

**Option 2: CAH Swing Bed QAPI Comprehensive Data Abstraction Form**

**Section 1: Identification Information**

A. Unique Patient Identifier														

B: Swing Bed Admission Date					
Month		Day		Year	
				20	

C: Patient Date of Birth					
Month		Day		Year	

D1: Admitted to Swing Bed From:			
Choose one	Where was the patient immediately before Swing Bed admission?		
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>			01. Home/Community (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)
	02. Nursing home (long-term care facility)		
	03. Skilled Nursing Facility (SNF or another hospital swing bed program)		
	04. Short-Term General Hospital (IPPS or CAH)		
	05. Long Term Care Hospital (LTCH) (free standing or hospital-based unit)		
	06. Inpatient Rehabilitation Facility (free standing or hospital-based unit)		
	07. Inpatient Psychiatric Facility (psychiatric hospital or unit)		
	08. Intermediate Care Facility (ID/DD facility)		
	09. Hospice (home or institutional facility)		
	10. Home under care of organized home health service organization		
	99. Not listed (ie: VA, prison, other)		

D2. Admitted to Acute From:			
Choose one	Where was the patient before the acute admission		
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>			01. Home/Community (e.g., private home/apt, board/care/assisted)
	02. Nursing Home (SNF/LTC)		
	03. Other		

E. Expected primary payer source for swing bed stay			
Choose one			
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>			01. Medicare
	02. Medicare Advantage		
	03. Medicaid		
	04. Commercial Insurance (includes Blue Cross)		
	05. Self-pay		
	99. Other (ie: VA, Champus/Tricare, Prison)		

**Section 2: Risk Adjustment Elements**

**A: Primary Medical Condition Category (see descriptions provided)**

<p><b>Enter Code</b></p> <table border="1"><tr><td> </td><td> </td></tr></table>			<p><b>Indicate the primary medical condition upon which the patient's skilled needs are based on</b></p> <ul style="list-style-type: none"><li>01. Stroke</li><li>02. Non-Traumatic Brain Dysfunction</li><li>03. Traumatic Brain Dysfunction</li><li>04. Non-Traumatic Spinal Cord Dysfunction</li><li>05. Traumatic Spinal Cord Dysfunction</li><li>06. Progressive Neurological Condition</li><li>07. Other Neurological Conditions</li><li>08. Amputation</li><li>09. Hip and Knee Replacement</li><li>10. Fractures and Other Multiple Trauma</li><li>11. Other Orthopedic Conditions</li><li>12. Debility, Cardiorespiratory Conditions</li><li>13. Medically Complex Conditions</li></ul>

B. Surgery	
Enter Code <input type="checkbox"/>	Did the patient have major surgery during the <u>100 days prior to swing bed admission?</u> (general anesthesia and at least one overnight stay as IP or OP) 0. No 1. Yes 8. Unknown

**C. Prior Functioning**

**Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury

<b>Coding:</b> <b>3. Independent</b> - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper <b>2. Needed Some Help</b> - Patient needed partial assistance from another person to complete any activities <b>1. Dependent</b> - A helper completed all the activities for the patient <b>8. Unknown</b> <b>9. Not Applicable</b>	↓	<b>Enter Codes in Boxes</b> <input type="checkbox"/> <b>A. Self-Care:</b> Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury <input type="checkbox"/> <b>B. Indoor Mobility (Ambulation):</b> Code the patient's need for assistance with walking from room to room (with or without device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury <input type="checkbox"/> <b>C. Stairs:</b> Code the patient's need for assistance with internal or external stairs (with or without a device such as a cane, crutch, or walker) prior to the current illness, exacerbation, or injury <input type="checkbox"/> <b>D. Functional Cognition:</b> Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury
---	---	---

**D. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury

↓	<b>Check all that apply</b>
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair and/or scooter
<input type="checkbox"/>	C. Mechanical lift (i.e., hoist, chair lift, stair lift)
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

