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GAFFEY HEALTHCARE
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Swing Bed Regulatory Requirements Revised Again!




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Nationwide Client Base

GAFFEY HEALTHCARE
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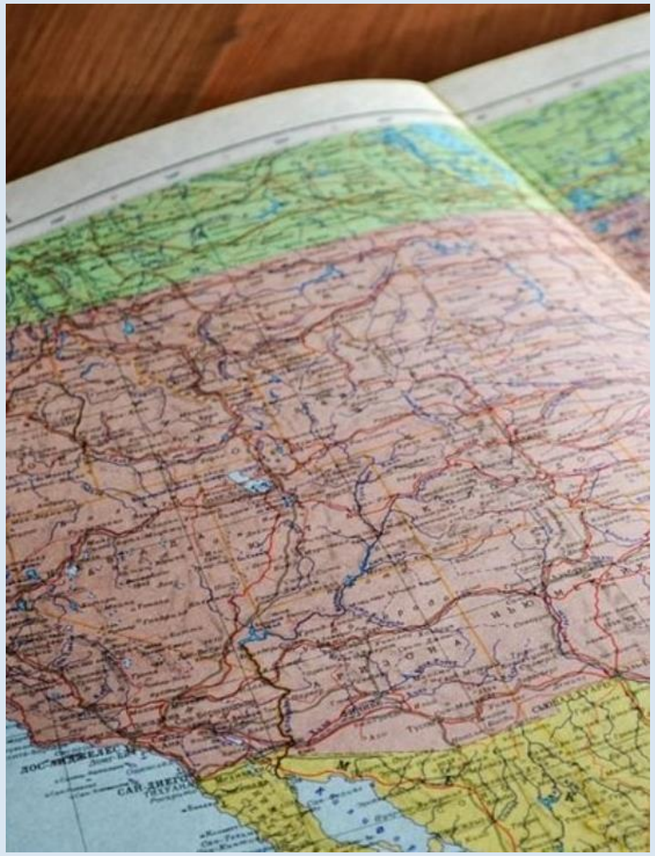

Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and critical access hospitals
- Example managed hospital client includes Barrett Hospital and Healthcare in Dillon, MT. Ranked as a Top 100 Critical Access Hospital for 8 years in a row
- Example technology and AR services client includes two-hospital NFP system in southeast GA with numerous associated physician practices

Preferred vendor to:

- California Critical Access Hospital Network
- Western Healthcare Alliance
- Partner with Illinois Critical Access Hospital Network
- Vizient Group Purchasing Organization

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GAFFEY HEALTHCARE
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Areas of Expertise

Strategy - Solutions - Support

Governance & Strategy

- Executive management & leadership development
- Community health needs assessment
- Lean culture

Finance

- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

Recruitment

- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

INSTRUCTIONS FOR TODAY'S WEBINAR

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all of your questions – but if we don't get to them during the webinar we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

HEALTHTECH S3

www.healthtechs3.com

Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

St.Charles conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn also has extensive experience in working with rural hospitals to both develop and strengthen Swing Bed programs.

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2020 QUARTER 1 WEBINARS

What's New In The 2020: Physician Fee Schedule That May Impact Your Care Coordination Program?
Date: January 23, 2020 **Time:** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/3ayuXER

Swing Bed Regulatory Requirements Revised – Again!
Date: January 24, 2020 **Time:** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Regional Chief Clinical Officer*
https://bit.ly/2Gcw27l

New Discharge Planning Requirements – What You Need To Know
Date: February 7, 2020 **Time:** 12:00 pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Regional Chief Clinical Officer*
https://bit.ly/30LDC2z

Health Promotion Is The Goal Of An Effective Care Coordination Program – Are You Reaching Your Goal?
Date: February 20, 2020 **Time:** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/2RF4RHU

Implementing An Effective Quality Assurance/Performance Improvement Program – A Cheerleader's Guide
Date: March 6, 2020 **Time:** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Regional Chief Clinical Officer*
https://bit.ly/2RkkGol

