SWING-BED POTENTIAL TRACKING FORM

FACILITY NAME ______________________________

Patient Name	Acute Admit Date	Admit Diagnosis	Medicare A Benefits	Days Available	Verified By	MD Notified of SB Potential	Estimated Acute LOS	Qualified Days			Skilled Service Nursing/Rehab	Swing-Bed Admit Date	Case Manager
								1	2	3			

RUG-IV Medicare Pre-Admission Screening Form

Complete prior to admission and readmission by Medicare Nurse and Rehab Representative for any resident with a Medicare card and a 3-day qualifying hospital stay or when discharging someone from a Medicare Part A covered stay.

Resident Information

Resident Name:	Age:	Sex:	Medicare Days: Available:	Used:
Primary Diagnosis:		Secondary Diagnosis:		
Hospital:	Phone#	Admit Date:	Discharge Date:	
Prior Nursing Home	Phone#	Admit Date:	Discharge Date:	
Physician:	Phone"	Initial Certification: Y N	SNF Order: Y N	

Rehabilitation Plus Extensive Services

ADL Score of 2-16	YES NO	Receives one of the following Extensive Services while a resident in SNF: ▪ Isolation ▪ Tracheostomy Care ▪ Ventilator or Respirator
45 minute or more of therapy	YES NO	

Rehabilitation – During the first 7 days in facility the resident will receive

720 minutes or more 5x/week by at least 1 disciples and 3x/week by a second -	YES NO	**325** minutes or more by at least 1 discipline 5x/week	YES NO
500 minutes or more by at least 1 discipline 5x/week	YES NO	**150** minutes or more by any combination of disciplines	YES NO

45 minutes or more 3x/week ***AND*** 2 restorative nursing services

- Urinary and/or Bowel toileting program*
- Splint or brace assistance
- Transfer training
- Eating or swallowing training
- Communication training
- Passive and/or Active ROM*
- Bed mobility and/or walking training*
- Dressing or grooming training
- Amputation/prosthesis care

* Count as one services even if both provided

ADL Score of 0-16

Extensive Services Qualifiers – After Admission to SNF the resident has one of the following

Has ADL score of 2-16	YES NO	Tracheostomy Care AND Ventilator	YES NO
Infectious Isolation requiring a room alone	YES NO	Tracheostomy Care OR Ventilator	YES NO

If ADL score 0 or 1 and meets criteria for Extensive Services group, will re-classify into the Clinically Complex RUG group

Special Care High Qualifiers – Does the resident have one of the following Skilled Services

Has ADL score of 2-16	YES NO	Fever ***AND*** pneumonia	YES NO
Comatose ***AND*** ADL dependent or did not occur	YES NO	Fever ***AND*** vomiting	YES NO
Septicemia	YES NO	Fever ***AND*** weight loss	YES NO
Diabetes with both: daily injections (7 days) ***AND*** Insulin order changes on 2+ days	YES NO	Fever ***And*** Tube feeding**	YES NO
Quadriplegia ***AND*** ADL≥ 5	YES NO	Parenteral /IV fluids for nutrition/hydration any setting in the last 7 days	YES NO
COPD ***AND*** SOB when lying flat	YES NO	Respiratory Therapy + 7 days	YES NO

If ADL score 0 or 1 and meets criteria for Extensive Services group, will re-classify into the Clinically Complex RUG group

Special Care Low – Does the resident have one of the following Skilled Services

Cerebral Palsy with ADL ≥ 5	YES NO	Any 1 Stage 3 or 4 pressure ulcer with 2 TXs***	YES NO
Multiple Sclerosis with ADL ≥ 5	YES NO	2 or more Stage 2 pressure ulcers with 2 TXs***	YES NO
Parkinson's with ADL ≥ 5	YES NO	2 or more venous/arterial ulcers with 2 TXs***	YES NO
Respiratory failure ***AND*** Oxygen while a resident	YES NO	1 Stage 1 and 1 venous/arterial ulcer with 2 TXs***	YES NO
Dialysis **while a resident**	YES NO	Foot Infection, diabetic ulcer, or other open lesion of foot with dressing /w or w/o medication	YES NO
Feeding Tube **	YES NO	Radiation therapy **while a resident**	YES NO

If ADL score 0 or 1 and meets criteria for Extensive Services group, will re-classify into the Clinically Complex RUG group

Additional Qualifier Information

** Tube Feed requirements – 51% or more of total calories OR 26-50% of total calories and 501cc or more daily fluid intake in last 7 days.

*** Selected Ulcer Treatments:

- Pressure relieving chair/bed – count as one even if both provided
- Ulcer care
- Turning/repositioning
- Application of dressing (not to feet)
- Nutrition/hydration interventions
- Application of ointments (not to feet)

Clinically Complex – Does the resident have one of the following Skilled Services

Pneumonia	YES NO	Chemotherapy **while a resident**	YES NO
Hemiplegia/hemiparesis with ADL ≥ 5	YES NO	Oxygen therapy **while a resident**	YES NO
Surgical Wound with selected TXs	YES NO	IV medications **while a resident**	YES NO
Open lesion with selected TXs	YES NO	Transfusion **while a resident**	YES NO
Burns (2nd or 3rd degree)	YES NO	Selected Skin TXs – Surgical wound care **or** Application of dressing or ointment (not to feet)	

NOTE: Resident with ADL score of 0-1 and meeting criteria for Extensive Services, Special Care High and Low will qualify in Clinically Complex RUG group.