E. Bladder & Bowel Continence	
Urinary Continence	
Choose one	During the Swing Bed Stay
<input type="checkbox"/>	0. Always Continent
	1. Occasionally incontinent (less than daily incontinence)
	2. Frequently incontinent (may have daily incontinence but with also some episodes of continent voiding)
	3. Always incontinent (no episodes of continent voiding)
	9. Not rated (patient had a catheter [indwelling, condom], urinary ostomy, or no urine output for the entire stay)
Bowel Continence	
Choose one	During the Swing Bed Stay
<input type="checkbox"/>	0. Always Continent
	1. Occasionally incontinent (one episode of bowel incontinence)
	2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
	3. Always incontinent (no episodes of continent bowel movements)
	9. Not rated (patient had an ostomy or did not have a bowel movement for the entire stay)
F. Unhealed Pressure Ulcers/Injuries at Swing Bed Admission	
<input type="checkbox"/>	0. No (Skip to next section)
	1. Yes (Answer question below)
↓	<b>Check all that apply</b>
<input type="checkbox"/>	Stage 2 Pressure Ulcer
<input type="checkbox"/>	Stage 3, 4, or Unstageable Pressure Ulcer

G. Fall History on Admission	
Choose one	Did the patient have a fall any time in the last month prior to swing bed admission?
<input type="checkbox"/>	0. No
	1. Yes
	9. Unable to determine

H. Total Parenteral Nutrition & Tube Feeding while in Swing Bed			
Total Parenteral Nutrition		Tube Feeding	
Choose one		Choose one	
<input type="checkbox"/>	0. No	<input type="checkbox"/>	0. No
	1. Yes		1. Yes

I. Communication	
Makes self understood:	
Choose one	Ability of patient to express ideas and wants, consider both verbal and non-verbal expression
<input type="checkbox"/>	0. Understood
	1. Usually understood - difficulty communicating some words or thoughts but is able if prompted or given time
	2. Sometimes understood - ability is limited to making concrete requests
	3. Rarely/never understood
Ability to understand others:	
Choose one	Ability of patient in understanding verbal content
<input type="checkbox"/>	0. Understands
	1. Usually understands - misses some part/intent of message but comprehends most
	2. Sometimes understands - responds adequately to simple, direct communication only
	3. Rarely/never understands

J. Comorbidities:	
Check all that apply	Indicate the patient's active comorbidities impacting skilled needs (must be included in provider's documentation)
<input type="checkbox"/>	<b>Major infections:</b> Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock; and Other Infectious Diseases
<input type="checkbox"/>	<b>Metastatic Cancer and Acute Leukemia</b>
<input type="checkbox"/>	<b>Diabetes:</b> Diabetes with Chronic Complications; Diabetes without Complications; Type I Diabetes Mellitus
<input type="checkbox"/>	<b>Other Significant Endocrine and Metabolic Disorders</b>
<input type="checkbox"/>	<b>Delirium and Encephalopathy</b>
<input type="checkbox"/>	<b>Dementia:</b> Dementia with Complications; Dementia without Complications
<input type="checkbox"/>	<b>Tetraplegia</b> (excluding complete tetraplegia) and <b>Paraplegia</b>
<input type="checkbox"/>	<b>Multiple Sclerosis</b>
<input type="checkbox"/>	<b>Parkinson's and Huntington's Diseases</b>
<input type="checkbox"/>	<b>Angina Pectoris</b>
<input type="checkbox"/>	<b>Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease</b>
<input type="checkbox"/>	<b>Hemiplegia, Other Late Effects of Cerebrovascular Accident:</b> Hemiplegia/Hemiparesis; Late Effects of Cerebrovascular Disease, Except Paralysis
<input type="checkbox"/>	<b>Dialysis Status and Chronic Kidney Disease - Stage 5</b>
<input type="checkbox"/>	<b>Urinary Obstruction and Retention</b>
<input type="checkbox"/>	<b>Amputations:</b> Traumatic Amputations and Complications; Amputation Status, Lower Limb/Amputation Complications; Amputation Status, Upper Limb
<input type="checkbox"/>	<b>Central Nervous System Infections:</b> Bacterial, Fungal, and Parasitic Central Nervous System Infections, Viral and Late Effects Central Nervous System Infections
<input type="checkbox"/>	<b>Lymphoma and Other Cancers</b>
<input type="checkbox"/>	<b>Other Major Cancers:</b> Colorectal, Bladder, and Other Cancers, Other Respiratory and Heart Neoplasms, Other Digestive and Urinary Neoplasms, Other Neoplasms
<input type="checkbox"/>	<b>Mental Health Disorders:</b> Schizophrenia; Major Depressive, Bipolar and Paranoid Disorders; Reactive and Unspecified Psychosis; Personality Disorders
<input type="checkbox"/>	<b>Aspirations, Bacterial and Other Pneumonias:</b> Aspiration and Specified Bacterial Pneumonias; Pneumococcal Pneumonia, Empyema, Lung Abscess
<input type="checkbox"/>	<b>Legally blind</b>
<input type="checkbox"/>	<b>Chronic Kidney Disease:</b> Stages 1-4, Unspecified: Chronic Kidney Disease, Severe (stage 4), Chronic Kidney Disease, Moderate (stage 3), Chronic Kidney Disease, Mild or Unspecified (stages 1, 2 or unspecified)
<input type="checkbox"/>	<b>Major Fracture</b> , except of skull, vertebrae or hip

