Compliance with Facility Initiated Transfer and Discharge Requirements

Handout #1

Participant Session Outline

Provided Courtesy Of

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Compliance with Facility-Initiated Transfer & Discharge Requirements

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Team TSI is now SHP

- In June 2020, Team TSI was purchased by SHP.

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Same Support Same Quality Same Commitment

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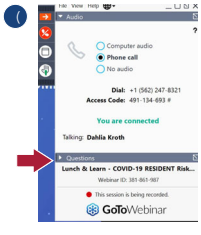
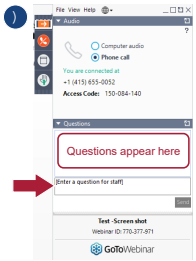
Go To Webinar – Questions & Handouts





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Today's Session Goals

- **Describe** the **OIG's** and **CMS facility-initiated** discharge investigation process.
- **Define** "facility-initiated discharge."
- **Review** and discuss **survey tags** relevant to "transfers and discharges."
- **Discuss** the survey team's **use** of the Discharge and Hospitalization Critical Element Pathways, and Care Area Probes.
- **Review** current **CMS waivers** that apply to facility transfers and discharges.

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The OIG Investigation Process

- The **OIG** is investigating **facility-initiated** discharges as a result of--
  - The number of **complaints** received by Ombudsman and CMS.
  - The number of **media reports** highlighting the rise in nursing home evictions.
- The OIG currently has **ongoing** work determining the **extent** to which State LTC Ombudsmen, State Survey Agencies, and CMS are **addressing** facility-initiated discharges.
- To **compliment** this work, the OIG will **examine** the **extent** to which nursing homes **meet** CMS **requirements** for **facility-initiated** discharges.
- CMS issued **S&C Letter 18-08** outlining its process for investigating discharges that violate federal regulations.

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Transfer and Discharge Defined

1. **Facility-initiated transfer or discharge** is defined as a transfer or discharge which the resident **objects** to, did **not** originate through a resident's verbal or written request, and/or is **not** in alignment with the resident's stated goals for care and preferences.
2. **Transfer and Discharge** is defined as movement of a resident to a bed **outside** of the certified facility whether that bed is in the **same** physical plant or **not**. Transfer and discharge does **not** refer to movement of a resident to a bed **within** the **same** certified facility.
3. **Transfer** refers to the **movement** of a resident from a bed in one certified facility to a bed in another certified facility when the resident **expects to return to the original facility**.
4. **Discharge** refers to the **movement** of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, **when return to the original facility is not expected**.

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Survey Tags Relevant to Transfer and Discharge Requirements

- **F622** – Transfer and Discharge Requirements.
- **F623** – Notice Requirements before Transfer or Discharge.
- **F624** – Preparation for Safe/Orderly Transfer or Discharge.
- **F625** – Notice of Bed Hold Policy Before and Upon Transfer.
- **F626** – Permitting Resident to Return to the Facility.
- **F660** – Discharge Planning.
- **F661** – Discharge Summary.

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Survey Tags That Should be Reviewed in Conjunction with Transfer and Discharge Requirements

- **F560** – Right to Refuse Certain Transfers.
- **F620** – Admission Policy.
- **F637** – Comprehensive Assessment after Significant Change.
- **F656** – Comprehensive Care Plans.
- **F838** – Facility Assessment.
- **F843** – Transfer Agreement.
- **F845** – Facility Closure-Administrator.
- **F846** – Facility Closure.

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F622 – Transfer and Discharge Requirements

1. **Facility requirements** and **documentation** at **F622 only** apply to transfers or discharges that are **initiated** by the facility, **not** by the resident. The **information** that **must** be provided to the **receiving** facility applies to **both** facility and resident initiated transfers.
2. **F622 specifies** the **limited conditions** under which a SNF/NF **may initiate** transfer or discharge of a resident, the **documentation** that **must** be included in the **medical record**, and **who** is responsible for **making** the documentation.
3. **Regulations** at **F622 limit** the circumstances under which a facility **can initiate** a transfer or discharge, thus **protecting** nursing home residents from involuntary discharge.

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F622 – Transfer and Discharge Requirements

Permitted Facility-Initiated Transfers/Discharges

1. The discharge or transfer is **necessary** for the **resident's** welfare and the facility **cannot** meet the resident's needs.
2. The **resident's** health has **improved** sufficiently so that the resident **no longer need**s the care and/or services of the facility.
3. The resident's clinical or behavioral status (or condition) **endangers** the **safety** of individuals in the facility.
4. The **resident's clinical or behavioral status** (or condition) otherwise **endangers** the **health** of individuals in the facility.
5. The **resident** has **failed**, after **reasonable** and **appropriate** notice to **pay**, or have paid under Medicare or Medicaid, for his or her stay at the facility.
6. The **facility ceases** to operate.

