HealthTech

SWING BED
An Important Resource for Critical Access Hospitals
Part 2

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Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

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Description

Swing Bed continues to be a critical program and revenue source for Critical Access Hospitals. However, because the Swing Bed regulatory requirements are different than those for acute care, it continues to be an area of confusion.

Part 2 of the Swing Bed series will focus on additional Swing Bed requirements, including culturally-competent trauma-informed care, recognizing and reporting abuse, the importance of an activities program, staff education, and the importance of quality metrics. The presentation will also review Swing Bed policies and procedures and other clinical policies that apply to Swing beds.

Learning Objectives

Upon completion of the webinar, the participant will be able to:

1. Describe culturally-competent trauma-informed care and strategies for implementation
2. Discuss requirements for recognizing and reporting abuse.
3. Identify the importance of outcome and process measures and how to collect data
4. Discuss how to implement an activities program
5. List required Swing Bed P&Ps and the approval process

Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing

Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

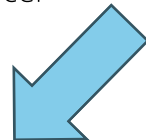
Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: February 13, 2026 | Time: 12pm CST
URL: https://bit.ly/4r6lvOt

Compassion fatigue – Building resilience

Presenter: Brian Merry, M.Ed., CEMSO, NRP - Director of EMS
Date: March 6, 2026 | Time: 12pm CST
URL: https://bit.ly/49KJOvp

Swing Beds: An important resource for CAH - Part 1

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 3, 2026 | Time: 12pm CST
URL: https://bit.ly/4qwYF3R



Swing Beds: An important resource for CAH - Part 2

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 17, 2026 | Time: 12pm CST
URL: https://bit.ly/45Pyq08

Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | Time: 12pm CST
URL: https://bit.ly/3Nx2nMa

Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | Time: 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | Time: 12pm CST
URL: https://bit.ly/3NtJUA9

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Swing Bed Resources ..REMINDER..

CMS Resources - Swing Bed

MLN Fact Sheet
Swing Bed Resources
MLN006951 May 2025
https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

TEAM (Transforming Episode Accountability Model)
https://www.cms.gov/priorities/innovation/innovation-models/team-model

Swing Bed Providers
https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/swing-bed-providers

CMS Resources - Manuals

Medicare Claims Processing Manual
Chapter 3: Inpatient Hospital Billing
8/14/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

Medicare Claims Processing Manual
Chapter 4: Part B Hospital (Including Inpatient Hospital Part B and OPPS)
11/22/2024
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

Medicare Claims Processing Manual
Chapter 6: SNF Inpatient Part A Billing and SNF Consolidated Billing
2/21/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

Medicare Benefit Policy Manual
Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance
10/5/2023
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

CMS Resources - Manuals, cont.

Medicare Benefit Policy Manual Chapter 10: Ambulance Services
11/26/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c10.pdf

Medicare Claims Processing Manual Chapter 30: Financial Liability Protections
10/31/2024
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

Other Resources

The Swing Bed Program: Impacting Patients, Providers, and Community
https://youtu.be/74ZeMBvcdnQ

RHIhub Understanding the Rural Swing Bed: More than Just a Reimbursement Policy - The Rural Monitor
https://www.ruralhealthinfo.org/rural-monitor/swing-beds/

Post-Acute Care in Rural Areas: The Role of *Swing Beds and Nursing Homes*
Rural Health Research Gateway
https://www.ruralhealthresearch.org/assets/5641-26183/post-acute-care-swing-bed-recap.pdf

Colorado Swing Bed Manual (2025)
Cost for non-members
https://coruralhealth.org/product/2025-cah-swing-bed-manual

ICAHN Swing Bed Manual (2025)
Not on web site yet
https://icahn.org/

Critical Access Hospital (CAH) Swing Bed Comprehensive Management Training: From Soup-To-Nuts – Idaho (2024)
Very comprehensive
https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=29067&dbid=0&repo=PUBLIC-DOCUMENTS

Montana Swing Bed Manual (2022)
Some references not current – but still good information
https://mtpin.org/education-meetings/education/swing-bed-resources/

Culturally Competent Trauma Informed Care

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Culturally - Competent Care

Culturally-Competent Care

§483.21(b)

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(iii) **Be culturally-competent and trauma-informed.**

Cultural Competence
The ability to interact with others in a way that shows you understand and respect their culture, values, and beliefs

Culturally Competent Provider
Possessing a level of knowledge-based skills in order to provide effective clinical care and improved quality of care for our members, while respecting their cultures, values, and beliefs

Provider Cultural Competency Plan Toolkit
https://www.alliancehealthplan.org/document-library/Provider-Cultural-Competency-Plan-Toolkit-Final-2024.pdf

National Culturally and Linguistically Appropriate Services (CLAS) Standards

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are **responsive** to

diverse cultural health beliefs and practices,

preferred languages,

health literacy,

and other communication needs.