The Art And Science Of Interim Placement: Speed Dating
Date: March 11, 2020 **Time:** 12pm CST
Presenter: Mike Lieb, *Vice President – Interim Services, HealthTechS3*
https://bit.ly/3avl6Qt

Recruiting A Difference Maker For Your Rural Hospital
Date: March 19, , 2020 **Time:** 12pm CST
Presenter: Peter Goodspeed – *VP of Executive Search, HTS3 Executive Recruiting*
https://bit.ly/37jyyVw

Managing Behavioral Health Patients In Your Primary Care Practice With Collaborative Care Management
Date: March 26, 2020 **Time:** 12pm CST
Presenters: Faith M Jones, *MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/36mmL7j

ALL WEBINARS ARE RECORDED

Swing Bed Regulatory Resources

- State Operations Manual Appendix W – Critical Access Hospitals (Rev. 183, 10-12-18)
- State Operations Manual Appendix A – Hospitals (Rev. 183, 10-12-18)
- State Operations Manual Appendix PP – Long Term Care (Rev. 173, 11-22-17)
- Omnibus Burden Reduction Final Rule CMS – 3346-F
  - https://www.cms.gov/newsroom/fact-sheets/omnibus-burden-reduction-conditions-participation-final-rule-cms-3346-f
  - file:///C:/Users/carol/OneDrive/Documents/Resources/2019-20736%20Federal%20Register.pdf
- Discharge Planning
  - https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences
  - file:///C:/Users/carol/OneDrive/Documents/Resources/2019-20732%20discharge%20planning%20rules.pdf

Swing Bed Changes Summary (from CMS)

1. Removing the requirement for a facility to request or allow swing-bed patients to perform services for the facility

2. Removing the requirement for the facility to provide an ongoing activities program that is directed by a qualified professional because the patient's activity needs are addressed in the nursing care plan

3. Removing the requirement for facilities with more than 120 beds to employ a qualified social worker on a full-time basis because of the hospital swing-bed and CAH bed limit requirements

4. Removing the requirement for facilities to assist residents in obtaining routine and 24-hour emergency dental care because of the existing requirement for hospitals and CAHs to provide care in accordance with the needs of the patient (emergent and non-emergent)

Elimination Of Some Cross References to Appendix PP

Hospitals providing swing-bed services must meet all of the requirements at 42 CFR part 482, which includes the swing-bed requirements at § 482.58 for patients receiving swing-bed services, and CAHs providing swing-bed services must meet all of the requirements at 42 CFR part 485, subpart F, which includes the swing-bed requirements at § 485.645 for patients receiving swing-bed services.

The swing-bed requirements within the hospital and CAH CoPs include a subset of cross-referenced long-term care requirements contained in 42 CFR part 483, subpart B, for which hospital and CAH swing-bed providers are surveyed as they are for all of the CoPs in their respective programs.

We have determined that some of the cross-referenced long-term care requirements for hospitals and CAH swing-bed providers are unnecessary and unduly burdensome, given their focus on “residents” and longer length of stays, which we believe are not relevant to swing-bed patients.

Right to Choose or Refuse to Perform Services

Hospital: Remove cross reference to §483.10(f)(9) at §482.58(b)(1)
CAH: Remove cross-reference to §483.10(f)(9) at §485.645(d)(1)

We are removing the cross-referenced long-term care requirement which gave the resident the right to choose to or refuse to perform services for the facility if they so choose.

We expect hospital and CAH swing-bed providers who do offer patients the option of providing services for the facility to have current policies and procedures that reflect this policy that includes protocol for establish an agreement between the two parties.

Right to Choose or Refuse to Perform Services Action Steps

- ❑ Determine if you will keep the *"right to choose or refuse to perform services"* as a hospital policy
  - Not applicable to most swing bed programs
- ❑ Remove from patient rights – if you choose to eliminate
- ❑ Revise policies – if you choose to eliminate
- ❑ Revise Swing Bed packet- if you choose to eliminate

Activities

Hospital: Remove cross-reference to §483.24(c) at §482.58(b)(4)
CAH: Remove cross-reference to §483.24(c) at §485.645(d)(4)

We are removing the cross-reference requiring the facility to provide an ongoing activity program based on the resident's comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation.

