard is met.

2. Review the job description. Does it state this is a full-time position?

3. Review the credentials of the social worker to verify compliance.
11.06.01  (Formerly 11.05.00)
Specialized Rehabilitative Services: Provision of Services.

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, respiratory therapy and health rehabilitative services for a mental disorder and illness and intellectual disability or services of a lesser intensity as per 42 CFR 483.120(c), are required in the resident’s comprehensive plan of care, the facility must:

(1) Provide the required services; or

(2) In accordance with 42 CFR §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act. Obtain the required services from an outside resource (in accordance with §483.75(h) of 42 CFR 483.75) from a provider of specialized rehabilitative services.

The intent of this regulation is to assure that residents receive necessary specialized rehabilitative services as determined by the comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psychosocial well being.

Specialized rehabilitative services are considered a facility service and are included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.

A facility is not obligated to provide specialized rehabilitative services if it does not have residents who require these services.

If a resident develops a need for these services after admission, the facility must either provide the services, or, where appropriate, obtain the service from an outside resource.

For a resident with mental illness (MI) or intellectual disability (ID) to have his or her specialized needs met, the individual must receive all services necessary to assist the individual in maintaining or achieving as much independence and self determination as possible.

CHART REVIEW
Review the medical record for physical therapy.

Determine the extent of follow through with the comprehensive care plan. Verify from the chart that the resident is receiving frequency and type of therapy as outlined in the care plan.

1. Physical Therapy
   • What did the facility do to improve the resident’s muscle strength? The resident’s balance?
   • What did the facility do to determine if an assistive device would enable the resident to reach or maintain his/her highest practicable level of physical function?
   • If the resident has an assistive device, is he/she encouraged to use it on a regular basis?
   • What did the facility do to increase the amount of physical activity the resident could do (for example, the number of repetitions of an exercise, the distance walked)?
   • What did the facility do to prevent or minimize contractures, which could lead to decreased mobility and increased risk
Specialized services for mental illness or intellectual disability refers to those services to be provided by the State which can only be delivered by personnel or programs other than those of the nursing facility (NF) because the overall level of NF services is not as intense as necessary to meet the individual’s needs.

“Mental health rehabilitative services for MI and ID” refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff who come into contact with the resident who is mentally ill or who has intellectual disabilities. These services are necessary regardless of whether or not they require additional services to be provided for or arranged by the State as specialized services.

Mental health rehabilitative services for MI and ID may include, but are not limited to:

1. Consistent implementation during the resident’s daily routine and across settings, of systematic plans which are designed to change inappropriate behavior.

2. Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness.

3. Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal).

2. Occupational Therapy
   • What did the facility do to decrease the amount of assistance needed to perform a task?
   • What did the facility do to decrease behavioral symptoms?
   • What did the facility do to improve gross and fine motor coordination?
   • What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration?
   • What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards?

3. Speech, Language Pathology
   • What did the facility do to improve auditory comprehension?
   • What did the facility do to improve speech production?
   • What did the facility do to improve expressive behavior?
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<th>STANDARD / ELEMENT</th>
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<th>SCORING PROCEDURE</th>
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<td>4.</td>
<td>Development, maintenance and consistent implementation across settings of those programs designed to each individual’s daily living skills they need to be more independent and self-determining, including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, and mental health education, money management, and maintenance of the living environment.</td>
<td>- What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiologic evaluation?&lt;br&gt;- For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?</td>
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<td>5.</td>
<td>Crisis intervention services.</td>
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<td>6.</td>
<td>Individual, group, and family psychotherapy.</td>
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<td>7.</td>
<td>Development of appropriate personal support networks.</td>
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<td>8.</td>
<td>Formal behavior modification programs.</td>
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<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
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Questions to ask individuals with MI or ID—
- Who do you talk to when you have a problem or need something?
- What do you do when you feel happy? Sad? Can’t sleep at night?
- In what activities are you involved, and how often?

