SWING BEDS

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<th>SCORING PROCEDURE</th>
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<tr>
<td>32.00.00 Condition of Participation: Special Requirements for Hospital Providers of Long-Term Care Services (&quot;Swing-Beds.&quot;)</td>
<td>Surveyors assess the manner and degree of non-compliance with the swing bed standards in determining whether there is condition-level compliance or non-compliance.</td>
<td>DOCUMENT REVIEW AND INTERVIEW</td>
<td>□ 1 = Compliant □ 2 = Not Compliant □ NA = Chapter Not Applicable; facility has no swing-beds.</td>
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</table>

A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in 42 CFR §409.30, and be reimbursed as a swing-bed hospital, as specified in 42 CFR §413.114.

§482.58

32.00.01 Eligibility.
A hospital must meet the following eligibility requirements:

1. The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see 42 CFR §413.24(d)(5).

2. The hospital is located in a rural area. This includes all areas not delineated as “urbanized” areas

The swing-bed concept allows a hospital 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.

Allowing a hospital to operate swing-beds is done by issuing a "swing-bed approval."

- If the facility fails to meet the swing-bed “requirements” (not the same as the provider CoPs), and the facility chooses not to initiate a plan of correction, they lose the approval to operate swing-beds and receive swing-bed reimbursement. The facility does not go on a

DOCUMENT REVIEW AND INTERVIEW
1. Verify the total number of hospital beds meets eligibility requirements.
2. Verify the facility meets criteria as a rural facility.
3. Verify the facility does NOT have a nursing waiver in place.
4. Verify the facility has not had a termination of swing bed approval within the 2 years prior to application.

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Healthcare Facilities Accreditation Program (HFAP) Accreditation Requirements for Acute Care Hospitals © 2018 HFAP 32-1
by the Census Bureau, based on the most recent census.

(3) The hospital does not have in effect a 24-hour nursing waiver granted under 42 CFR §488.54(c).

(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.

§482.58(a)
§482.58(a)(1)
§482.58(a)(2)
§482.58(a)(3)
§482.58(a)(4)

termination track. If the hospital continues to meet the CoPs for the provider type, it continues to participate in Medicare, but loses swing-bed approval.

Swing beds do not have to be located in a special section of the hospital.

The patient does not have to change locations in the hospital merely because their status changes unless the hospital requires it.

- The change in status from acute care to swing-bed status can occur within the same part of the hospital for swing-bed admission.

- Likewise, a patient may be discharged from one hospital and admitted in swing bed status to another hospital that has swing bed approval.

There must be discharge orders changing status 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 hospital or transfers to another hospital with swing bed approval.

If the patient remains within the hospital, 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. There is no length of stay restriction for any hospital swing-bed patient. There is no Medicare requirement to place a swing-bed patient in a nursing home and
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<td>there are no requirements for transfer agreements between hospitals and nursing homes.</td>
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<td>The statute governing Medicare payment requires a 3-day qualifying stay in any hospital or CAH prior to admission to a swing bed in any hospital or CAH, or admission to a skilled nursing facility (SNF). The Medicare beneficiary’s swing-bed stay must fall within the same spell of illness as the qualifying stay.</td>
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<td>• This requirement applies only to patients who are Medicare beneficiaries who seek Medicare coverage of their SNF services. It is not enforced through the survey and certification process, since it is a payment requirement.</td>
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<td>In accordance with SOM Section 2037 hospitals seeking swing bed approval are screened prior to survey for their eligibility for swing beds. However, the CMS Regional Office makes the determination whether the hospital has satisfied the eligibility criteria, regardless of whether the State Survey Agency or Accrediting Organization, as applicable, recommends approval of swing bed status.</td>
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<td>This requirement does not apply to patients who are not receiving Medicare reimbursement.</td>
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### SWING BEDS