Does the resident have a history of depression	*YES*	*NO*

Activities of Daily Living (ADL) Score Index

Bed Mobility How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.	**Independent/ Supervision** /w or w/o staff help	**= 0**	**Toilet Use** How resident uses the toilet, bedpan, urinal, or commode; transfers on/off toilet; cleanse self after toileting; changes pad, clothing management; manages ostomy or catheter. Do not include emptying elimination containers.	**Independent/ Supervision** /w or w/o staff help	**= 0**
	Limited assistance /w or w/o staff help	**= 1**		**Limited assistance** /w or w/o staff help	**= 1**
	Extensive assistance 1 person	**= 2**		**Extensive assistance** 1 person	**= 2**
	Total dependence 1 person	**= 3**		**Total dependence** 1 person	**= 3**
	Extensive or Total dependence 2 person	**= 4**		**Extensive or Total dependence** 2 person	**= 4**
	Bed Mobility Score			**Toilet Use**	
Transfer How resident moves between surfaces including to or from; bed, chair, wheelchair, standing position (excludes to/from bath or toilet).	**Independent/ Supervision** /w or w/o staff help	**= 0**	**Eating** How resident eats and drinks, regardless of skill. Include intake or nutrition by other means; tube feeding, total parenteral nutrition, IV fluids for nutrition or hydration.	**Independent, Supervision, or Limited Assist** with no set-up or set-up only	**= 0**
	Limited assistance /w or w/o staff help	**= 1**		**Independent, Supervision or Limited Assist** 1 or 2 person	**= 2**
	Extensive assistance 1 person	**= 2**		**Extensive /Total Dependence** with no set-up or set-up only	**= 2**
	Total dependence 1 person	**= 3**		**Extensive Assist** 1 or 2 person	**= 3**
	Extensive or Total dependence 2 person	**= 4**		**Total Dependence** 1 or 2 person	**= 4**
	Transfer Score			**Eating Score**	

NOTES

Physician Certification and Recertification Form

Resident Name _____ Health Insurance Card Number _____

Initial CERTIFICATION of resident at time of admission.

Admission Date _____

I certify that post-hospital SNF services as a practical matter are required to be given on an inpatient basis because of the above-named resident's need for daily skilled nursing care and/or daily skilled rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving hospital services prior to his/her transfer to the SNF.

Signature of Physician _____ Date _____

First RECERTIFICATION of SNF inpatient care following the initial certification on or before the 14th day after admission.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

Second RECERTIFICATION of SNF inpatient care on or before the 30th day following the first recertification.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

Third RECERTIFICATION of SNF inpatient care on or before the 30th day following the second recertification.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

Resident Name _____

SWING-BED

PHYSICIAN ADMISSION PROGRESS NOTE

The history & physical and /or discharge summary from the acute hospitalization will serve as the history & physical for admission to Swing-Bed services. ____ Yes (Nursing to copy) ____ No (See new H&P

Reason for Skilled Nursing Admission:

☐ Rehabilitation Needs Secondary to:
- ☐ CVA ☐ Hip FX/THR ☐ TKR ☐ Amputation ☐ Neuro. Dx.
- ☐ Decreased Functional Ability secondary to: _____

_____

☐ Skilled Nursing Needs Secondary to: (list Do.) _____

_____

Functional Status **Prior** to this Hospitalization:
- ☐ Independent
- ☐ Needed assistance with mobility & activities of daily living
- ☐ Dependent

Treatment Plan/Goals of Admission to the Swing-Bed Unit:
- ☐ Physical Therapy (see clarification orders for specific therapy treatment plan)
- ☐ Occupational Therapy (see clarification orders for specific therapy treatment plan)
- ☐ Speech Therapy (see clarification orders for specific therapy treatment plan)
- ☐ IV medication
- ☐ IV fluids
- ☐ Respiratory Therapy X 7days/week
- ☐ Enteral Feedings
- ☐ Wound/Skin Care
- ☐ Nutrition and /or hydration
- ☐ End Stage Disease
- ☐ Other (Specify): _____

Estimated Length of Stay: ☐ 1 week or less ☐ 2 weeks ☐ 3 weeks or more

Current Discharge Plan:
- ☐ Return Home
- ☐ Assisted Living Facility
- ☐ Skilled Nursing Facility
- ☐ Rehabilitation Center
- ☐ Other (Specify): _____

Patient's DNR wishes have been discussed on admission to the Swing-Bed:
- ☐ Yes ☐ No (If no specify reason):_____

I certify that post-hospital extended care services as a practical matter are required to be given on an inpatient basis because the patient's need for daily skilled nursing care and /or rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving hospital services prior to Swing-Bed services.

Physician's Signature: _____ Date: _____

Patient:	Room:

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