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11.06.02 (Formerly 11.05.01)
Rehabilitative Service Orders: Qualifications.
Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

§483.465(b)

Specialized rehabilitative services are provided for individuals under a physician’s order by a qualified professional.

Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional.

Once a resident has met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will follow to maintain functional and physical status.

“Qualified personnel,” means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws.

Health rehabilitative services for MI and ID must be

**CHART REVIEW**
Review medical records for physician orders and the record for the services performed.

1. Determine if there are any problems in quality of care related to maintaining or improving functional abilities. Determine if these problems are attributable in part to the qualifications of specialized rehabilitative services staff.

2. Determine from the care plan and record that rehabilitative services are provided under the written order of a physician and by qualified personnel. If a problem in a resident’s rehabilitative care is identified that is related to the qualifications of the care providers, it may be necessary to validate the care provider’s qualifications.

This standard is not met as evidenced by:

□ 1 = Compliant
□ 2 = Not Compliant

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Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Critical Access Hospitals

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<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
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<td>implemented consistently by all staff unless the nature of the services is such that they are designated or required to be implemented only by licensed or credentialed personnel.</td>
<td>3. If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with MI or ID, how has the facility arranged for the necessary direct or staff training services to be provided?</td>
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11.07.01 **(Formerly 11.06.00) Dental Services.**

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

§483.55

This requirement makes the facility directly responsible for the dental care needs of its residents.

The facility must ensure that a dentist is available for residents. They can satisfy this requirement by employing a staff dentist or having a contract / arrangement with a dentist to provide services.

For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose an additional charge for the services.

Medicaid residents may not be charged.

For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well-being.

INTERVIEW & DOCUMENT REVIEW

1. Interview the person in charge of the swing bed unit to determine how dental services are provided.

2. If there are contract services, review the contract.

This standard is not met as evidenced by:
11.07.02 (Formerly 11.06.01) SKILLED NURSING FACILITY:
Charges for Dental Services
Availability of Services.

A facility –
(1) Must provide or obtain from an outside resource, in accordance with 42 CFR §483.75(a)(2) of 42 CFR 483.75, routine and emergency dental services to meet the needs of each resident.

(2) May charge a Medicare resident an additional amount for routine and emergency dental services.

(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility.

For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose and additional charge for the services.

For Medicaid residents, the facility must provide the resident, without charge, all emergency dental services, as well as those routine dental services that are covered under the state plan.

For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well being.

“Routine dental services” means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures).

“Emergency dental services” includes 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, appropriately treated by a dentist that requires immediate attention.

“Prompt referral” means, within reason, as soon as
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| 11.07.03 **(Formerly 11.06.02)** SKILLED NURSING FACILITY: Dental Appointments Resident Assistance. | The facility must, if necessary or requested, assist the resident:  
- In making appointments; and  
- By arranging for transportation to and from the dentist's offical dental services location; and  
- Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. | DOCUMENT REVIEW  
Review the policy and procedure to determine the requirement was met.  
INTERVIEW  
Interview staff / patients to determine if the policy defines actual practice.  
1. Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them?  
2. Are residents missing teeth and may be in need of dentures?  
3. Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene?  
4. Are resident’s dentures intact? Properly fitted? | □ 1 = Compliant  
□ 2 = Not Compliant  
□ Not Applicable if a Nursing Facility
This standard is not met as evidenced by: |

...the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

“**Routine dental services**” means inspection of the oral cavity for signs of disease, diagnosis of the dental plate adjustments, smoothing of broken teeth, and limited prosthodontics, e.g. taking impressions for dentures and fitting dentures.

“**Emergency dental services**” includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problems of the oral cavity that require immediate attention.”

“**Prompt referral**” means, within reason, as soon as the dentures are lost or damaged.

Referral does not mean the resident must see a dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.
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Promptly refer residents with lost or damaged dentures to a dentist.