HHS.gov National CLAS Standards
https://thinkculturalhealth.hhs.gov/clas/standards

National Culturally and Linguistically Appropriate Services (CLAS) Standards

There are also standards related to:

1) Governance, Leadership & Workforce
2) Communication & Language Assistance
3) Engagement, Continuous Improvement & Accountability

HHS.gov National CLAS Standards
https://thinkculturalhealth.hhs.gov/clas/standards

Applying Culturally Competency Standards to Swing Bed

Conduct an assessment of cultural competency based on the CLAS standards
Include staff – leaders – providers - volunteers

Based on the survey --- identify improvement opportunities

Applying Culturally Competency Standards to Swing Bed

Learn as much as you can about the populations you serve that will impact the delivery of healthcare services and promote optimal outcomes

!!!! Don’t Assume !!!!

Just because I am______________________

Doesn’t mean I have the same cultural beliefs, religious practices, etc. as other __________

Applying Culturally Competency Standards to Swing Bed

Provide culturally competency training for **all** staff – leaders – providers – volunteers

Include culturally competency in job descriptions and performance evaluations

Appling Culturally Competency Standards to Swing Bed

Include questions as part of the initial nursing / social work / case management assessment to identify:

- Cultural practices
- Health beliefs and practices
- Preferred language
- Health literacy
- Other communication needs

Incorporate culturally competent care in the plan of care – and communicate with all care givers including providers

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Trauma-Informed Care

Trauma Informed Care

§483.21(b)
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(iii) **Be culturally-competent and trauma-informed.**

Becoming "trauma-informed" means recognizing that people often have many different types of trauma in their lives.

Provider Cultural Competency Plan Toolkit
https://www.alliancehealthplan.org/document-library/Provider-Cultural-Competency-Plan-Toolkit-Final-2024.pdf

Trauma-Informed Care

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

"Trauma." SAMHSA-HRSA Center for Integrated Health Solutions. Substance Abuse and Mental Health Services Administration. 30 Nov 2016. Accessed at: https://www.samhsa.gov/resource/dbhis/samhsas-concept-trauma-guidance-traumainformed-approach.

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

Adapted from Concept of Trauma and Guidance for a Trauma-Informed Approach: https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma-Informed Care Strategies

- **Engage patients in the treatment process**. Involve patients in decision-making and the development of their care plan, rather than dictating the course of action.
- **Screen for trauma**. Determine the best screening tools and methods to use based on the health care setting and patient population.
- **Train staff in trauma-specific treatment approaches**. Identify and train staff using an evidence-based model that best meets the needs of your organization's care model and population served.
- **Engage referral sources and partner organizations**. Work with community partners and within a system of care to develop a robust trauma-informed referral network

Advancing Trauma-Informed Care - Center for Health Care Strategies
www.chcs.org/project/advancing-trauma-informed-care

Potential Sources of Trauma

- Veterans
- Survivors of natural & human-caused disasters
- Holocaust survivors
- Survivors of abuse
- Any experience that threatened death or physical harm
- **Generational trauma**
- Serious illness
- Forced displacement
- Loss of spouse or family member
- Loss of Home
- Loss of Independence
- **History of witnessing any of these types of events**

Generational Trauma

Generational trauma is trauma that extends from one generation to the next.

Generational trauma can be passed down through families by biological, environmental, psychological, and social means.

Assess Trauma at Admission (Social Work, Care Manager, Nurse, Provider)

- ❑ Has there been anything within the last six months to a year that has caused you to be upset or very worried?
- ❑ Have you experienced the loss of a close friend, relative or a pet that you loved recently?
- ❑ Have you had any past trauma in your life that we should know about so we can better care for you?
- ❑ If you have experienced some kind of trauma is there something that helps you feel better?
- ❑ Is there anything we can do to help while you are in the hospital?