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F622 – Transfer and Discharge Requirements
Emergency Transfers to Acute Care

1. Residents who are sent **emergently** to the hospital are **considered** facility-initiated transfers **because** the resident's **return** is generally expected.
2. Residents who are sent to the **emergency room must** be permitted to **return** to the facility, **unless** the resident meets **one** of the criteria under which the facility **can** initiate discharge.
3. In a situation where the **facility initiates** discharge while the resident is in the hospital following **emergency** transfer, the facility must have **evidence** that the resident's status is **not** based on his or her condition at the time of transfer and meets one of the criteria at **F622**.

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F622 – Transfer and Discharge Requirements
Refusal of Treatment or Care

1. A **resident's declination** of treatment does **not** constitute grounds for discharge, **unless** the facility is **unable** to meet the **needs** of the resident or **protect** the health and safety of others.
2. The **facility** must be able to **demonstrate** that the resident or, if applicable, the resident's representative, **received** information regarding the **risks** of refusal of treatment.
3. Staff must have **conducted** the appropriate assessment to **determine** if **care plan revisions** would **allow** the facility to **meet** the resident needs or protect the health and safety of others.

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F622 – Transfer and Discharge Requirements
Discharge Pending Appeal

1. When a **resident** chooses to **appeal** his or her discharge from the facility, the facility may **not** discharge the resident **while** the appeal is pending. If a resident's **initial** Medicaid application is **denied** but appealed, the resident is **not** considered to be in nonpayment status. Thus, an appeal **suspends** a finding of nonpayment. Appeal procedures vary by State.
2. If the **resident**, or if applicable, their representative, **appeals** his or her discharge **while in a hospital**, facilities **must** allow the resident to **return** pending their appeal, **unless** there is evidence that the facility **cannot** meet the resident's needs, or the resident's return would **pose** a danger to the health or safety of the resident or others in the facility.
3. If there are **concerns** related to a facility's determination that it **cannot** meet a resident's needs, surveyors **will assess** whether the facility has **admitted** residents with **similar** needs.

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F622 – Transfer and Discharge Requirements
Required Documentation

1. The **medical record** must show **documentation** of the **basis** for the transfer or discharge. This documentation must be made **before**, or as close as possible to the **actual** time of transfer or discharge.
2. For transfers or discharges relative to the facility **not** being able to provide the necessary care, or the resident **no longer** needs the care, the resident's **physician** must document information about the **basis** for the transfer or discharge.
3. For transfers or discharges relative to the facility's **inability** to **meet** the resident's needs, the documentation made by the resident's physician **must** include:
   - The **specific** resident needs the facility could **not** meet;
   - The facility **efforts** to meet those needs; and
   - The **specific** services the **receiving** facility **will** provide to **meet** the needs of the resident which **cannot** be met at the **current** facility.

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F622 – Transfer and Discharge Requirements
Required Documentation-Cont'd

4. In circumstances where the transfer or discharge is **based** on the **safety** and **health** of **other** individuals, documentation regarding the **reason** for the transfer or discharge **must** be provided by a **physician**, **not** necessarily the attending physician.
5. **Documentation** of the transfer or discharge **may** be completed by a non-physician practitioner (NPP) in accordance with State law.

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F622 – Transfer and Discharge Requirements
Investigative Procedure

1. Surveyors are **instructed** to briefly **review** the **most recent** comprehensive assessment, comprehensive care plan, progress notes, and orders to **identify** the **basis** for the transfer or discharge.
2. During this review, **surveyors** are to **identify** the **extent** to which the facility has **developed** and **implemented** interventions to **avoid** transferring or discharging the resident, in **accordance** with the resident's needs, goals for care, and professional standards of practice.
3. This information is used to **guide observations** and **interviews** in order to **investigate** any identified concerns.
4. Surveyors are instructed to **observe** for **visual cues** of **psychosocial distress** and **harm**.

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F623 – Notice Requirements Before and Upon Transfer or Discharge

1. The **requirements at F623 only apply to facility-initiated** transfers and discharges, **not** resident-initiated transfers and discharges.
2. This **review** will address the **requirement** to send a notice in situations where the **facility initiates** a transfer or discharge, **including** discharges that **occur** while the resident **remains** in the **hospital** after **emergency** transfer.
3. Whether or not a **resident agrees** with the facility's decision, the requirements at **F623 apply** whenever a **facility initiates** the transfer or discharge.

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F623 – Notice Requirements Before and Upon Transfer or Discharge
Notice of Transfer or Discharge

1. The **facility** must **notify** the resident and the resident's representative(s) of the transfer or discharge and the **reasons** for the move in **writing** and in a **language** and manner they understand.
2. Additionally, the facility must send a **copy** of the **notice** of transfer or discharge to the **representative** of the Office of the State Long-Term Care (LTC) Ombudsman.
3. Notice to the Office of the State LTC Ombudsman must **occur** before or as **close** as possible to the **actual** time of a **facility-initiated** transfer or discharge. The **medical record** must contain **evidence** that the notice was **sent** to the Ombudsman.