§483.55(a)(34)

§483.55(a)(34)(i)

§483.55(a)(34)(ii)

§483.55(a)(45)

**NOTE:**

- §483.55(b) Nursing Facilities does not usually apply to Medicare reimbursed swing-bed residents because Medicare swing-bed residents receive skilled nursing care comparable to services provided in a SNF not a NF.

- If a swing-bed resident is a NF level patient, apply standard §483.55(b) as appropriate.

11.07.04 (Formerly 11.06.03) NURSING FACILITIES: Provision of Dental Services

Availability of Services.

The facility-

(i) Must provide or obtain from an outside resource, in accordance with 42 CFR §483.75(or §483.75), the following dental services to meet the needs of each resident:

“Routine dental services” means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited

**DOCUMENT REVIEW**

1. Review the policy to determine it meets the requirement.

2. Observe and interview patients to determine if the policy is being followed.

This standard is not met as evidenced by:
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<td>(i) Routine dental services (to the extent covered under the State plan)</td>
<td>prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures).</td>
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<td>(ii) Emergency dental services</td>
<td>“Emergency dental services” includes 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, appropriately treated by a dentist that requires immediate attention.</td>
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<tr>
<td>§483.55(b)</td>
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<td>§483.55(b)(1)</td>
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<td>§483.55(b)(1)(i)</td>
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<td>§483.55(b)(1)(ii)</td>
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11.07.05 (Formerly 11.06.04)

**NURSING FACILITIES:**

**Dental Appointments Resident Assistance.**

The facility must, if necessary or if requested, assist the resident—

- In making appointments.
- By arranging for transportation to and from the dentist’s office/dental services locations.

*Must promptly refer residents with lost or damaged dentures to a dentist.*

**Self-explanatory.**

**OBSERVATION, INTERVIEW & CHART REVIEW**

1. Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them?

2. Are residents missing teeth and may be in need of dentures?

3. Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene?

4. Are resident’s dentures intact? Properly fitted?

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<td>Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</td>
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<tr>
<td>Must have a policy identifying those circumstances when the loss or damage of dentures is the facility’s responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility’s responsibility; and</td>
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<tr>
<td>Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.</td>
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§483.55(b)(2)
§483.55(b)(2)(i)
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<td>§483.55(b)(2)(ii)</td>
<td>The intent of the regulation on transfer and discharge provisions is to significantly restrict a facility’s ability to transfer or discharge a resident once that resident has been admitted to the facility to prevent dumping of high care or difficult residents. This requirement applies to transfer or discharges that are initiated by the facility, not by the resident.</td>
<td>CHART REVIEW</td>
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<tr>
<td>§483.55(b)(3)</td>
<td>Review the records of at least 5 swing-bed patients transferred/discharged from the facility since the last survey in order to determine the reasons for transfer/discharge documented by the physician.</td>
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<td>§483.55(b)(4)</td>
<td>This standard is not met as evidenced by:</td>
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<td>§483.55(b)(5)</td>
<td>CHART REVIEW</td>
<td>During closed record review, determine the reasons for transfer/discharge.</td>
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<tr>
<td>11.08.01 (Formerly 11.02.00) Transfer and Discharge: Definition.</td>
<td>If transfer is due to a significant change in the resident’s condition, the facility must conduct the appropriate assessment, prior to any transfer or discharge to determine if a new care plan would allow the facility to meet the resident’s needs. If the significant change in the resident’s condition is an emergency, immediate transfer should be arranged.</td>
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<td>Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.</td>
<td>CHART REVIEW</td>
<td></td>
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<tr>
<td>11.08.02 (Formerly 11.02.01) Transfer &amp; Discharge: Facility Requirements.</td>
<td>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—</td>
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<tr>
<td>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—</td>
<td>(A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility.</td>
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<td>(A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility.</td>
<td>(B) The transfer or discharge is</td>
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<td>(B) The transfer or discharge is</td>
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appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility.

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

(D) The health of individuals in the facility would otherwise be endangered.

(E) The resident 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 resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge resident allowable charges only under Medicaid.