Patient receiving swing-bed series in a hospital or CAH are not long term residents of the facility and generally only receive swing bed services for a brief period of tine for transition after the provision of acute care services.

We expect that for those patients who receive swing-bed services for an extended period of time, their nursing care plan – as required by §482.23(b)(4) for hospitals and §485.635(d)(4) for CAHs – is based on assessing the patient's nursing care needs - and will support care that holistically meets the needs of the patient, taking into consideration physiological and psychosocial factors.

Activities

Comment:
However, one commenter noted that in the event a swing-bed patient receives care for an extended period of time, the nursing care plan will not include interest-based group and individual activities that support the patient's physical, mental and psychosocial well-being. The commenter noted that therapeutic or recreational activities differ significantly from the goals that normally would be identified in a nursing care plan.

Response:
We appreciate the comments received and continue to believe that this change is appropriate. It is expected that hospitals and CAHs, using an interdisciplinary approach, are providing services that meet the needs of all of their patients, including those receiving swing-bed services, regardless of their length of stay.

In addition, nursing care plans are intended to provide direction on the type of nursing care the needed by the patient, stemming from the patient's diagnoses, that is organized based on the specific needs of the patient.

The care plan is dynamic and should change as the needs of the patient change. As a result, if the needs of the patient include interest-based group and individual activities that support the patient's physical, mental and psychosocial well-being, we expect that the hospital or CAH will provide these services to the patient.

Activities
Questions

1. Will you continue to complete an activities assessment and plan for ALL patients? **Why or Why Not?**
2. If YES – who will be responsible? Will it change from who is doing it now?
3. How will you define “extended” period of time?
4. Does the current nursing assessment and care plan includes psychosocial assessment?
5. How will you ensure that patient’s psychosocial needs are met?

Activities
Action Steps

- ❑ Determine your approach and process
- ❑ Revise activities policy
- ❑ Revise Swing Bed admission information for patients (usually includes information about activities)
- ❑ Add psychosocial assessment to nursing assessment and care plan (if not in place)
- ❑ Provide education for interdisciplinary team

Social Work

Hospital: Remove §482.58(b)(5)
CAH: Remove §485.645(d)(5)

Removing the requirement for facilities with more than 120 beds to employ a qualified social worker on a full-time basis Final Rule Action: We are finalizing this proposed change without revision. §§482.58(b)(5) and 485.645(d)(5) (incorporating long-term care facility requirements at §483.70(p)): Any facility with more than 120 beds must employ a qualified social worker on a full-time basis.

In accordance with the hospital and CAH swing-bed requirements, hospital swing-bed providers are not permitted to have more than 100 beds while CAH swing-bed providers are not permitted to have more than 25 beds for the provision of inpatient or swing-bed services.

Based on feedback from stakeholders, removing this requirement would eliminate confusion for providers and accreditation organizations.

Dental Care

Hospital: Remove cross-reference to §483.55(a)(1) at §482.58(b)(8)
CAH: Remove cross-reference to §483.55(a)(1) at §485.645(d)(7)

Under our long-term care facility requirements, the facility, must provide routine and emergency dental services to meet the needs of each resident, or obtain them from an outside resource, in accordance with §483.70(g).

Hospitals and CAHs are required to provide care in accordance with the needs of the patient that have been identified in such patients' plans of care; this could include non-emergency dental care.

We expect that hospital swing-bed providers are currently addressing the emergent dental care needs of their patients under the existing hospital CoP at §482.12(f)(2), which requires that hospitals have written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

Similarly, we expect that CAH swing-bed providers are currently addressing the emergent dental care needs of their patients under the existing emergency services CoP at §485.618, which requires CAHs to provide emergency care necessary to meet the needs of its inpatients and outpatients.