<b>Section 3:</b>	
<b>Therapy Utilization (during the swing bed stay)</b>	
<b>Did patient receive any therapy while in Swing Bed? (Not counting the initial therapy assessment)</b>	
<b>Choose one</b>	Regardless of frequency or number of days per week
<input type="checkbox"/>	0. No
	1. Yes
<b>If yes, which discipline was provided?</b>	
<b>Check all that apply</b>	Therapy was a skilled need provided based on a PT/OT/SLP evaluation
<input type="checkbox"/>	1. Physical Therapy
<input type="checkbox"/>	2. Occupational Therapy
<input type="checkbox"/>	3. Speech Therapy

<b>Swing Bed Programming (see descriptions provided)</b>	
<b>Enter Code</b>	Indicate more specific medical/physical rehab program the patient was admitted for based on primary skilled needs (not comorbidities)
<input type="text"/> <input type="text"/>	<ul style="list-style-type: none"> <li>01. Cardiac Rehabilitation (ie: post MI, CHF, Cardiac procedures/surgery, CABG)</li> <li>02. Pulmonary Rehabilitation (ie: COPD, Emphysema, Chronic Bronchitis)</li> <li>03. Post-Stroke Rehabilitation</li> <li>04. Pneumonia Management and Rehabilitation</li> <li>05. Short-Term Medical Management (a 2-4 day extension of acute care until treatment regimen is considered effective)</li> <li>06. Wound Care Management</li> <li>07. Long-term IV Management</li> <li>08. Management of Newly Diagnosed Specific Conditions (ie: newly diagnosed diabetes or new ostomy)</li> <li>09. Neuro-Muscular Disease Specific Rehabilitation (ie: Parkinson, Multiple Sclerosis)</li> <li>10. Orthopedic Rehabilitation</li> <li>11. Short-term New Tracheostomy Care</li> <li>12. Short-term Ventilation Rehabilitation</li> <li>13. Post Bariatric Surgery Rehabilitation</li> <li>14. Short-term Nutritional Support (ie: J/G Tube, TPN)</li> <li>15. Short-term Pain Management</li> <li>16. General Malaise and/or Debility Rehabilitation</li> <li>17. Post-acute Kidney Disease Management</li> <li>18. Medically Complex/Multiple Trauma</li> </ul>