(F) The facility ceases to operate.

discharged for the sake of the resident’s welfare and the resident’s needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization) or the resident’s health improved to the extent that the transferred / discharged resident no longer needed the services of the facility?

3. Did a physician document in the record if residents were transferred because the health of individuals in the facility is endangered?

4. Do the records of residents transferred / discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary?

5. If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident’s physician justify why the facility could not meet the needs of this resident.
The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.
11.08.03  (Formerly 11.02.02) Transfer and Discharge: Required Documentation Requirements.
When the facility transfers or discharges a resident under any of the circumstances specified above in 42 CFR §483.15(c)(1)(i)(A), the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) The documentation in the resident’s medical record must include:

(A) The basis for the transfer per 42 CFR 483.15 (c)(1)(i) of this section.

(B) In accordance with 42 CFR 483.15 (c)(1)(i)(A), the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required must

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**CHART REVIEW**

1. Verify upon chart review of patients who were transferred that documentation of the reason for transfer was documented by a physician.

2. Verify the medical record contains documentation of the transfer or discharge prepared by a physician.
be made by —

(A) The resident’s physician when transfer or discharge is necessary as described above in 42 CFR 483.15(c)(1)(A) or (B); and

(B) A physician when transfer or discharge is necessary under as described above in 42 CFR 483.15(c)(1)(i)(C) or (D).

(iii) Information provided to the receiving provider must include a minimum of the following:

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

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.
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<td>(E) Comprehensive care plan goals.</td>
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<td>(F) All other necessary information, including a copy of the resident’s discharge summary, consistent with 42 CFR §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</td>
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§483.15(c)(2)
§483.15(c)(2)(i)
§483.15(c)(2)(i)(A)
§483.15(c)(2)(i)(B)
§483.15(c)(2)(ii)
§483.15(c)(2)(ii)(A)
§483.15(c)(2)(ii)(B)
§483.15(c)(2)(iii)
§483.15(c)(2)(iii)(A)
§483.15(c)(2)(iii)(B)
§483.15(c)(2)(iii)(C)
§483.15(c)(2)(iii)(D)
§483.15(c)(2)(iii)(E)
§483.15(c)(2)(iii)(F)

§483.12(a)(3)
§483.12(a)(3)(i)
§483.12(a)(3)(ii)
11.08.04  **(Formerly 11.02.03) Notice Before Transfer.**
Before a facility transfers or discharges a resident, the facility must—

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

(ii) Record the reasons for the transfer or discharge in the resident’s medical clinical record in accordance with 42 CFR 483.15(c)(2) (see above); and

(iii) Include in the notice the items described in 42 CFR 483.15(c)(5).

§483.15(c)(3)

**DOCUMENT REVIEW AND CHART REVIEW**

1. Review the policies and procedures to verify all required elements were addressed.

2. Review at least 5 transferred or discharged patient records to determine that the documentation was complete, including all required criteria.
   - The resident / representative was provided written notification of the transfer / discharge in a language they understood.
   - A copy of the transfer / discharge notification was sent to the Office of the State Long-Term Care Ombudsman.

This standard is not met as evidenced by:
### 11.08.05 Timing of the Notice

Except when specified in 42 CFR 483.15(c)(4)(ii) and 42 CFR 483.15(c)(8), the notice of transfer or discharge required must be made by the facility at least 30 days before the resident is transferred or discharged. Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered;

(B) The health of individuals in the facility would be endangered;

(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge;

(D) An immediate transfer or discharge is required by the resident’s urgent medical needs; or

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<td>§483.15(c)(3)(i)</td>
<td>Self-explanatory.</td>
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<td>§483.15(c)(3)(ii)</td>
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<td>§483.15(c)(3)(iii)</td>
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**DOCUMENT REVIEW AND CHART REVIEW**

1. Review the policy to verify the requirement was met.

2. Review a minimum of 3 transfer/discharge records to determine compliance.

- Verify the notice was made at least 30 days before the transfer/discharge unless there were other qualifying reasons for transferring sooner to ensure the safety and health of the resident.
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(4)
§483.15(c)(4)(i)
§483.15(c)(4)(ii)
§483.15(c)(4)(ii)(A)
§483.15(c)(4)(ii)(B)
§483.15(c)(4)(ii)(C)
§483.15(c)(4)(ii)(D)
§483.15(c)(4)(ii)(E)

11.08.06 (Formerly 11.02.05) Self-explanatory.