As a result, we believe that this portion of the requirement is duplicative, given the current CoP requirements.

Dental Care
Action Steps

- ❑ Determine if your policy for dental care needs to be revised – or incorporate in another policy
- ❑ Revise Swing Bed packet (if needed)
- ❑ Provide education for the interdisciplinary team

You must still provide emergent dental care if needed

CMS Summary - Discharge Planning

1. New discharge planning requirements, as mandated by the IMPACT act for hospitals, HHAs, and CAHs, that requires facilities to assist patients, their families, or the patient's representative in selecting a post-acute care (PAC) services provider or supplier by using and sharing PAC data on quality measures and resource use measures. This data must be relevant and applicable to the patient's goals of care and treatment preferences.

2. New discharge planning process requirements for CAHs and HHAs (such requirements did not exist before). Revised language that now requires a hospital (or CAH) to discharge the patient, and also transfer or refer the patient where applicable, along with his or her necessary medical information (current course of illness and treatment, post-discharge goals of care, and treatment preferences), at the time of discharge, to not only the appropriate post-acute care service providers and suppliers, facilities, agencies, <u>but also to other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.</u>

3. New requirement that sends necessary medical information to the <u>receiving facility or appropriate PAC provider (including the practitioner responsible for the patient's follow-up care)</u> after a patient is discharged from the hospital or transferred to another PAC provider or, for HHAs, another HHA.

4. Hospitals must ensure and support patients' rights to access their medical records in the form and format requested by the patient, if it is readily producible in such form and format (*including in an electronic form or format when such medical records are maintained electronically*).

Discharge Planning – Post Acute Care (PAC) Quality Measures

§485.43(c)(8) – New - Hospitals
§484.642(c)(8) – New - CAHs

New discharge planning requirements, as mandated by the IMPACT act for hospitals, HHAs, and CAHs, that requires facilities to assist patients, their families, or the patient's representative in selecting a **post-acute care (PAC) services provider or supplier by using and sharing PAC data on quality measures and resource use measures**.

This data must be relevant and applicable to the patient's goals of care and treatment preferences.

We would also expect the hospital – CAH – HHA - to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process.

We believe that providers have the ability and knowledge to interpret and discuss the publicly available data on quality and resource use measures at the most basic levels. We note that we do not expect providers to give overly detailed and complex analyses of the quality and resource use data, which may only service to confuse patients and/or their caregivers, nor do we expect providers to attempt to provide patients and their caregivers with data that do not exist regarding PAC facilities. We expect providers to put forth their best effort to answer patient questions regarding the data.

Implementation Date – 60 days after date of publication of final rule. (60 days from September 30)

Discharge Planning – PAC Quality Measures

Comment:
One commenter stated that the requirement to utilize data on quality measures and data on resource use measures could be utilized to discourage the use of CAH swing beds in rural communities. Since the CAH swing bed program does not have to report data on its performance, referring facilities will list CAH Swing Bed on their referral list delivered to patients, but would have no data to include on the list. The commenter suggested that we require referring facilities to note on their discharge provider list that CAH swing beds are not required to report data similar to freestanding SNFs.

Response:
The CAH's responsibility is to advise and assist patients with their choices based on quality data and the patient's goals of care and treatment preferences. As such, we do not believe that any provider will be disadvantaged with this requirement.

PAC Quality Measures

Welcome to the Post-Acute Quality Initiatives Home Page
Updates:
August 13, 2018
We have updated the webpages for the IMPACT Act with up-to-date information pertaining to quality measures and activities associated with data standardization as required under the IMPACT Act of 2014. For upcoming stakeholder engagement opportunities and general announcements, refer to the **IMPACT Act of 2014 Spotlight Announcements & Opportunities for**

Stakeholder Engagement pages.
Please submit questions to: **PACQualityInitiative@cms.hhs.gov**

General Information:
This webpage is intended to provide information pertaining to the Centers for Medicare & Medicaid Services (CMS)-related quality improvement initiatives. This site will serve as a general information platform for information for all stakeholders, including the public.