Implement Strategies to Prevent Re-Traumatization

- Provide Choice (time to get up, time to go to bed, meal times)
- Patient Voice: Listen to the patient and establish mutual goals
- Family / Friends support
- Mitigate specific triggers
  - Loud noises
  - Male nurses (or female)
  - War movies
  - Holocaust Survivors
    - Water
    - Medical uniforms
    - Loud noises
    - Restriction of food, clothing

Identify strategies specific to the type of trauma and patient input to mitigate triggers

Goal

YOUR GOAL IS TO IDENTIFY TRAUMA AND TO PREVENT RE-TRAUMATIZATION

YOU ARE NOT PROVIDING COUNSELING / THERAPY

Abuse, Neglect, Exploitation, and Misappropriation of Property

Definition - Abuse

§485.645(d)(3) -- §483.5

Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

Definition - Neglect

§485.645(d)(3) -- §483.5

Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.

Examples of individual failures include, but are not limited, to the following: Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;

Definitions – Sexual Abuse, Willful, Exploitation, Misappropriation of Property

§485.645(d)(3) -- §483.5

Sexual abuse: non-consensual sexual contact of any type with a resident.

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

Exploitation: taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.

Misappropriation of resident property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

Freedom from Abuse and Restraints

§485.645(d)(3) -- §483.12(a) 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.

Restraints

§485.614(e)(1-4) -- §483.10(e)(1)

The regulation limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints.

There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint [See §483.12(a)(2)].

However, the practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint.

MORE ABOUT RESTRAINTS

Your hospital policies for restraints also apply to Swing Bed. However, Appendix PP has a broader definition of restraints

§483.12(a)(2) Guidance

Examples of facility practices that meet the definition of a physical restraint include, but are not limited to:

- Placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed
- Placing a resident on a concave mattress so that the resident cannot independently get out of bed
- Tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted
- Placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently
- Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising
- Applying leg or arm restraints, hand mitts, soft ties or vests that the resident cannot remove
- Holding down a resident in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care
- Placing a resident in an enclosed framed wheeled walker, in which the resident cannot open the front gate or if the device has been altered to prevent the resident from exiting the device
- Using a position change alarm to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm

Background Checks and Reporting

§485.645(d)(3) -- §483.12(a) The facility must:

(3) Not employ or otherwise engage individuals who

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

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

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

Note: This includes employees in all departments as well as contract staff, providers and volunteers

Policies and Procedures

§485.645(d)(3) -- §483.12(b)

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 policies and procedures to investigate any such allegations

Note: This is not the same type of policy used for general in the emergency department or other hospital departments

All staff should have education on the policy and reporting procedures at least annually

Investigation and Reporting

§485.645(d)(3) -- §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.

Investigation and Reporting

§485.645(d)(3) -- §483.12(c)

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

(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.

Activities

Activities

There is no requirement CAH Swing Bed CoPs
However ---- some states still have requirements for formal activities program

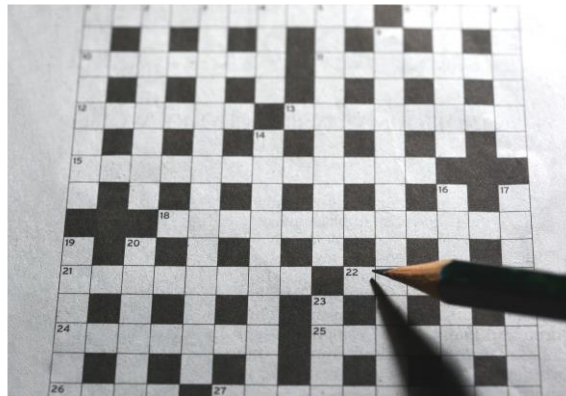
Federal; Register:
CAH: Remove cross-reference to §483.24(c) at §485.645(d)(4)
We are removing the cross-reference requiring the facility to provide an ongoing activity program based on the resident's comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation.

Patients 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 time 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 Intent & Definitions

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



Activities Intent & Definitions

Intent §483.24(c)
To ensure that facilities implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a **resident's physical, mental, and psychosocial well-being and independence**. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

Definition §483.24(c)
Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is **intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health**. **These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence**

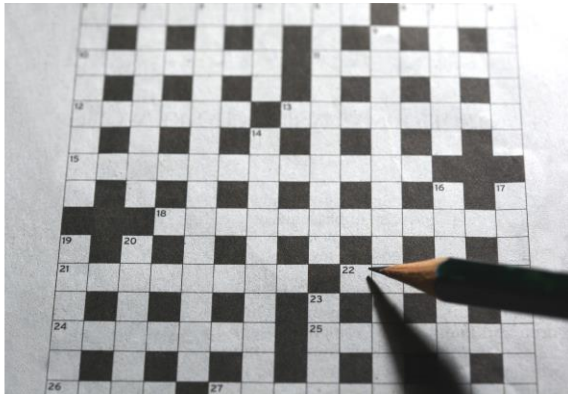
What To Do????