Contents of the Notice
The written notice specified in 42 CFR 483.15(c)(3) must include the following:

(i) The reason for transfer or discharge.

(ii) The effective date of transfer or discharge.

(iii) The location to which the resident is transferred or discharged.

(iv) A statement of the resident’s appeal rights, including the name, address (mailing and email), and telephone.

CHART REVIEW
Review a minimum of 3 transfer / discharge records to determine compliance.

☐ 1 = Compliant
☐ 2 = Not Compliant

This standard is not met as evidenced by:
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- **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.**

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.

(vi) 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 Act of 2000; and.

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address.
### Orientation for Transfer or Discharge

**A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.**

- **This orientation must be provided in a form and manner that the resident can understand.**
- **A facility must provide sufficient**

  “Sufficient preparation” means the facility informs the resident where he or she is going and takes steps within its control to assure safe transportation.

  Some examples of orientation may include:
  - Trial visits, if possible, by the resident to a new location.
  - Working with family in requesting their assistance in assuring the resident that valued possessions are not left behind or lost.
  - Orienting staff in the receiving facility to resident’s daily patterns.

**CHART REVIEW**

Review social service notes to see if appropriate referrals have been made and, if necessary, resident counseling has occurred.

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<th>Score</th>
<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
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<td></td>
<td>This standard is not met as evidenced by:</td>
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§483.15(c)(5)
§483.15(c)(5)(i)
§483.15(c)(5)(ii)
§483.15(c)(5)(iii)
§483.15(c)(5)(iv)
§483.15(c)(5)(v)
§483.15(c)(5)(vi)
§483.15(c)(5)(vii)
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<td>§483.15(c)(7)</td>
<td>Reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the care plan.</td>
<td>DOCUMENT REVIEW AND INTERVIEW 1. Interview the facility administrator to determine a process is in place. 2. Verify the facility has a written policy that contains all required elements.</td>
<td>1 = Compliant 2 = Not Compliant</td>
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<td>requirements of §483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part’s locations.</td>
<td>part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF, or (iii) solely for the convenience of staff.</td>
<td>contains all required elements.</td>
<td>met as evidenced by:</td>
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<tr>
<td>§483.15(c)(9)</td>
<td>The intent of this regulation is to ensure appropriate discharge planning and communication of necessary information to the continuing care provider.</td>
<td><strong>CHART REVIEW</strong> Review a select group of medical records to determine the requirement was met.</td>
<td>1 = Compliant 2 = Not Compliant</td>
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<td>11.08.10 (Formerly 11.04.07) Discharge Summary. When the facility anticipates discharge a resident must have a discharge summary that includes: (i) A recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident’s status to include items in 42 CFR 483.20, at the time of the discharge that is available for a release to authorized persons and agencies, with the consent of the resident or resident’s representative, and (iii) Reconciliation of all pre-discharge medications with the resident’s</td>
<td>“Post discharge plan of care” means the discharge planning process, which includes assessing continuing care needs and developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community. When the facility “anticipates discharge” means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition), or due to the resident’ death. “Adjust to his or her new living environment” means that the post-discharge plan should describe the resident’s and family’s preferences for care, and how care should be coordinated if continuing treatment involves multiple care givers. It should identify specific resident needs after discharge, such as:</td>
<td>1. Does the discharge summary have information pertinent to continuing care for the resident? 2. Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)? 3. Do discharge plans address necessary post discharge care? 4. Has the facility aided the resident and his/her family in locating and coordinating post discharge services? 5. What types of pre-discharge preparation and education has the facility provided the</td>
<td>This standard is not met as evidenced by:</td>
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| post-discharge medications (both prescribed and over-the-counter). | • personal care,  
• sterile dressing, and  
• physical therapy, as well as  
• describe resident/caregiver education needs to prepare the resident for discharge. | | |