About CMS' Quality Initiatives:
Quality health care for people with Medicare is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). HHS and CMS began launching quality initiatives in 2001 to assure quality health care for all Americans through accountability and public reporting. Various quality initiatives touch every aspect of the healthcare system. Some initiatives focus on publicly reporting quality measures for settings such as nursing homes, home health agencies and dialysis facilities. Consumers can use the quality measures information that is available on **www.medicare.gov** for these healthcare settings to assist them in making healthcare choices or decisions.
As CMS moves forward with its strategies to facilitate quality measurement and quality improvement across multiple settings, this site will serve as a guide for post-acute care measurement development-related information.

About Reports and Links:
We intend to provide reports on this site that we hope will serve as an opportunity to educate and inform the public about work related to various quality initiatives. The bottom section of the page will provide these reports as downloads. In addition, we will provide links to other websites for additional information related to quality initiatives. Please know that although this site may not be able to serve as an exhaustive resource, we are looking forward to providing information related to quality initiatives that may span several settings so that you are able to find materials in one location. As materials are added related to our various, quality initiatives, CMS expects that sub-pages will be added to this webpage.
We encourage readers to browse the page, including downloads and links, frequently for materials and information, as well as web page enhancements and updates.

PAC Quality Measures

Nursing Home Compare
https://www.medicare.gov/nursinghomecompare/search.html

Hospital Compare
https://www.medicare.gov/hospitalcompare/search.html

Inpatient Rehab
https://www.medicare.gov/inpatientrehabilitationfacilitycompare

Home Health Compare (SNF)
https://www.medicare.gov/homehealthcompare/search.html

Long Term Care Hospital
https://www.medicare.gov/longtermcarehospitalcompare

PAC Quality Measures

Nursing Home Results
44 nursing homes within 50 miles from the center of 98502

Name	Overall Rating	Health Inspections	Staffing	Quality Measures	Distance
Puget Sound Healthcare Center					
Regency Olympia Rehabilitation and Nursing Center					
Providence Mother Joseph Care					

Discharge Planning – PAC Quality Measures Action Steps

- ❑ Develop a list of “referral” PACs (including your hospital --- swing bed)
- ❑ Access Quality Data from CMS web site
- ❑ Develop template information for patients with both choice of facilities and corresponding PAC data
  - Decide how you are going to provide PAC data on your swing bed program
- ❑ Develop documentation templates to include verification that information was provided to the patient --- and their choice of PAC
- ❑ Identify who is responsible in your organization for compiling and providing data to patients
- ❑ Educate staff and providers on new process
- ❑ Audit for compliance
- ❑ Identify frequency that data is updated for each PAC on CMS web site – and ensure the data you are providing patients is the most “current”

Discharge Planning – Necessary Medical Information

§485.43(b) – Hospitals
§484.642(b) – CAHs

Discharge and transfer of the patient and provision and transmission of the patient's necessary medical information'' for each section. The final standards at §§482.43(b) and 485.642(b) incorporate and combine revised provisions from the proposed requirements at §482.43(c), (d), and (e) for hospitals and §485.642(c), (d), and (e) for CAHs, respectively.

Sections 482.43(b) and 485.642(b) state that the hospital (or CAH) must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post- discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

Discharge Planning – Necessary Medical Information

Comment:
One commenter requested that CMS create an exception for real time discharge summaries for transfers from acute care to SNF facilities. The commenter noted that while it is essential to know a patient's medical and treatment history, the discharge summary requirement does not make sense if information is being sent when the transfer is from the ''doctor to him or herself'' and from the ''nurse to the same nurse.'' The commenter further pointed out that this may be an issue in rural communities, where the practitioners are the same on either side of the transfer.