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<tr>
<td>32.00.02 Skilled Nursing Facility Services.</td>
<td>The facility must be in substantial compliance with the following skilled nursing facility requirements which are scored individually.</td>
<td><strong>DOCUMENT REVIEW</strong> Swing-bed standards within this chapter are applicable to only those acute care hospitals that have a Medicare provider agreement for Swing-beds.</td>
<td>Scoring deferred.</td>
</tr>
<tr>
<td>(1) Resident rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), (e)(4), (f)(4)(ii), (f)(4)(iii), (f)(9), (h), (g)(8), (g)(17), and (g)(18)) introductory text,</td>
<td></td>
<td>This requirement is scored individually throughout the chapter.</td>
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<td>(2) Admission, transfer, and discharge rights (§483.5) definition of transfer and discharge, (§483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7)),</td>
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<td>(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)),</td>
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<td>(4) Patient activities (§483.24(c)),</td>
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<td>(5) Social services (§483.40(d)) and (483.70(p)),</td>
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<td>(6) Discharge Planning (§483.20(e)),</td>
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<td>(7) Specialized rehabilitative services (§483.65),</td>
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(8) Dental services (§483.55), §482.58(a)

32.01.01 Resident Rights. 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.

§483.10

The facility must provide the resident or resident’s representative a written list of rights afforded to the swing-bed resident, including the right:
1. To request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive (§483.10(c)(6));
2. To choose his or her attending physician (§483.10(d));
3. To be informed of, and participate in his or her treatment (§483.10(c)(1));

Long-term residents have rights guaranteed to them under federal and state law.

OBSERVATION, CHART REVIEW, AND INTERVIEW
1. Verify the facility has a process to provide a written list of the resident rights to the swing-bed resident.
2. Verify the list of resident rights includes all required elements.
3. Review medical records to verify the resident rights have been provided to the resident / resident’s representative.

This standard is not met as evidenced by:
4. To be fully informed in language of his or her total health status, including his or her medical condition (§483.10(c)(1));

5. To be fully informed, in advance, of changes to the plan of care (§483.10(c)(2)(iii));

6. To personal privacy, confidentiality, and security of his or her personal and medical records (§483.10(h));

7. To refuse the release of personal and medical records, except per 483.70(i)(2) and federal or state laws (§483.10(h));

8. To choose to or refuse to perform services for the facility (§483.10(f)(9));

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));

10. To have privacy of communications (§483.10(h));
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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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<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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<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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<td>15. To be free from abuse, neglect, misappropriation of property, and exploitation (§483.12).</td>
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</table>
32.01.02 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.

§483.10(c)(6)

“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.

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.

DOCUMENT REVIEW, CHART REVIEW AND INTERVIEW

1. Review the facility’s policies to determine the requirement is met.

2. Review medical records to determine that advance directives were requested on all patients and copies are available.

3. Review the records of sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.

4. Determine to what extent the facility educates its staff regarding advance directives.

5. Determine to what extent the facility provides education for the community regarding individual rights under State law to formulate advance directives.

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?
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 law regarding advance directives;
- Provide for educating staff regarding the facility’s policies and procedures on advance directives;

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>• 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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### 32.01.03 Choice of Attending Physician

**The resident has the right to choose his or her attending physician.**

1. **The physician must be licensed to practice, and**
   - 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.

2. **If the physician chosen by the resident refuses to or does not**
   - 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

### DOCUMENT REVIEW AND INTERVIEW

1. Review the facility’s policies to determine the requirement is met.

2. Interview patients to verify they were given the opportunity to select their own personal physician.

This standard is not met as evidenced by:
meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

(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.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(5) If the resident subsequently selects another attending

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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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)

32.01.04 Planning and Implementing Care.
The resident has the right to be informed of, and participate in, his or her treatment, including:

- 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.

§483.10(c)
§483.10(c)(1)

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 changes.

“Participates in planning care and treatment,” means that the resident is afforded the opportunity to select from alternative treatments, to the level of his ability to understand.

This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment.

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

**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 understandable to residents.

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?

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.

☐ 1 = Compliant
☐ 2 = Not Compliant

This standard is not met as evidenced by:

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<td>of technical words, providing interpreters for non-English speaking residents, using sign language when needed, or other interventions, as appropriate.</td>
<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>
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<td>“Total health status” includes;</td>
<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>
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<td>• functional status,</td>
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<td>• psychosocial status, and</td>
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<td>• sensory and physical impairments.</td>
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<td>32.01.05 Informed of Care and Treatment.</td>
<td>“Informed in advance,” means that the resident receives information necessary to make a health care decision.</td>
<td>CHART REVIEW AND INTERVIEW</td>
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<td>The resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but</td>
<td>The information should include his/her medical condition, changes in his/her medical condition, the</td>
<td>1. Interview the person responsible for the Swing-bed services to determine how the standards are met.</td>
<td>1 = Compliant</td>
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<td>not limited to:</td>
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<td>2. Review medical records for evidence that the</td>
<td>2 = Not Compliant</td>
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<td>This standard is not met as evidenced by:</td>
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<td><strong>not limited to:</strong></td>
<td>benefits and reasonable risks of the recommended treatment, and reasonable alternatives.</td>
<td>resident has been notified in advance of care and treatment and changes in care.</td>
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<td>• The right to be fully informed, in advance, of changes to the plan of care.</td>
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<td>§483.10(c)(2)(iii)</td>
<td>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.</td>
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<td>32.01.06 Personal Privacy &amp; Confidentiality.</td>
<td>“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 visitation purposes.</td>
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<td>The resident has the right to personal privacy and confidentiality of his/her personal and medical records.</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.</td>
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<td>(1) 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>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</td>
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<tr>
<td>(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other</td>
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**INTERVIEW AND OBSERVATION**

1. Interview residents to determine if the staff respect the resident’s privacy relating to communication, mail, and packages.

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.
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<td>materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</td>
<td>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>
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<tr>
<td>(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §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.</td>
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§483.10(h)  
§483.10(h)(1)  
§483.10(h)(2)  
§483.10(h)(3)  
§483.10(h)(3)(i)  
§483.10(h)(3)(ii)
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<td>32.01.07 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.</td>
<td>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.</td>
<td>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?</td>
<td>1 = Compliant 2 = Not Compliant</td>
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| 32.01.08 Mail.     | The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:  
(i) Privacy of such communications,  
(ii) Have access to stationery, postage, and writing implements at the resident’s own expense. | **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 = Compliant  
2 = Not Compliant |
| 32.01.09 Access & Visitation Rights. | 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. | 1 = Compliant  
2 = Not Compliant |

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<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>
<td>§483.10(f) §483.10(f)(4)(ii) §483.10(f)(4)(iii)</td>
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#### 32.01.10 Personal Property.

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

§483.10(e)(2)

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:
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<td>32.01.11 Married Couples.</td>
<td>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.</td>
<td>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.</td>
<td>DOCUMENT REVIEW AND OBSERVATION 1. Review the facilities policies to determine that the requirement is met. 2. Observe the residents area to determine that if married residents are patients they have the arrangement if they request it.</td>
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<td>§483.10(e)(4)</td>
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<td>This standard is not met as evidenced by:</td>
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<td>32.02.01 Medicaid &amp; Medicare Notification.</td>
<td>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.</td>
<td>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. 1. Telephone 2. Television / radio for personal use 3. Personal comfort items including smoking materials, notions, novelties, and confections 4. Cosmetic and grooming items and services in excess of those for which payment is made 5. Personal clothing 6. Personal reading matter</td>
<td>DOCUMENTS, CHART REVIEW, AND INTERVIEW 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?</td>
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<td>This standard is not met as evidenced by:</td>
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| that the facility offers and for which the resident may be charged, and the amount of charges for those services; and | • Gifts purchased on behalf of a resident  
• Flowers and plants  
• Social events and entertainment offered outside the scope of the activities program  
• Non-covered special care services such as privately hired nurses or aides  
• Private room, except when therapeutically required for example, isolation for infection control  
• Specially prepared or alternative food requested |  |  |

(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).

§483.10(g)(18)  
§483.10(g)(17)  
§483.10(g)(17)(i)  
§483.10(g)(17)(i)(A)  
§483.10(g)(17)(i)(B)  
§483.10(g)(17)(i)(B)(ii)  

32.02.02 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.

The facility has written policies that depict the process for ensuring the representative of the incompetent resident acts on behalf of the resident.

**DOCUMENT REVIEW AND CHART REVIEW**

1. Review facility policies to verify all required elements are met.

2. Review the medical record of at least one patient adjudged incompetent by a court to determine these requirements are met.

This standard is not met as evidenced by:
representative appointed under State law to act on the resident's behalf.

- The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

§483.10(b)(7)

### 32.03.01 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.**

§483.12(b)

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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.

