

## Swing Bed Pilot Project Data Collection Form

Unique Patient Identifier															

A0900: Patient Date of Birth								
Month		Day		Year				

A1900: Swing Bed Admission Date								
Month		Day		Year				
				20				

A1800: Entered From	
Choose one	
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>01. Community</b> (private home/apartment, board/care, assisted living, group home)
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>02. Another nursing home or swing bed</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>03. Acute hospital</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>04. Psychiatric hospital</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>05. Inpatient rehabilitation facility</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>06. ID/DD Facility</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>07. Hospice</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>09. Long Term Care Hospital</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>99. Other</b>

Expected primary payer source for swing bed stay	
Choose one	
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>01. Medicare</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>02. Medicare Advantage</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>03. Medicaid</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>04. Commercial Insurance (includes Blue Cross)</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>05. Self-pay</b>
<input style="width: 100%; height: 100%;" type="checkbox"/>	<b>06. Other</b>



**Risk Adjustment Elements**

**I0020. Primary Medical Condition: Indicate the patient's primary medical condition category included in provider's documentation**

<p>Enter Code</p> <input type="text"/>	<p>Indicate the patient's primary medical condition category that best describes the primary reason for admission</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><li>14. Other Medical Conditions</li></ul>
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**J2000. Prior Surgery: Indicate if patient has had prior surgery (inpatient)**

<p>Enter Code</p> <input type="text"/>	<p>Did the patient have major surgery during the <b>100 days prior to admission?</b></p> <ul style="list-style-type: none"><li>0. No</li><li>1. Yes</li><li>8. Unknown</li></ul>
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**Risk Adjustment Elements: Prior Functioning**

**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury

<p><b>Coding:</b></p> <p><b>3. Independent</b> - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper</p> <p><b>2. Needed Some Help</b> - Patient needed partial assistance from another person to complete activities</p> <p><b>1. Dependent</b> - A helper completed the activities for the patient</p> <p><b>8. Unknown</b></p> <p><b>9. Not Applicable</b></p>	↓	<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, or 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

**GG0110. 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"/>	<b>A. Manual wheelchair</b>
<input type="checkbox"/>	<b>B. Motorized wheelchair and/or scooter</b>
<input type="checkbox"/>	<b>C. Mechanical lift</b>
<input type="checkbox"/>	<b>D. Walker</b>
<input type="checkbox"/>	<b>E. Orthotics/Prosthetics</b>
<input type="checkbox"/>	<b>Z. None of the above</b>

Risk Adjustment Elements	
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M0210. Patient had one or more unhealed pressure ulcers/injuries at swing-bed admission	
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<input type="checkbox"/>	0. No (Skip to next section)
<input type="checkbox"/>	1. Yes (Answer question below)

<input type="checkbox"/> <b>M0300: Number of pressure ulcers/injuries</b>	
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<input type="checkbox"/>	One or more Stage 1 pressure ulcers/injuries
<input type="checkbox"/>	One or more Stage 2 pressure ulcers/injuries
<input type="checkbox"/>	One or more Stage 3 pressure ulcers/injuries
<input type="checkbox"/>	One or more Stage 4 pressure ulcers/injuries
<input type="checkbox"/>	One or more unstageable pressure ulcers/injuries due to non-removable dressing, slough and/or eschar, or deep tissue injury

B0700. Makes self understood: Ability of patient to express ideas and wants, consider both verbal and non-verbal expression	
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<b>Choose one</b>	
<input type="checkbox"/>	<b>0. Understood</b>
	1. <b>Usually understood</b> - difficulty communicating some words or thoughts but is able if prompted or given time
	2. <b>Sometimes understood</b> - ability is limited to making concrete requests
	3. <b>Rarely/never understood</b>

B0800. Ability to understand others: Ability of patient in understanding verbal content	
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<b>Choose one</b>	
<input type="checkbox"/>	<b>0. Understands</b>
	1. <b>Usually understands</b> - misses some part/intent of message but comprehends most
	2. <b>Sometimes understands</b> - responds adequately to simple, direct communication only
	3. <b>Rarely/never understands</b>

J1700. History of Falls: Did the patient have a fall anytime in the six (6) months prior to admission?	
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<b>Choose one</b>	
<input type="checkbox"/>	1. Yes
	0. No

**Risk Adjustment Elements**

**Brief Interview for Mental Status (BIMS)**

**C0100. Should Brief Interview for Mental Status be Conducted?** Attempt to conduct interview with all patients

Enter code <input type="checkbox"/>	0. <b>No</b> (patient is rarely/never understood). <b>Go to Memory/Recall Ability section below</b> 1. <b>Yes</b> , continue to Repetition of Three Words below
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**C0200. Repetition of Three Words**