Response:
We understand the commenter's concerns about a repetitive or time consuming process for rural or small hospitals or CAHs, particularly when the services being provided to the patient changes from acute inpatient to swing bed. We note that the discharge planning process does apply to patients whose status changes from acute inpatient to swing bed services.

Discharge Planning – Medical Information Action Steps

- ❑ Review current processes – and determine what needs to be changed
- ❑ Develop policies
- ❑ Develop template (checklist) to ensure all information is provided to PAC and other providers of care including physicians who will provide follow-up care
- ❑ Educate staff and providers
- ❑ Audit for compliance

SWING BED
Brief Overview of October 2018 Changes

1. Choice of Physician - **Clarification**
2. Timelines for Reporting Abuse - **New**
3. PASARR – **Clarification**
4. Culturally-Competent and Trauma Informed Care – **New**
5. Plan of Care – **Additional language** and **Clarification**
6. Dental Care – **Clarification** of Timelines – **NO LONGER APPLICABLE WITH 2019 CHANGES**
7. Transfer & Discharge Information – **Additional Language - New**
8. Notification of Ombudsman Notification - **New**

Choice of Personal Physician

CAH: C-0364 §483.10(d) Free Choice The resident has the right to-(1) Choose a personal attending MD/DO
Hospital: A-1511 §483.10(d) Free Choice The resident has the right to-(1) Choose a personal attending physician

The right of a LTC resident to choose his or her own attending physician is a long standing patient right, which was established at section 1819(c)(1)(A)(i) of the Act by section 4201 of the Omnibus Budget Reconciliation Act of 1987 and at section 1919(c)(1)(A)(i) by section 4211 of the Omnibus Budget Reconciliation Act of 1987. We included the right to choose a physician in this rulemaking in order to support the statutory requirement, and remind stakeholders that it is not a new requirement and therefore should add no new regulatory burden.
Federal Register /Vol. 81, No. 192 /Tuesday, October 4, 2016 /Rules and Regulations

Abuse

CAH: C-0381 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) 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.

(2) Have evidence that all alleged violations are thoroughly investigated.

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

(4) Report the results of all investigations to the administrator or his or her 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.

PASARR

A PASARR is not required – but you must incorporate it in the plan of care if the patient has a PASRR that has previously been completed

CAH: C-0388 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)
§483.21(b) Comprehensive care plans.
(1)(i): Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
*NOTE: The CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Also, note that CAHs are not required to complete the PASARR. However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.

Hospital: A-1572 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)
§482.58(b)(6) Discharge planning (§483.20(e)
§483.20(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part 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.
(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 status assessment.

Trauma Informed Care

C-0388 §485.645(d)(6)
(3) The services provided or arranged by the facility, as outlined by the
iii. Be culturally-competent and trauma-informed

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

http://traumainformedcareproject.org/index.php

Trauma Informed Care

1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?

2. Have you experienced the loss of a close friend, relative or a pet that you loved recently?

3. Have you had any past trauma in your life that we should know about so we can better care for you?

4. If you have experienced some kind of trauma is there something that helps you feel better?

5. Is there anything we can do to help while you are in the hospital?

MY QUESTIONS – NOT FROM CMS

DON'T PROBE – NO IS NO

Comprehensive Care Plan – Interdisciplinary Team

(2) A comprehensive care plan must be—

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

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

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Timelines must be congruent with your Length of Stay.

For example: IDT meeting within 48 – 72 hours of admission to develop comprehensive plan of care.

Comprehensive Care Plan

C-0388 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a **comprehensive person-centered care pla**n for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

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

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

(i) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(ii) In consultation with the resident and the resident's representative(s)—

The resident's goals for admission and desired outcomes.

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

(B) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Discharge

C-0388 §483.21(c)(2):

When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(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 paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

(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-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.

Ombudsman

CAH: §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language 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.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii)Include in the notice the items described in paragraph (c)(5) of this section

Hospital: §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language 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.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

THANK YOU

I hope this information has been helpful

Please contact me if you would like to schedule a review of your Swing Bed Program or have questions about the presentation

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