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

§483.21(c)(2)  
§483.21(c)(2)(i)  
§483.21(c)(2)(ii)  
§483.21(c)(2)(iii)  
§483.21(c)(2)(iv)  

§483.21(i)  
§483.21(i)(1)  
§483.21(i)(2)  
§483.21(i)(3)
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<td>11.09.01 Assisted Nutrition and Hydration.</td>
<td>Parameters of nutritional status that are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels).</td>
<td>• Determine if residents selected for a comprehensive review, or focused review as appropriate, have maintained acceptable parameters of nutritional status.</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
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<tr>
<td>Assisted nutrition and hydration includes:</td>
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<tr>
<td>• Naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids.</td>
<td>Weight: Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should consider the loss or gain in light of the individual’s former life style as well as the current diagnosis.</td>
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<td>Based on a resident’s comprehensive assessment, the facility must ensure that a resident:</td>
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<tr>
<td>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance and protein levels, unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; and</td>
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<td>(2) Is offered sufficient fluid intake to maintain proper hydration and health.</td>
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<td>§483.25(g)(1) §483.25(g)(2)</td>
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### Suggested parameters for evaluating significance of unplanned and undesired weight loss:

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<thead>
<tr>
<th>Interval</th>
<th>Significant Loss</th>
<th>Severe Loss</th>
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<tbody>
<tr>
<td>1 month</td>
<td>5%</td>
<td>&gt;5%</td>
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<tr>
<td>3 months</td>
<td>7.5%</td>
<td>&gt;7.5%</td>
</tr>
<tr>
<td>6 months</td>
<td>10%</td>
<td>&gt;10%</td>
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</table>

The following formula determines percentage of loss:

\[
\% \text{ of body weight loss} = \left(\frac{\text{usual weight} - \text{actual weight}}{\text{usual weight}} \times 100\right)
\]

In evaluating weight loss, consider the resident’s usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food?

### Suggested laboratory values are:

- Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion)

- Plasma Transferrin >60 yr.: 180 - 380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.)

### Chart Review and Document Review

1. Determine if residents selected for a comprehensive review, or focused review as appropriate, have maintained acceptable parameters of nutritional status.

   - Where indicated by the resident’s medical status, have clinically appropriate therapeutic diets been prescribed?

2. For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable—

   - Did the facility identify factors that put the resident at risk for malnutrition?

   - What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)?

   - Were staff responsibilities for maintaining nutritional status clear,
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<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
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<tbody>
<tr>
<td>• Hemoglobin:</td>
<td>Males: 14-17 g/dl Females: 12-15 g/dl</td>
<td>including monitoring the amount of food the resident is eating at each meal and offering substitutes?</td>
<td></td>
</tr>
<tr>
<td>• Hematocrit:</td>
<td>Males: 41-53 Females: 36-46</td>
<td>• Was this care provided consistently?</td>
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<tr>
<td>• Potassium:</td>
<td>3.5 – 5.0 mEq/L</td>
<td>• Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?</td>
<td></td>
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<tr>
<td>• Magnesium:</td>
<td>1.3 – 2.0 mEq/L</td>
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Some laboratories may have different “normals.” Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents.

Consider abnormal values in conjunction with the resident’s clinical condition and baseline normal values.

