



**Section 2: Risk Adjustment Elements**

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

Enter Code

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Indicate the primary medical condition upon which the patient's skilled needs are based on

- 01. Stroke
- 02. Non-Traumatic Brain Dysfunction
- 03. Traumatic Brain Dysfunction
- 04. Non-Traumatic Spinal Cord Dysfunction
- 05. Traumatic Spinal Cord Dysfunction
- 06. Progressive Neurological Condition
- 07. Other Neurological Conditions
- 08. Amputation
- 09. Hip and Knee Replacement
- 10. Fractures and Other Multiple Trauma
- 11. Other Orthopedic Conditions
- 12. Debility, Cardiorespiratory Conditions
- 13. Medically Complex Conditions

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

### C. Prior Functioning

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

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

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

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

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

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

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

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

**J. Comorbidities:**

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

**Section 3:**

**Therapy Utilization (during the swing bed stay)**

**Did patient receive any therapy while in Swing Bed? (Not counting the initial therapy assessment)**

<b>Choose one</b>	Regardless of frequency or number of days per week
<input type="checkbox"/>	0. No
	1. Yes

**If yes, which discipline was provided?**

<b>Check all that apply</b>	Therapy was a skilled need provided based on a PT/OT/SLP evaluation
<input type="checkbox"/>	1. Physical Therapy
<input type="checkbox"/>	2. Occupational Therapy
<input type="checkbox"/>	3. Speech Therapy

**Section 4. Exclusions**

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

**Choose  
ONLY One**

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

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



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

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

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

**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

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

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

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

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

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

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

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

**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
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- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

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

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

<b>Admission Performance</b>	
<b>Enter Codes</b> ↓ in Boxes ↓	
<input type="text"/>	<b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel
<input type="text"/>	<b>M. 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
<input type="text"/>	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
<input type="text"/>	<b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail
<input type="text"/>	<b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor
<input type="checkbox"/>	<b>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"/>	<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
<input type="checkbox"/>	<b>RR1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized
<input type="text"/>	<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space
<input type="checkbox"/>	<b>SS1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized

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

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

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

**Coding:**

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

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

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
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- 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. 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

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

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

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

**Coding:**

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

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

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

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

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

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

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

**Coding:**

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

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

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- 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 ↓	
□ □	<b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel
□ □	<b>M. 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
□ □	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail (if coded 07, 09, 10 or 88 then skip to P. Picking up object)
□ □	<b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail
□ □	<b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor
□	<b>Q1. Does the patient use a wheelchair and/or scooter?</b> 0. No → Skip rest of questions 1. Yes → Continue to Wheel 50 feet with two turns
□ □	<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
□	<b>RR1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized
□ □	<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
□	<b>SS1. Indicate the type of wheelchair or scooter used</b> 1. Manual 2. Motorized

## Section 7: Discharge Information

### A. Swing Bed Discharge Date

Month	Day	Year
<input type="text"/>	<input type="text"/>	20 <input type="text"/>

### B. Discharge Disposition

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

### C. Post Swing Bed 30-day Discharge Follow-up (Complete only one section unless patient was readmitted to acute and for ED visit)

Enter choice of 00 thru 02, if applicable <input type="text"/>	<b>00. No Attempt to Contact Patient/Family</b>
	<b>01. Contact with Patient/Family Attempted 3 times, no Response</b>
	<b>02. Patient Reached but Readmission/ Observation to Another Facility Unknown</b>
Enter choice of 03 thru 06, if applicable <input type="text"/>	<b>03. Patient not Readmitted to any Facility</b>
	<b>04. Planned Return to Acute or SB/SNF</b>
	<b>05. Return to Acute (same condition)</b>
	<b>06. Return to Acute (new condition)</b>
Enter choice of 07 or 08, if applicable <input type="text"/>	<b>07. Visit to ED/Observation (same condition)</b>
	<b>08. Visit to ED/Observation (new condition)</b>
<input type="text"/>	<b>09. Deceased (post discharge)</b>