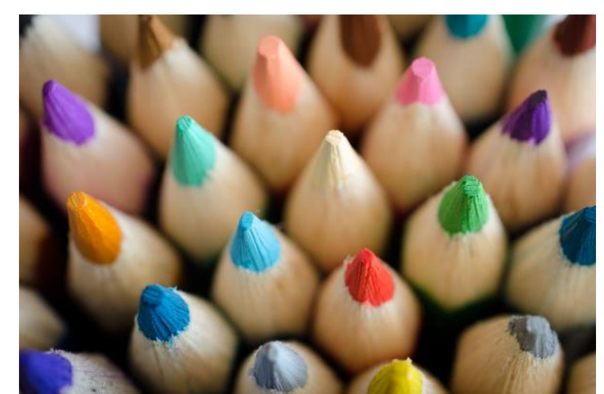
1. Swing Bed Rural Hospital (**not CAH**) ---- must provide activities per regulation

2. CAH Swing Bed

- Identify **WHO** will complete activities assessment
- Identify **WHO** will complete the activities plan
- Identify **WHO** will provide and document activities

Strongly recommend activities are offered to ALL Swing Bed patients



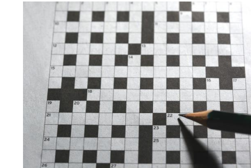


Activities Plan

Patient will remain active to the extent appropriate for physical abilities and cognition. Patient will participate in an activity at least twice (2) per day.

Staff will provide

- Word search and puzzles daily
- Visit/Reminisce with patient at least twice daily
- Invite the patient to activities in LTC
- Walk the patient outside at least once per day (weather permitting)
- Books on Tape



Passive

Patient is interested in her own activities and doesn't need staff to provide activities. Patient likes:

- Kindle Books
- Crochet
- Knitting
- Visiting with family

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Quality Assurance Performance Improvement

Swing Bed Performance Measures

There are no publicly available performance measures for Swing Bed

So, We Have to Build Our Own

Swing Bed Performance Measures
Rural Health Research Center

1. **Discharge disposition** (e.g., number of swing-bed patients discharged home and to other settings; percent of swing-bed patients going back to same level of assistance as prior to stay; number of discharges to home or long-term care facility)

2. **Average length of stay** (e.g., average number of days for swing-bed stay, average length of stay compared to goal)

3. **Readmission** (e.g., number of swing-bed discharges readmitted to the CAH for acute care within 30 days; number of readmissions back to swing-bed; combined CAH acute care readmission rate for acute and swing-bed discharges

Measuring Swing Bed Quality
Ira Moscovice, PhD University of Minnesota Rural Health Research Center
https://www.ruralcenter.org/sites/default/files/FMTRSV071318.pdf

Swing Bed Performance Measures Rural Health Research Center

4. **Functional status** (e.g., admission and discharge scores on Barthel Index, Functional Independence Measure, or MDS Section GG; various physical therapy and occupational therapy tests to measure walking, gait and balance, sit to stand, and cognitive performance)

5. **Process of care/teamwork** (e.g., frequency of team rounds to patient bedside to discuss goals, updating of communication board in patient room, etc.)

6. **Patient Experience of Care/Patient Satisfaction** (e.g., HCAHPS survey for discharged swing-bed patients and inpatients combined, consultant-developed survey for discharged swing-bed patients, food satisfaction card with meals, post-discharge follow-up phone calls)

7. **Additional measures (e.g., falls, skin integrity, infections)**

Measuring Swing Bed Quality
Ira Moscovice, PhD University of Minnesota Rural Health Research Center
https://www.ruralcenter.org/sites/default/files/FMTRSV071318.pdf

Swing Bed Performance Measures Stroudwater

1. **Return to Acute Care from Swing Bed (Unplanned)**

This measure scores the percentage of the hospital's swing bed patients who were re-hospitalized after a swing bed admission