**Section 4. Exclusions**

**If any of the following apply, skip to Discharge and 30-day Follow-Up**

**Choose ONLY One**

<input type="checkbox"/>	01. Died while in Swing Bed
<input type="checkbox"/>	02. Left the swing bed program against medical advice (AMA)
<input type="checkbox"/>	03. Discharged to hospice care
<input type="checkbox"/>	04. Unexpectedly discharged to a short-stay acute hospital/CAH
<input type="checkbox"/>	05. <b>Planned</b> Short Medical Management for 3 days (3 midnights) or less
<input type="checkbox"/>	06. Independent with all mobility activities at the time of admission (all 15 mobility items are coded 06)
<input type="checkbox"/>	07. Patient with any of the following medical conditions: coma/persistent vegetative state; complete tetraplegia; locked-in syndrome; severe anoxic brain damage, cerebral edema, or compression of brain
<input type="checkbox"/>	08. Younger than 21 years old
<input type="checkbox"/>	09. Not receiving Physical Therapy or Occupational Therapy (including those only receiving PT for wound care)

**If None of the exclusions above apply complete the Functional Abilities sections**



**Section 5: Functional Abilities at the Start of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**A. Self-care Assessment on Admission** (Assessment period is days 1 to 2 of the Swing Bed Stay)

Code the patient's usual performance at the start of the swing bed stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the swing bed stay (admission), code the reason. Code the patient's end of Swing Bed stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of stay (discharge) goal(s).

**Coding:**  
**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.  
*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

Admission Performance	Discharge Goal	1. Set goals only for self-care activities the team plans to work on. Must be part of the plan.
↓	↓	2. If the performance of an activity was coded 88 during admission assessment, a discharge goal should be coded using six-point scale if patient is expected to perform activity by discharge
Enter Codes in Boxes		3. A goal can be to maintain the present level if working towards that
□ □	□ □	<b>A. Eating:</b> The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient
□ □	□ □	<b>B. Oral hygiene:</b> The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment
□ □	□ □	<b>C. Toileting hygiene:</b> The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment
□ □	□ □	<b>E. Shower/bathe self:</b> The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
□ □	□ □	<b>F. Upper body dressing:</b> The ability to dress and undress above the waist, including fasteners, if applicable
□ □	□ □	<b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear
□ □	□ □	<b>H. Putting on/taking off footwear:</b> The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable

**Section 5: Functional Abilities at the Start of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**B. Mobility Assessment on Admission (page 1 of 2)**

Code the patient's usual performance at the start of the swing bed stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the swing bed stay (admission), code the reason. Code the patient's end of Swing Bed stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of Swing bed Stay (discharge) goal(s).

**Coding:**  
**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

Admission Performance	Discharge Goal	1. Set goals only for self-care activities the team plans to work on. Must be part of the plan.
↓ Enter Codes in Boxes ↓		2. If the performance of an activity was coded 88 during admission assessment, a discharge goal should be coded using six-point scale if patient is expected to perform activity by discharge
		3. A goal can be to maintain the present level if working towards that
□ □	□ □	<b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed
□ □	□ □	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed
□ □	□ □	<b>C. Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed and with no back support
□ □	□ □	<b>D. Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
□ □	□ □	<b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair)
□ □	□ □	<b>F. Toilet transfer:</b> The ability to get on and off a toilet or commode
□ □	□ □	<b>G. Car transfer:</b> The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt
□ □	□ □	<b>I. Walk 10 feet:</b> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space
□ □	□ □	<b>J. Walk 50 feet with two turns:</b> Once standing, the ability to walk at least 50 feet and make two turns
□ □	□ □	<b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space

**Section 5: Functional Abilities at the Start of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**B. Mobility Assessment on Admission** (page 2 of 2)

Code the patient's usual performance at the start of the swing bed stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the swing bed stay (admission), code the reason. Code the patient's end of Swing Bed stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of Swing bed Stay (discharge) goal(s).