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<th>OBSERVATION AND CHART REVIEW</th>
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<tr>
<td>1. Review the facility’s policies to determine all elements of the requirement are met.</td>
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<tr>
<td>2. Interview the person responsible for the Swing bed unit to determine how the requirement was met.</td>
</tr>
<tr>
<td>3. Interview a resident to determine that the requirement was met.</td>
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This standard is not met as evidenced by:

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The facility has written policies establishing:
1. Unacceptable hiring practices, and
2. The procedure for reporting to the State nurse aide registry or licensing authorities any knowledge of court actions that would indicate unfitness to serve as an employee.

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.

“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.
The facility must:

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

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

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.

Chemical Restraint is defined as a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

Discipline is defined as any action taken by the facility for the purpose of punishing or penalizing residents.

Convenience is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interest.

Medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. The facility must
engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities).

32.03.04 Freedom From Abuse, Neglect, and Exploitation.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms.

§483.12

“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 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

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 continually trying to find and use less
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<td>use of a resident’s belongings or money without the resident’s consent.</td>
<td>restrictive alternatives?</td>
<td>INTERVIEW AND DOCUMENT REVIEW</td>
<td>1 = Compliant</td>
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<td>h. If residents are temporarily separated in secured units, staff should carry keys to these units at all times.</td>
<td>2 = Not Compliant</td>
<td>1. On interview determine if the facility has had any of the alleged violations and ask how these were handled.</td>
<td>1 = Compliant</td>
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<tr>
<td>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.</td>
<td></td>
<td>2. Review the policy and procedure to determine that it meets the requirement.</td>
<td>2 = Not Compliant</td>
</tr>
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32.03.05 Reporting Allegations of Patient Mistreatment, Neglect, or Abuse. 
*In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:*  
- Ensure that all alleged violations 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.

§ 483.12(c)
§ 483.12(c)(1)

32.03.06 Investigation of Alleged Abuse.
In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

- Have evidence that all alleged

Investigations should occur as close to the time of the incident as possible.

The chain of evidence should be secured in a safe place.

**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.

This standard is not met as evidenced by:
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violations are thoroughly investigated and

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

§483.12(c)(2)
§483.12(c)(3)

32.03.07 Reporting Allegations of Abuse.

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

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

§483.12(c)(4)

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 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 ombudsman; adult protective services; Medicaid fraud and abuse unit)?

32.04.01 Activities Program.
The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to

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

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,
support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

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

(i) Is licensed or registered, if applicable, by the State in which practicing; and

(ii) Is

(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or

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, and visitors.

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 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

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| (C) **Is a qualified occupational therapist or occupational therapy assistant; or** | 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. | | |
| (D) **Has completed a training course approved by the State.** | | | |

§483.24(c)  
§483.24(c)(1)  
§483.24(c)(2)  
§483.24(c)(2)(i)  
§483.24(c)(2)(ii)  
§483.24(c)(2)(ii)(A)  
§483.24(c)(2)(ii)(B)  
§483.24(c)(2)(ii)(C)  
§483.24(c)(2)(ii)(D)  

5. **Review clinical records and activity attendance records of residents to determine if**--  
- Activities reflect individual resident history indicated by the comprehensive assessment;  
- Care plans address activities that are appropriate for each resident based on the comprehensive assessment;  
- Activities occur as planned; and  
- Outcomes / responses to activities
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<td>32.04.02  <strong>Coordinate Assessments.</strong></td>
<td>The facility has written policies and procedures that describe the coordination of the pre-admission screening with the PASARR resident review assessment.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong>&lt;br&gt;1. Verify the facility has written policies that outline this coordination.&lt;br&gt;2. Interview the social worker and/or other staff to determine how the PASARR is used to screen and refer these residents.</td>
<td>[ ] 1 = Compliant [ ] 2 = Not Compliant</td>
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A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in 42 CFR 483.128 and 483.130 to the maximum extent practicable to avoid duplicative testing and effort.

**Coordination includes—**

1. **Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.**

   - The Level I is an evaluation to identify individuals with Mental Illness (MI) or Intellectual/Developmental Disability (ID/DD). In the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

   - Level II is the function of evaluating and deterring whether Nursing Facility services and specialized services are needed.