2. **Return to Acute Post 30-day Discharge**

This measure scores the percentage of swing bed patients who were readmitted to the hospital's acute unit within 30 days from the swing bed discharge date

3. **Risk-Adjusted Performance Improvement in Mobility**

This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in mobility based on 17 measured activities

4. **Risk-Adjusted Performance Improvement in Self-Care**

This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in self-care based on 7 measured activities

5. **Discharge to Community**

This measure scores the percentage of the hospital's swing bed patients who were discharged to home/community

Critical Access Hospital Swing Bed Programs Outperform Skilled Nursing Facilities on Quality Performance
https://www.stroudwater.com/critical-access-hospital-swing-bed-programs-outperform-skilled-nursing-facilities-on-quality-performance-according-to-new-report-by-stroudwater-associates/

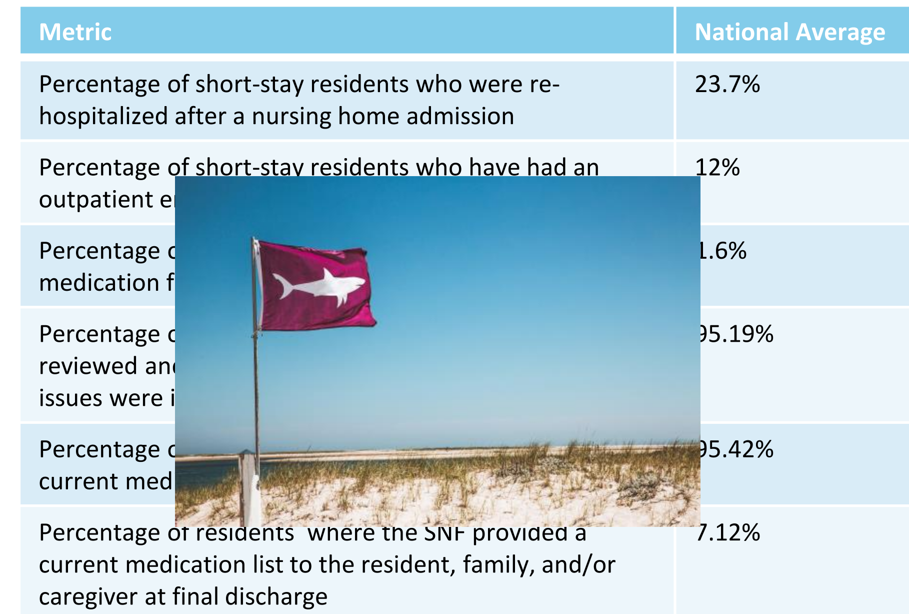
Skilled Nursing Facilities Quality Reporting (Short Length of Stay)

IMPORTANT

1) Nursing Home Compare includes multiple measures but they are updated quarterly. Data is current as of 1/2026.

2) Benchmarks are for “large” populations and should not be used for low volume Swing Bed

3) Targets need to be set internally and usually a number – not rate based



Metric	National Average
Percentage of short-stay residents who were re-hospitalized after a nursing home admission	23.7%
Percentage of short-stay residents who have had an outpatient e	12%
Percentage c medication f	1.6%
Percentage c reviewed and issues were i	95.19%
Percentage c current med	95.42%
Percentage of residents where the SNF provided a current medication list to the resident, family, and/or caregiver at final discharge	7.12%

Skilled Nursing Facilities Quality Reporting

Metrics	National Average
1. Percentage of short-stay residents who were re-hospitalized after a nursing home admission	23.9%
2. Percentage of short-stay residents who have had an outpatient emergency department visit	12%
3. Percentage of short-stay residents who got antipsychotic medication for the first time	1.6%
4. Percentage of residents whose medications were reviewed and who received follow-up care when medication issues were identified	95.27%
5. Percentage of residents where the SNF provided a current medication list to the next health care setting	95.95%
6. Percentage of residents where the SNF provided a current medication list to the resident, family, and/or caregiver at final discharge	96.28%

Current as of 3/2026
https://www.medicare.gov/care-compare/?providerType=NursingHome

Skilled Nursing Facilities Quality Reporting

Metrics	National Average
7. Percentage of short-stay residents who needed and got a flu shot for the current flu season	79.74%
8. Percentage of health care personnel who got a flu shot for the current season	42.0%
9. Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia	81.68%
10. Percentage of residents with pressure ulcers/pressure injuries that are new or worsened	2.29%
11. Percentage of residents who are at or above an expected ability to care for themselves and move around at discharge	57.35%