**Coding:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

Admission Performance	Discharge Goal	
↓	↓	<b>Enter Codes in Boxes</b>
		<p>1. Set goals only for self-care activities the team plans to work on. Must be part of the plan.</p> <p>2. If the performance of an activity was coded 88 during admission assessment, a discharge goal should be coded using six-point scale if patient is expected to perform activity by discharge</p> <p>3. A goal can be to maintain the present level if working towards that</p>
□ □	□ □	<b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel
□ □	□ □	<b>M. 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
□ □	□ □	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
□ □	□ □	<b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail
□ □	□ □	<b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor
		<p><input type="checkbox"/> <b>P1. Does the patient use a wheelchair and/or scooter?</b></p> <p style="margin-left: 20px;"><b>0. No</b> → Skip rest of questions</p> <p style="margin-left: 20px;"><b>1. Yes</b> → Continue to Wheel 50 feet with two turns</p>
□ □	□ □	<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
		<p><input type="checkbox"/> <b>RR1. Indicate the type of wheelchair or scooter used</b></p> <p style="margin-left: 20px;">1. <b>Manual</b></p> <p style="margin-left: 20px;">2. <b>Motorized</b></p>
□ □	□ □	<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space
		<p><input type="checkbox"/> <b>SS1. Indicate the type of wheelchair or scooter used</b></p> <p style="margin-left: 20px;">1. <b>Manual</b></p> <p style="margin-left: 20px;">2. <b>Motorized</b></p>

**Section 6: Functional Abilities at the end of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**A. Self-care Assessment on Discharge (to be completed the day before or on the discharge day)**

Code the patient's usual performance at the end of the swing bed stay for each activity using the 6-point scale. If activity was not attempted at the end of the swing bed stay, code the reason.

**Coding:**  
**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.  
*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

Discharge Performance	
Enter Codes ↓ in Boxes ↓	
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Eating:</b> The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>B. Oral hygiene:</b> The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>C. Toileting hygiene:</b> The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>E. Shower/bathe self:</b> The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>F. Upper body dressing:</b> The ability to dress and undress above the waist, including fasteners, if applicable
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<b>H. Putting on/taking off footwear:</b> The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable

**Section 6: Functional Abilities at the end of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**B. Mobility Assessment on Discharge - to be completed on day before or on the discharge day (page 1 of 2)**

Code the patient's usual performance at the end of the swing bed stay for each activity using the 6-point scale. If activity was not attempted at the end of the swing bed stay, code the reason.

**Coding:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

Discharge Performance	
Enter Codes ↓ in Boxes ↓	
<input type="text"/> <input type="text"/>	<b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed
<input type="text"/> <input type="text"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed
<input type="text"/> <input type="text"/>	<b>C. Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support
<input type="text"/> <input type="text"/>	<b>D. Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
<input type="text"/> <input type="text"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair)
<input type="text"/> <input type="text"/>	<b>F. Toilet transfer:</b> The ability to get on and off a toilet or commode
<input type="text"/> <input type="text"/>	<b>G. Car transfer:</b> The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt
<input type="text"/> <input type="text"/>	<b>I. Walk 10 feet:</b> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space
<input type="text"/> <input type="text"/>	<b>J. Walk 50 feet with two turns:</b> Once standing, the ability to walk at least 50 feet and make two turns
<input type="text"/> <input type="text"/>	<b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space

**Section 6: Functional Abilities at the end of the Swing Bed Stay (based on MDS v1.17.2 Section GG)**

**B. Mobility Assessment on Discharge - to be completed on day before or on the discharge day (page 1 of 2)**

Code the patient's usual performance at the end of the swing bed stay for each activity using the 6-point scale. If activity was not attempted at the end of the swing bed stay, code the reason.