**NOTE:** There is no requirement that facilities order the tests referenced above.

**Clinical Observations:** Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, and swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.
Risk factors for malnutrition are—
• Drug therapy that may contribute to nutritional deficiencies such as —
  o Cardiac glycosides
  o Diuretics
  o Anti-inflammatory drugs
  o Antacids (antacid overuse)
  o Laxatives (laxative overuse)
  o Psychotropic drug overuse
  o Anticonvulsants
  o Antineoplastic drugs
  o Phenothiazines
  o Oral hypoglycemics
• Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations;
• Depression or dementia;
• Therapeutic or mechanically altered diet;
• Lack of access to culturally acceptable foods;
• Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and
• Cancer

Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not
be possible include, but are not limited to—

- Refusal to eat and refusal of other methods of nourishment;

- Advanced disease (i.e., cancer, malabsorption syndrome);

- Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns);

- Radiation or chemotherapy;

- Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism;

- Gastrointestinal surgery; and

- Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice.

“Therapeutic diet” means a diet ordered by a MD/DO as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet, (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).
The intent of this regulation is to provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident’s status.

The facility is expected to use resident observation and communication as the primary source of information when completing the assessment. In addition to direct observation and communication with the resident, the facility should use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident’s MD/DO, family members, or outside consultants and review of the resident’s record.

**CHART REVIEW**
Review a sample of medical records.
Verify:
- A complete assessment has been done for each, consistent with the standard.

This standard is not met as evidenced by:
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<th>STANDARD / ELEMENT</th>
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<tr>
<td>(vii) Psychosocial well-being</td>
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<td>(viii) Physical functioning and structural problems</td>
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<td>(ix) Continence</td>
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<tr>
<td>(x) Disease diagnoses and health conditions</td>
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<td>(xi) Dental and nutritional status</td>
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<tr>
<td>(xii) Skin condition</td>
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<td></td>
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<tr>
<td>(xiii) Activity pursuit</td>
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<td></td>
</tr>
<tr>
<td>(xiv) Medications</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(xv) Special treatments and procedures</td>
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<td>(xvi) Discharge</td>
<td>potentialplanning</td>
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<td>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) through the resident assessment protocols</td>
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<td>participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</td>
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§483.20(b)(1)
§483.20(b)(1)(i) through §483.20(b)(1)(xviii)
§483.20(b)(2)
§483.20(b)(2)(i)
§483.20(b)(2)(ii)
§483.20(b)(2)(iii)

### 11.10.02 (Formerly 11.04.01) Assessment Timeframes.

When Required.

Subject to the timeframes prescribed below in 42 CFR §413.343(b), a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified below in 42 CFR 483.20(b)(2)(i) through (iii).

**NOTE to Critical Access Hospitals (CAHs):** The timeframes prescribed in 42 CFR §413.343(b) DO NOT APPLY to CAHs.

The intent of this regulation is to assess residents in a timely manner.

“Admission” to the facility is defined as an initial stay or a return stay (not a readmission) in the facility. A “return stay” applies to those residents who are discharged without expectation that they will return to the facility, but who do return to the facility.

A “readmission” is an expected return to the facility following a temporary absence for hospitalization, off-site visit or therapeutic leave.

Items in (b)(2) of this section would include comprehensive assessments of a resident which were

**CHART REVIEW**

Verify:
- Assessments have been completed within 14 days of admission.

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<tr>
<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
<th>N/A = Not Applicable for CAHs</th>
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</table>

This standard is not met as evidenced by:
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<th>SCORING PROCEDURE</th>
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<tr>
<td>(i)</td>
<td>Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</td>
<td>done within 14 days of admission; within 14 days of a significant change in the resident’s physical or mental condition; or done on an annual review. These assessments need to be in the final discharge summary.</td>
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§483.20(b)(2)
§483.20(b)(2)(i)

11.10.03  (Formerly 11.04.02)
Reassessments.
Subject to the timeframes prescribed below in 42 CFR §413.343(b), a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified below in 42 CFR 483.20(b)(2)(i) through (iii).

NOTE to Critical Access Hospitals (CAHs): The timeframes prescribed in 42 CFR §413.343(b) do not apply to CAHs.

(ii) Within 14 calendar days after A “significant change” may include, but is not limited to, any of the following, or may be determined by a MD/DO’s decision if uncertainty exists.