Current as of 3/2026
https://www.medicare.gov/care-compare/?providerType=NursingHome

Skilled Nursing Facilities Quality Reporting

Metrics	National Average
12. Percentage of SNF residents who experience one or more falls with major injury during their SNF stay	0.48%
13. Percentage of residents who are at or above an expected ability to care for themselves at discharge	50.94%
14. Percentage of residents who are up to date with their Covid-19 vaccines	25.2%
15. Percentage of SNF health care personnel who are up to date with their COVID-19 vaccines	8.2%
16. Rate of successful return to home or community from a SNF	50.57%
17. Rate of potentially preventable hospital readmission 30 days after discharge from a SNF	10.72%
18. Percentage of infections residents got during their SNF stay that resulted in hospitalization	7.12%

Current as of 3/2026
https://www.medicare.gov/care-compare/?providerType=NursingHome

Recommended Utilization and Quality Measures

Utilization Measures

1. Discharges
2. Swing Bed days
3. Average length of stay
4. Average daily census

Quality Measures

1. Discharge to prior place of residence
2. Return to acute care or emergency department (unplanned)
3. Return to acute care within 30-days of discharge
4. Risk-adjusted performance Improvement in mobility (if able to measure)
5. Risk-adjusted performance improvement in self-care (if able to measure)

Recommended Process & Other Measures

- Referrals
- Source of referrals
- Time from referral to accept / decline
- Referrals not accepted by reason
- Attendance at multi-disciplinary meetings
- Chart Audits – documentation compliance

Choose data that is easy to collect

Collect both process and outcome measures

Choose data that is important to your program goals

Revisit metrics periodically

HealthTech

Improvement

Goals Must Be Specific - and - Measurable - and - Time-Limited

Swing Bed Program ADC will increase from 4 to 6 patients within the next 12 months

We will start admitting patients with complex wound care needs within 3 months

Goals Must Be Achievable

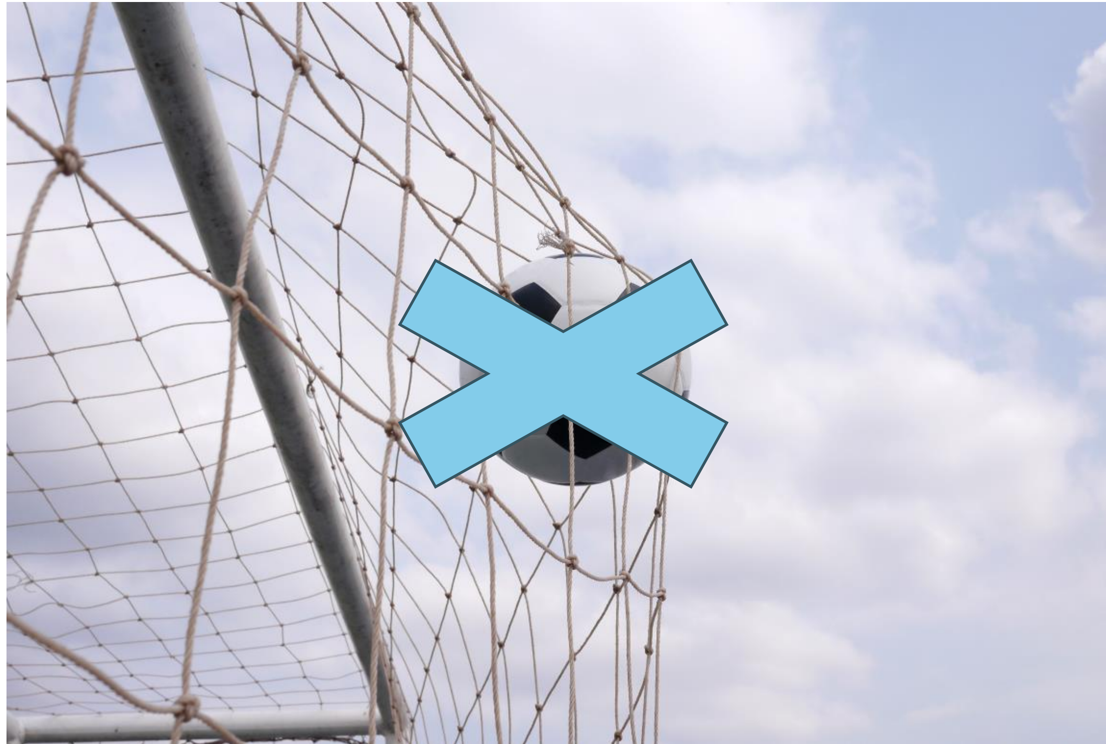
Swing Bed Program ADC will increase from **4 to 15** patients within the next **6 months**