Enter code <input type="checkbox"/>	<p>Ask patient: <i>"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: <b>sock, blue, and bed</b>. Now tell me the three words."</i></p> <p><b>Number of words repeated after first attempt</b></p> <p>0. <b>None</b> 1. <b>One</b> 2. <b>Two</b> 3. <b>Three</b></p> <p>After the patient's first attempt, repeat the words using cues (<i>"sock, something to wear; blue, a color; bed, a piece of furniture"</i>). You may repeat the words up to two more times.</p>
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**C0300. Temporal Orientation (orientation to year, month, and day)**

Enter code <input type="checkbox"/>	<p>Ask patient: <i>"Please tell me what year it is right now."</i></p> <p><b>A. Able to report correct year</b></p> <p>0. <b>Missed by &gt;5 years</b> or no answer 1. <b>Missed by 2-5 years</b> 2. <b>Missed by 1 year</b> 3. <b>Correct</b></p>
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Enter code <input type="checkbox"/>	<p>Ask patient: <i>"What month are we in right now."</i></p> <p><b>B. Able to report correct month</b></p> <p>0. <b>Missed by &gt;1 month</b> or no answer 1. <b>Missed by 6 days to 1 month</b> 2. <b>Accurate within 5 days</b></p>
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Enter code <input type="checkbox"/>	<p>Ask patient: <i>"What day of the week is today?"</i></p> <p><b>C. Able to report correct day of the week</b></p> <p>0. <b>Incorrect</b> or no answer 1. <b>Correct</b></p>
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**C0400. Recall**

Enter code <input type="checkbox"/>	<p>Ask patient: <i>"Let's go back to an earlier question. What were those three words that I asked you to repeat?"</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.</p> <p><b>A. Able to recall "sock"</b></p> <p>0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("something to wear") 2. <b>Yes, no cue required</b></p>
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Enter code <input type="checkbox"/>	<p><b>B. Able to recall "blue"</b></p> <p>0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("a color") 2. <b>Yes, no cue required</b></p>
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Enter code <input type="checkbox"/>	<p><b>C. Able to recall "bed"</b></p> <p>0. <b>No</b> - could not recall 1. <b>Yes, after cueing</b> ("a piece of furniture") 2. <b>Yes, no cue required</b></p>
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Enter code <input type="text"/>	<b>C0500.</b> What was the patient's BIMS Summary Score from questions above? <i>Values should be 00 to 15</i>
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**C0900. Memory/Recall Ability: please complete the below. Check all that patient is able to recall correctly if not able to perform BIMS.**

<input type="checkbox"/>	Current season	<input type="checkbox"/>	That he or she is in a hospital swing bed
<input type="checkbox"/>	Location of own room	<input type="checkbox"/>	None of the above were recalled
<input type="checkbox"/>	Staff names and faces		

**Risk Adjustment Elements**

H0300. Urinary Continence		H0400. Bowel Continence	
Choose one		Choose one	
<input type="checkbox"/>	0. Always Continent	<input type="checkbox"/>	0. Always Continent
	1. Occasionally incontinent		1. Occasionally incontinent
	2. Frequently incontinent		2. Frequently incontinent
	3. Always incontinent		3. Always incontinent
	9. Not rated, pt had catheter, ostomy, or no urine output		9. Not rated, pt had ostomy or did not have bowel movement

K0510A. Total parenteral nutrition		K0150B. Tube Feeding	
Choose one		Choose one	
<input type="checkbox"/>	1. Yes	<input type="checkbox"/>	1. Yes
	0. No		0. No

**Comorbidities: Indicate the patient's comorbidities included in provider's documentation**

Check all that apply	
<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 Complication; 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

**Exclusions**

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

**Check all  
that Apply**

Died while in Swing Bed

Left the swing bed program against medical advice

Discharged to hospice care

Unexpectedly discharged to a short-stay acute hospital/CAH

Length of stay of less than 3 days

Independent with all self-care activities at the time of admission

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

Younger than 21 years old

Not receiving Physical Therapy or Occupational Therapy

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



**Functional Abilities - Admission**

**GG0130. Self-Care at Admission: Assessment period is days 1 through 3**

**Code the patient's usual performance at the start of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF stay (admission), 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**

Admission Performance	
Enter Codes ↓ in Boxes ↓	
<input type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input type="text"/>	<b>F. Upper body dressing:</b> The ability to dress and undress above the waist, including fasteners, if applicable
<input type="text"/> <input type="text"/>	<b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear
<input type="text"/> <input 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

**Functional Abilities - Admission (1 of 2 pages)**

**GG0170. Mobility at Admission: Assessment period is days 1 through 3**

**Code the patient's usual performance at the start of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF stay (admission), 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.*