**Coding:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

**If activity was not attempted, code reason:**

- 07. **Patient refused**
- 09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

<b>Discharge Performance</b>	
<b>Enter Codes</b> ↓ in Boxes ↓	
<input type="text"/>	<b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel
<input type="text"/>	<b>M. 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
<input type="text"/>	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
<input type="text"/>	<b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail
<input type="text"/>	<b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor
<input type="checkbox"/>	<b>Q1. Does the patient use a wheelchair and/or scooter?</b> 0. No → Skip rest of questions 1. Yes → Continue to Wheel 50 feet with two turns
<input type="text"/>	<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
<input type="checkbox"/>	<b>RR1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized
<input type="text"/>	<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space
<input type="checkbox"/>	<b>SS1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized

**Section 7: Discharge Information**

A. Swing Bed Discharge Date					
Month		Day		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	20	<input type="text"/>

**B. Discharge Disposition**

Enter Code <input type="text"/>	<b>01. Home/Community</b> (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)			
	<b>02. Nursing home</b> (long-term care facility)			
	<table border="1"> <tr> <td rowspan="2">Pick One <input type="checkbox"/></td> <td>a. New Stay at a Nursing Home</td> </tr> <tr> <td>b. Returned to a Nursing Home</td> </tr> </table>	Pick One <input type="checkbox"/>	a. New Stay at a Nursing Home	b. Returned to a Nursing Home
	Pick One <input type="checkbox"/>		a. New Stay at a Nursing Home	
		b. Returned to a Nursing Home		
	<b>03. Skilled Nursing Facility (SNF)</b>			
	<table border="1"> <tr> <td rowspan="2">Pick One <input type="checkbox"/></td> <td>a. New Stay at a Skilled Nursing Facility</td> </tr> <tr> <td>b. Returned to a Skilled Nursing Facility</td> </tr> </table>	Pick One <input type="checkbox"/>	a. New Stay at a Skilled Nursing Facility	b. Returned to a Skilled Nursing Facility
	Pick One <input type="checkbox"/>		a. New Stay at a Skilled Nursing Facility	
		b. Returned to a Skilled Nursing Facility		
	<b>04. Short-Term Acute Hospital</b> (CAH or IPPS)			
	<table border="1"> <tr> <td rowspan="2">Pick One <input type="checkbox"/></td> <td>a. Planned Return to Acute Hospital</td> </tr> <tr> <td>b. Unplanned Return to Acute Hospital</td> </tr> </table>	Pick One <input type="checkbox"/>	a. Planned Return to Acute Hospital	b. Unplanned Return to Acute Hospital
Pick One <input type="checkbox"/>	a. Planned Return to Acute Hospital			
	b. Unplanned Return to Acute Hospital			
<b>05. Long Term Care Hospital (LTCH)</b> (free standing hospital or hospital-based unit)				
<b>06. Inpatient Rehabilitation Facility</b> (free standing hospital or hospital-based unit)				
<b>07. Inpatient Psychiatric Facility</b> (psychiatric hospital or unit)				
<b>08. Intermediate Care Facility</b> (ID/DD facility)				
<b>09. Hospice</b> (home or institutional facility)				
<b>10. Home under care of organized home health service organization</b>				
<b>11. Deceased (during swing bed stay)</b>				
<b>99. Not listed (ie, VA, prison)</b>				

**C. Clinical Post-Discharge Follow-up for patients discharged to community including Home with HH or Hospice or ID/DD facility (01, 08, 09, 10)**

	A post-discharge follow-up call was made within 24-72 hrs. (and documented) with patient/family to determine their knowledge of S&Ss to report (if applicable), check on medication reconciliation (all names, dosages and times taken), status of follow-up appointments, HH activated (if applicable), DME delivery (if applicable), issues with transportation, access to medication, assistance at home... (minimum but not necessarily comprehensive list based on the patient and services in the area)
<input type="checkbox"/>	<b>0. No Attempt to Contact Patient/Family</b>
	<b>1. Contact with Patient/Family Attempted 3 times, no Response</b>
	<b>2. Yes, follow-up was completed</b>