   (For more information, see 42 CFR 483.128)

2. **Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in mental status or condition.**
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<td>32.05.01 Social Services</td>
<td><strong>Medically-related social services</strong> 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 <strong>could</strong> include, for example:</td>
<td><strong>CHART REVIEW</strong> 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.</td>
<td>☐ 1 = Compliant ☐ 2 = Not Compliant</td>
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<td>§483.20(e)</td>
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**change in status assessment.**

§483.40(d)

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

**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?

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Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Acute Care Hospitals

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<td>6. Discharge planning services (<strong>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 facilities</strong>).</td>
<td>5. What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan?</td>
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<td>7. Providing or arranging provision of needed counseling services;</td>
<td>6. 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>8. 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. Finding options that meet the physical and emotional needs of each resident;</td>
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<td>10. Meeting the needs of residents who are grieving; and</td>
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<td>11. 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.
### 32.05.02 Qualification of Social Worker

Any 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. **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 health care 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**

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<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
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1. Review the resume of the social worker and the job description to determine that the standard is met.

2. Review the credentials of the social worker to verify compliance.

This standard is not met as evidenced by:
### 32.06.01 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 rehabilitative services for a mental disorder 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.

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...
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<tr>
<td>Enlightenment</td>
<td>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.</td>
<td>of pressure ulcer occurrence?</td>
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<td></td>
<td>“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.</td>
<td>2. Occupational Therapy</td>
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<td>Mental health rehabilitative services for MI and ID may include, but are not limited to:</td>
<td>• What did the facility do to decrease the amount of assistance needed to perform a task?</td>
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<tr>
<td></td>
<td>1. Consistent implementation during the resident’s daily routine and across settings, of systematic plans which are designed to change inappropriate behavior.</td>
<td>• What did the facility do to decrease behavioral symptoms?</td>
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<td></td>
<td>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.</td>
<td>• What did the facility do to improve gross and fine motor coordination?</td>
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<td>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).</td>
<td>• What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration?</td>
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<td>• What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards?</td>
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<td>3. Speech, Language Pathology</td>
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<td>• What did the facility do to improve auditory comprehension?</td>
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<td>• What did the facility do to improve speech production?</td>
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<td>• What did the facility do to improve expressive behavior?</td>
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4. 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.

5. Crisis intervention services.

6. Individual, group, and family psychotherapy.

7. Development of appropriate personal support networks.

8. Formal behavior modification programs.

- What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiologic evaluation?

- For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?

4. Rehabilitative Services For MI And ID

- What did the facility do to decrease incidents of inappropriate behaviors, for individuals with ID, or behavioral symptoms for persons with MI? To increase appropriate behavior?

- What did the facility do to identify and treat the underlying factors behind tendencies toward isolation and withdrawal?

- What did the facility do to develop and maintain necessary daily living skills?

- How has the facility modified the training strategies it uses with its residents to account for the special learning needs of its residents with MI or ID?
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<td><strong>32.06.02  Rehabilitative Service Orders: Qualifications.</strong></td>
<td>Specialized rehabilitative services are provided for individuals under a physician’s order by a qualified professional.</td>
<td><strong>CHART REVIEW</strong> Review medical records for physician orders and the record for the services performed.</td>
<td></td>
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<td>Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.</td>
<td>Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional.</td>
<td>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.</td>
<td>1 = Compliant</td>
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<tr>
<td>§483.65(b)</td>
<td>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.</td>
<td>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.</td>
<td>2 = Not Compliant</td>
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<td>“Qualified personnel,” means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws.</td>
<td>3. If the facility does not employ professional</td>
<td>This standard is not met as evidenced by:</td>
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<td>Health rehabilitative services for MI and ID must be implemented consistently by all staff unless the</td>
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<td>Questions to ask individuals with MI or ID—</td>
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<td>- Who do you talk to when you have a problem or need something?</td>
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<td>- What do you do when you feel happy? Sad? Can’t sleep at night?</td>
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<td>- In what activities are you involved, and how often?</td>
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<td>nature of the services is such that they are designated or required to be implemented only by licensed or credentialed personnel.</td>
<td>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>
<td>INTERVIEW &amp; DOCUMENT REVIEW</td>
<td></td>
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#### 32.07.01 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. |

| 1 | Compliant |
| 2 | Not Compliant |

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

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</table>
| **32.07.02 SKILLED NURSING FACILITY:** Patient Liability for Dental Care. | 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 the dentures are lost or damaged. Referral does not | DOCUMENT REVIEW | 1 = Compliant  
2 = Not Compliant  
Not Applicable if a Nursing Facility  
This standard is not met as evidenced by: |

**A facility –**

(1) **Must provide or obtain from an outside resource, in accordance with 42 CFR §483.70(g), 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;**

§483.55(a)(1)  
§483.55(a)(2)  
§483.55(a)(3)
32.07.03 SKILLED NURSING FACILITY: Resident Dental Appointments.
The facility must, if necessary or requested, assist the resident:

- In making appointments; and
- By arranging for transportation to and from the 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.