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- 88. **Not attempted due to medical condition or safety concerns**

Admission Performance	
Enter Codes ↓ in Boxes ↓	
□ □	<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 with feet flat on the floor, 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

**Functional Abilities - Admission (2 of 2 pages)**

**GG0170. Mobility at Admission: Assessment period is days 1 through 3**

**Code the patient's usual performance at the start of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF stay (admission), 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.*

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- 88. **Not attempted due to medical condition or safety concerns**

Admission Performance	
Enter Codes ↓ in Boxes ↓	
<input type="text"/> <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"/> <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
<input type="text"/> <input type="text"/>	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail
<input type="text"/> <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"/> <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="text"/>	<b>P1. 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"/> <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="text"/>	<b>RR1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized
<input type="text"/> <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="text"/>	<b>SS1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized

**Functional Abilities - Discharge**

**GG0130. Self-Care at Discharge: Assessment period is the last 3 days of the swing bed stay**

**Code the patient's usual performance at the end of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the end of the SNF stay (admission), 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.

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- 88. **Not attempted due to medical condition or safety concerns**

Discharge Performance	
Enter Codes ↓ in Boxes ↓	
<input type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input 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 type="text"/> <input type="text"/>	<b>F. Upper body dressing:</b> The ability to dress and undress above the waist, including fasteners, if applicable
<input type="text"/> <input type="text"/>	<b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear
<input type="text"/> <input 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

**Functional Abilities - Discharge (1 of 2 pages)**

**GG0170. Mobility at Discharge: Assessment period is the last 3 days of the swing bed stay**

**Code the patient's usual performance at the end of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the end of the SNF stay (admission), code the reason.**

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- 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

**Functional Abilities - Discharge (2 of 2 pages)**

**GG0170. Mobility at Discharge: Assessment period is the last 3 days of the swing bed stay**

**Code the patient's usual performance at the end of the SNF stay (admission) for each activity using the 6-point scale. If activity was not attempted at the end of the SNF stay (admission), 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>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"/> <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
<input type="text"/> <input type="text"/>	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail
<input type="text"/> <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"/> <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 GG0170R, Wheel 50 feet with two turns
<input type="text"/> <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"/> <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

## Discharge Information

A2000. Swing Bed Discharge Date				
Month	Day	Year		
<input type="text"/>	<input type="text"/>	20	<input type="text"/>	<input type="text"/>

30-Day Follow-Up Status	
Check One	
<input type="text"/>	<b>00. No Attempt to Contact Patient/Family</b>
<input type="text"/>	<b>01. Contact with Patient/Family Attempted 3 times, no Response</b>
<input type="text"/>	<b>02. Patient Reached but Readmission/Observation to Another Facility Unknown</b>
<input type="text"/>	<b>03. Patient not Readmitted to any Facility</b>
<input type="text"/>	<b>04. Patient received care at Acute, Swing Bed, Observation or ED</b>

A2100. Patient's Discharge Status	
Check One	
<input type="text"/>	<b>01. Community</b> (private home/apartment, board/care, assisted living, group home)
<input type="text"/>	<b>02. Another nursing home or swing bed</b>
<input type="text"/>	<b>03. Acute hospital</b>
<input type="text"/>	<b>04. Psychiatric hospital</b>
<input type="text"/>	<b>05. Inpatient rehabilitation facility</b>
<input type="text"/>	<b>06. ID/DD facility</b>
<input type="text"/>	<b>07. Hospice</b>
<input type="text"/>	<b>08. Deceased</b>
<input type="text"/>	<b>09. Long Term Care Hospital</b>
<input type="text"/>	<b>99. Other</b>

30 Day Follow Up Description	
<input type="checkbox"/>	Readmitted to Our Facility Acute Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	Readmitted to Our Facility Acute New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	Readmitted to Our Facility Swing Bed Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	Readmitted to Our Facility Swing Bed New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	ED Visit at Our Facility Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	ED Visit at Our Facility New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	Observation Stay at Our Facility Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	Observation Stay at Our Facility New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	Readmitted to Acute or Placed on Observation at Other Facility Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	Readmitted to Acute or Placed on Observation at Other Facility New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	Readmitted to Acute or Placed on Observation at Other Facility Unknown
<input type="checkbox"/>	Readmitted to Other Facility (Swing Bed/SNF) Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	Readmitted to Other Facility (Swing Bed/SNF) New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	Readmitted to Other Facility (Swing Bed/SNF) Unknown
<input type="checkbox"/>	ED Visit at Other Facility Same or Related Condition as the Swing Bed stay
<input type="checkbox"/>	ED Visit at Other Facility New Condition Different from the Swing Bed Stay
<input type="checkbox"/>	ED Visit at Other Facility Unknown