We will start admitting patients with complex wounds starting tomorrow

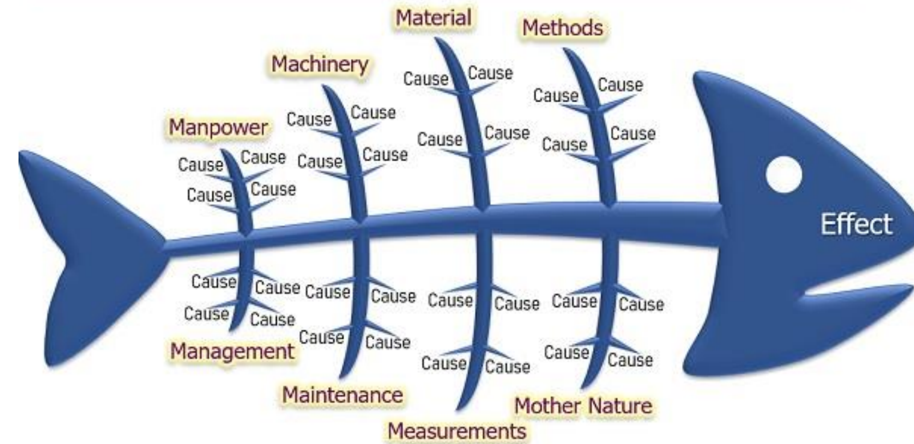
Goals Must Have an Action Plan

Goal: Begin Admitting Patients with Complex Wounds within 3 months			
WHAT	**WHO**	**WHEN**	**STATUS**
Contract with wound care specialist	CFO	Jan 1	
Complete education and competency for RNs	Nurse Educator Wound Care Specialist	Feb 1	

Goals Without a Plan Will Fail



An Action Plan Without First Understanding Root Cause… Will Fail!



Always Look for Root Cause

For areas of non-compliance drill down to find root cause. Non-compliance is usually about a broken or ineffective process, not individuals.

Root Cause

Problem statement (Be as specific as possible)

Ask why five times or until root cause is determined

Why? Why? Why? Why? Why?

To validate root causes, ask the following:

If you removed this root cause, would this event or problem have been prevented?

Assign Responsibility - Expect Accountability

Policies and Procedures

You MAY use hospital policies and add Swing Bed specific requirements

BUT

Important that staff are able to find P&Ps that only apply to Swing Bed if you choose to combine them with other policies

Facility Policies that Apply to Swing Bed Partial List Only

- Advance Directives
- Discharge Planning
- Emergency Preparedness
- Fall Prevention and Post-Fall Follow-Up
- HIPPA and Privacy
- Human Resources
- Infection Control
- Life Safety
- Medical Records
- Medication Administration
- Organ Procurement
- Pain Assessment and Reassessment
- Right to be photographed or refuse
- Restraints
- Staffing
- **And more……………………………….**

Swing Bed Policies
A Snapshot

Pre-Admission

- Who collects information about the patient
- Who determines benefit days available
- Who requests pre-authorization if required
- Who makes the decision to admit or deny admission
- Who is responsible for providing patient a choice of post-acute care providers

Patient Disclosures at Admission

- Patient Rights
- Choice of Physician
- Contact Information for Providers
- Financial Obligations
- Contact information for state agencies and ombudsman

Admission

- Comprehensive Assessment (by discipline)
- Provider responsibilities (H&P, orders, certification, etc.)

Continued Stay

- IDT meetings (who facilities – who attends, etc.)
- Development of multi-disciplinary plan of care
- Frequency of documentation (by discipline)
- Discharge planning (ongoing)

Discharge

- Patient - Discharge Notice
- Patient - NOMNC (Medicare)
- Notification of Ombudsman
- Required discharge Information to next post-acute care provider
- Discharge summary (provider)
- Summary / review of goals (all disciplines)