“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.

§483.55(a)(4)
§483.55(a)(4)(i)
§483.55(a)(4)(ii)
§483.55(a)(5)

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?
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| **32.07.04 NURSING FACILITIES:** Provision of Dental Services. | If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility. | **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.

   - **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 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.

   - **Provision of Dental Services.**  
     | 1 = Compliant | 2 = Not Compliant | Not Applicable if Skilled Nursing Facility  
   | §483.55(b) |  
   | §483.55(b)(1) |  
   | §483.55(b)(1)(i) |  
   | §483.55(b)(1)(ii) |  

This standard is not met as evidenced by:
### 32.07.05 NURSING FACILITIES: Appointments and Referrals.

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

- In making appointments.
- By arranging for transportation to and from the dental services locations.
- 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;
- 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

**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?

This standard is not met as evidenced by:

- 1 = Compliant
- 2 = Not Compliant
- Not Applicable if a Skilled Nursing Facility

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responsibility; and

- 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.

§483.55(b)(2)
§483.55(b)(2)(i)
§483.55(b)(2)(ii)
§483.55(b)(3)
§483.55(b)(4)
§483.55(b)(5)

32.08.01 Transfer and Discharge: Definition.
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.

§483.5

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.

CHART REVIEW
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

☐ 1 = Compliant
☐ 2 = Not Compliant

This standard is not met as evidenced by:
32.08.02 Transfer & Discharge: Facility Requirements.

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility.

(B) The transfer or discharge is 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

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.

During closed record review, determine the reasons for transfer / discharge.

1. Do records document accurate assessments and attempts through care planning to address the resident’s needs through multidisciplinary interventions, accommodation of individual needs, and attention to the resident’s customary routine?

2. Did the resident’s physician document the record if the resident was transferred / 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?
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<tr>
<td>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.</td>
<td>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.</td>
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(F) The facility ceases to operate.

(ii) 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.
32.08.03  Transfer and Discharge: 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

Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy.

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.

This standard is not met as evidenced by:

1 = Compliant
2 = Not Compliant
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 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 as described above in 42 CFR 483.15(c)(1)(i)(C) or (D).
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<td>32.08.04 Notice Before Transfer.</td>
<td>Self-explanatory.</td>
<td><strong>DOCUMENT REVIEW AND CHART REVIEW</strong></td>
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**Before a facility transfers or discharges a resident, the facility must—**

1. ** Notify the resident and if known, the resident’s representative of the discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**

2. **Record the reasons for the transfer or discharge in the resident’s medical record; and**

3. **Include in the notice the items described in 42 CFR 482.15c(5).**

- §483.15(c)(3)
- §483.15(c)(3)(i)
- §483.15(c)(3)(ii)
- §483.15(c)(3)(iii)

This standard is not met as evidenced by:

- 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.

1 = Compliant

2 = Not Compliant

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32.08.05 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 may 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

(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)

32.08.06 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 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

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

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

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 and telephone number of the agency responsible for the protection and advocacy of **individuals with a mental disorder** established under the Protection and Advocacy for Mentally Ill Individuals Act.

§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)
32.08.07 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.

§483.15(c)(7)

“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.
- 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.

There shall be documentation in the medical record of the preparation and orientation.

Chart Review

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

This standard is not met as evidenced by:
32.08.08  **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 post-discharge medications (both prescribed and over-the-counter).**

(iv) **A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-**

The intent of this regulation is to ensure appropriate discharge planning and communication of necessary information to the continuing care provider.

“**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’s 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:

- personal care,
- sterile dressing, and
- physical therapy, as well as
- describe resident/caregiver education needs to prepare the resident for discharge.

**CHART REVIEW**

Review a select group of medical records to determine the requirement was met.

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 resident and his/her family?
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
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*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)