- Deterioration in two or more activities of daily living (ADLs), or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appears permanent. For example, pronounced deterioration in function and communication following a stroke.

- Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb. Temporary loss of ability, such as during an acute illness, is not included.

CHART REVIEW
Verify:
- Reassessments have been completed within 14 days following a significant change in status.

☐ 1 = Compliant
☐ 2 = Not Compliant
☐ N/A = Not Applicable for CAHs

This standard is not met as evidenced by:
the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purposes of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires inter-disciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

§483.20(b)(2)(ii)  
§483.20(b)(2)(iii)

An interdisciplinary team, in conjunction with the resident, resident’s family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain.

11.10.04 (Formerly 11.04.03) Comprehensive Care Plans.

The facility must develop and implement a comprehensive person-centered care plan for each resident.

1. Does the care plan address the needs, strengths and preferences identified in the comprehensive assessment?

This standard is not

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Accreditation Requirements for Critical Access Hospitals

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consistent with the resident rights set forth at 42 CFR §483.10(c)(2) and 42 CFR §483.10(c)(3). The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the following--

(i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under 42 CFR §483.24, 42 CFR §483.25, 42 CFR §483.40; and

(ii) Any services that would otherwise be required under 42 CFR §483.24, 42 CFR §483.25, or 42 CFR §483.40 but are not provided due to the resident’s exercise of rights under 42 CFR §483.10, including the right to refuse treatment under 42 CFR §483.10(6)(46).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR

based on the comprehensive assessment.

The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident’s ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care.

The requirements reflect the facility’s responsibility to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

However, in some cases, a resident may wish to refuse certain services or treatments that professional staffs believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record.

2. Is the care plan oriented toward preventing avoidable declines in functioning or functional levels?

3. How does the care plan attempt to manage risk factors?

4. Does the care plan build on resident strengths?

5. Do treatment objectives have measurable outcomes?

6. Does the care plan reflect standards of current professional practice?

7. Corroborate information regarding the resident’s goals and wishes for treatment in the plan of care by interviewing residents; especially those identified as refusing treatment.

8. Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.

9. If the resident has refused treatment, does the care plan reflect the facility’s efforts to find alternative means to address the problem?
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(iv) In consultation with the resident and the resident’s representative(s)—

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

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

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
11.10.05 **(Formerly 11.04.04, 11.04.05, & 11.04.06)** Care Plan Requirements.

A comprehensive care plan must be—

(i) Developed within 7 days after the completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes but is not limited to:

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<tr>
<td>(A)</td>
<td>The attending physician (MD/DO),</td>
</tr>
<tr>
<td>(B)</td>
<td>A registered nurse with responsibility for the resident,</td>
</tr>
<tr>
<td>(C)</td>
<td>A nurse aide with responsibility for the resident</td>
</tr>
<tr>
<td>(D)</td>
<td>A member of the food</td>
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"Interdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.

- It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) are at the discretion of the facility.

The MD/DO must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-to-one discussions and conference calls.

The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. The facility should

**CHART REVIEW**

1. Was interdisciplinary expertise utilized to develop a plan to improve the resident’s functional abilities?

- For example, did an occupational therapist design need adaptive equipment or a speech therapist provide techniques to improve swallowing ability?

- Do the dietitian and the speech therapist determine, for example, the optimum textures and consistency for the resident’s food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident?

- Is there evidence of MD/DO involvement in development of the care plan (e.g., presence at care
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<tr>
<td>and nutrition services staff and other appropriate staff in disciplines as determined by the resident’s needs and...</td>
<td>encourage residents, surrogates, and representatives to participate in care planning, including encouraging attendance at care planning conferences if they so desire.</td>
<td>planning meetings, conversations with team members concerning the care plan, conference calls?</td>
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</table>
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality.

(ii) Be provided by qualified persons in accordance with each resident’s written plan of care.

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

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.
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