Develop Policy for each Swing Bed Regulatory Requirement

Rights and Responsibilities

- §483.10(b)(7) – Right to Make Decisions
- §483.10(c)(1) – Informed of Rights
- §483.10(c)(2)(iii) – Informed in Advance
- §483.10(c)(6) – Right to Refuse
- §483.10 Introductory text, (h) of this chapter) – Privacy and Confidentiality
- §483.10(d): Choice of Physician
- §483.10(e)(2) – Personal Possessions
- §483.10(e)(4) – Share a Room
- §483.10(f)(4)(ii) – Immediate Access to Visitors
- §483.10(g)(8) – Mail
- §483.10(g)(17) –Financial Obligations

§483.5 §483.15(c)(1) – Reasons for Transfer or Discharge. Not Discharge if Appeal Pending

- §483.15(c)(2): Documentation Requirements for Transfer and Discharge
- §483.15(c)(3): Notice before transfer. Notify Ombudsman
- §483.15(c)(4: Timing of notice
- §483.15(c)(7): Orientation for Transfer or Discharge
- §483.15(c)(8): Notice in advance of facility closure

§483.12(a)(1): Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion

- §483.12(a)(2): Free from Restraints
- §483.12(a)(3)(i): Not employe individuals found guilty of abuse….
- §483.12(a)(3)(ii): Not employ individuals with finding in State nurse aid registry
- §483.12(a)(3)(iii): Not employee individuals with disciplinary action against license for abuse
- §483.12(a)(4): Report to nurse state registry or licensing authority knowledge of actions by court of law that found unfitness for service

Develop Policy for each Swing Bed Regulatory Requirement (May be combined)

Abuse

- §483.12(b)(1): Prohibit Abuse
- §483.12(b)(2): P&P to investigate allegations of abuse
- §483.12(c)(1): Prevent abuse while investigation in process. Report within 2 hours if allegation of abuse or bodily injury
- §483.12(c)(2): Thoroughly investigate all allegations
- §483.12(c)(3): Prevent further abuse while investigation in process
- §483.12(c)(4): Report investigations to State within 5 working days

Social Services

- § 483.40(d): Provide medically related social services to attain or maintain highest practicable physical, mental and psychosocial wellbeing of each resident

Nutrition

- § 483.25(g)(1): Maintain acceptable parameters of nutritional status
- § 483.25((g)(2): Offered sufficient fluid intake

Assessment, Care Plan, Discharge

- § 483.20(b): Elements of comprehensive assessment
- § 483.21(b): Development of comprehensive care plan (Includes members of team who must be involved in developing care plan)
- § 483.21(c)(2): Elements of discharge summary

Rehab

- § 483.65: Provide rehab services if needed by patient. Provide services under written order of a physician

Dental

- § 483.55(a)(2): May charge a Medicare resident for dental services
- § 483.55(a)(3): Policy for when lost or damaged dentures is the facility responsibility
- § 483.55(a)(4): Make appointments and arrange for transportation
- § 483.55(a)(5): Refer for dental services with in 3 days. If doesn't occur document why. Provide for nutrition and hydration
- § 483.55(a)(5): Requirements for Medicaid patients

Patient Care Policies Development, Review and Approval

§ 485.635 Standard: Patient care policies

(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of § 485.631(a)(1).

(4) These policies are reviewed at least **biennially** by the group of professional personnel required under paragraph (a)(2) of this section and updated as necessary by the CAH.

Swing Bed Policy Review

At least every two years – or – when a new policy is developed, that is applicable to Swing Bed -- review as a Swing Bed Team--- not just an individual department

Swing Bed Team

Include At a Minimum

Provider, Case Management, Nursing, Dietary, Pharmacy, Rehabilitation

Implementation

Create a training / education plan

- May be different if this is a minor revision rather than a new P&P or a major rewrite
- May need to include competency – not just education
- Include training, education, competency – as part of the P&P review and approval

IMPORTANT FOR BOTH NEW AND REVISED P&Ps

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Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing

Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: February 13, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4r6lvOt

Compassion fatigue – Building resilience

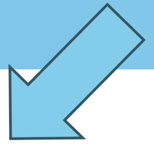
Presenter: Brian Merry, M.Ed., CEMSO, NRP - Director of EMS
Date: March 6, 2026 | **Time:** 12pm CST
URL: https://bit.ly/49KJOvp

Swing Beds: An important resource for CAH - Part 1

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 3, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4qwYF3R

Swing Beds: An important resource for CAH - Part 2

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 17, 2026 | **Time:** 12pm CST
URL: https://bit.ly/45Pyq08



Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3Nx2nMa

Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3NtJUA9