C. Post Swing Bed 30-day Discharge Follow-up (Complete only one section unless patient was readmitted to acute and for ED visit). Follow-up for patients discharged to community including Home with HH or Hospice or ID/DD facility (01, 08, 09, 10)	
Enter choice of 00 thru 02, if applicable <input type="text"/> <input type="text"/>	00. No Attempt to Contact Patient/Family
	01. Contact with Patient/Family Attempted 3 times, no Response
	02. Patient Reached but Readmission/ Observation to Another Facility Unknown
Enter choice of 03 thru 06, if applicable <input type="text"/> <input type="text"/>	03. Patient not Readmitted to any Facility
	04. Planned Return to Acute or SB/SNF
	05. Return to Acute (same condition)
	06. Return to Acute (new condition)
Enter choice of 07 or 08, if applicable <input type="text"/> <input type="text"/>	07. Visit to ED/Observation (same condition)
	08. Visit to ED/Observation (new condition)
<input type="text"/> <input type="text"/>	09. Deceased (post discharge)



**Section 8: Other Quality Measures**

A. Did the patient develop a new pressure ulcer/injury during the Swing Bed stay?	
Choose one	
<input type="checkbox"/>	0. No
	1. Yes

B. Fall during the Swing Bed stay		
	Enter Codes in Boxes	
<u>Coding:</u> 0. None 1. One 2. Two or more	<input type="checkbox"/>	<b>A. No injury</b> - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	<input type="checkbox"/>	<b>B. Injury (except major)</b> - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<input type="checkbox"/>	<b>C. Major Injury</b> - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

C. Did the patient develop a nosocomial infection during the Swing Bed stay?	
Choose one	
<input type="checkbox"/>	0. No
	1. Yes

**D. Vaccines****Influenza Vaccine**

Enter Code <input type="checkbox"/>	<b>A. Did the patient receive the influenza vaccine during this Swing Bed stay for this year's influenza vaccination season? →</b> <b>0. No →</b> Skip to C., If influenza vaccine not received, state reason <b>1. Yes →</b> Continue to B, date influenza vaccine received
--	--

	<b>B. Date influenza vaccine received →</b> Complete date and skip to Pneumococcal section Question A <table border="1" style="margin-left: 20px;"> <tr> <th style="width: 15%;">Month</th> <th style="width: 15%;">Day</th> <th style="width: 15%;">Year</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">20</td> </tr> </table>	Month	Day	Year			20
Month	Day	Year					
		20					

Enter Code <input type="checkbox"/>	<b>C. If influenza vaccine not received, state reason:</b> <b>1. Patient was not a Swing Bed patient</b> during this year's influenza vaccination season <b>2. Received outside of this Swing Bed stay</b> (including during acute stay) <b>3. Not eligible</b> - medical contraindication <b>4. Offered and declined</b> <b>5. Not offered</b> <b>6. Inability to obtain influenza vaccine</b> due to a declared shortage <b>9. None of the above</b>
--	---

**Pneumococcal Vaccine**

Enter Code <input type="checkbox"/>	<b>A. Is the patient's Pneumococcal vaccination up to date?</b> <b>0. No →</b> Continue to B, if Pneumococcal vaccine not received, state reason <b>1. Yes →</b> Stop
--	---

Enter Code <input type="checkbox"/>	<b>B. If Pneumococcal vaccine not received, state reason:</b> <b>1. Not eligible</b> - medical contraindication <b>2. Offered and declined</b> <b>5. Not offered</b>
--	---

**E. Medication Reconciliation****Medication Reconciliation on Admission to Swing Bed**

Enter Code <input type="checkbox"/>	<b>At the time of admission to Swing Bed did the staff complete medication reconciliation to include home medications and new medications from previous setting?</b> <b>0. No</b> - Medication reconciliation was not initiated or was incomplete <b>1. Yes</b> - There is documentation of a completed admission medication reconciliation in chart
--	--

**Medication Reconciliation on Discharge from Swing Bed**

Enter Code <input type="checkbox"/>	<b>At the time of discharge from Swing Bed did the staff complete medication reconciliation?</b> <b>0. No</b> - No documentation of reconciled medication list provided to subsequent provider and/or patient/family <b>1. Yes</b> - There is documentation in chart that medication reconciliation was provided to subsequent provider and/or patient/family
--	---