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F623 – Notice Requirements Before and Upon Transfer or Discharge
Notice of Transfer or Discharge – Cont'd

4. In **situations** where the facility has decided to **discharge** the resident while the resident is still **hospitalized**, the facility must send a **notice** of **discharge** to the resident, the resident's representative, and to a representative of the Office of the State LTC Ombudsman.
5. For **any other** types of **facility-initiated discharges**, the facility must provide **notice** of discharge to the resident and resident representative, along with a copy of the notice to the Office of the State LTC Ombudsman, at least **30 days prior** to the discharge or as **soon** as possible.
6. The copy of the **notice** to the **ombudsman** must be sent at the **same time** the notice is **provided** to the resident and resident representative.

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F623 – Notice Requirements Before and Upon Transfer or Discharge
Emergency Transfers

1. When a resident is **temporarily** transferred on an **emergency basis** to an **acute care** facility, **this** type of transfer is **considered** to be a **facility-initiated transfer** and a **notice** of transfer **must** be provided to the resident and resident representative **as soon as practicable**, according to the **Timing of Notice** requirements.
2. Copies of notices for **emergency** transfers **must also** still be **sent** to the **ombudsman**, but they may be **sent** when **practicable**, such as in a list of residents on a monthly basis.

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F623 – Notice Requirements Before and Upon Transfer or Discharge
Contents of the Notice

1. **The specific reason** for the transfer or discharge, including the basis per §483.15(c)(1)(i)(A)-(F) – Facility Requirements (F622);
2. **The effective date** of the transfer or discharge;
3. **The location** to which the resident is to be transferred or discharged;
4. **An explanation** of the right to appeal to the State;
5. **The name**, **address** (mail and email), and **telephone number** of the State entity which receives appeal hearing requests;
6. **Information** on **how** to request an appeal hearing;
7. **Information** on **obtaining assistance** in completing and submitting the appeal hearing request; and
8. **The name**, **address**, and **phone number** of the **representative** of the Office of the State Long-Term Care ombudsman.

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F623 – Notice Requirements Before and Upon Transfer or Discharge
Timing of the Notice

1. **Generally**, this notice **must** be provided **at least 30 days prior** to the transfer or discharge.
2. **Exceptions** to the 30-day requirement **apply** when the transfer or discharge is **affected because**:
   - The **resident's** welfare is at **risk**, and his or her needs **cannot** be met in the facility (i.e., emergency transfer to an acute care facility); **or**
   - The **health** or **safety** of **others** in the facility is **endangered**.
3. **In these cases**, the **notice** must be provided as **soon as practicable** and notice to the **ombudsman** in these situations **can** be sent when **practicable**, such as a list of residents on a monthly basis.

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F624 – Preparation for Safe and Orderly Transfer or Discharge

1. This tag **generally** addresses the **immediate orientation** and **preparation necessary** for a transfer, such as to a **hospital** emergency room or **therapeutic leave** where discharge planning is **not required** because the resident will **return**, or for an **emergent** or **immediate** discharge where a **complete** discharge planning process is not practicable.
2. Sufficient preparation and orientation **means** the facility **informs** the resident **why** they are leaving the facility, **where** he or she is going, and **takes steps** under its control to **minimize** anxiety.

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F624 – Preparation for Safe and Orderly Transfer or Discharge-Continued

3. The **facility** must **orient** and **prepare** the resident regarding his or her transfer or discharge in a **form** and **manner** that the **resident can understand**.
4. The **form** and **manner** of this orientation and preparation **must** take into consideration **factors** that **may** affect the **resident's ability** to **understand**, **such as** educational level, language and/or communication barriers, and physical and mental impairments.
5. The **facility** must also **document** this orientation in the medical record, **including** the resident's **understanding** of the transfer or discharge.

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F625 – Notice of Bed-Hold Policy Before and Upon Transfer

Intent and Definitions

1. **The Intent of F625** is to **ensure** that residents are made **aware** of a facility's bed-hold and reserve bed payment policy **before** and **upon** transfer to a **hospital** or when taking a **therapeutic** leave of absence **from** the facility.
2. **Bed-hold** is defined as: **Holding or reserving** a resident's bed while the resident is **absent** from the facility for therapeutic leave or hospitalization.
3. **Reserve Bed Payment** is defined as: **Payments** made by a State to the **facility** to **hold** a bed **during** a resident's **temporary** absence from a nursing facility.
4. **Therapeutic Leave** is defined as: **Absences** for **purposes other** than **required** hospitalization.

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F625 – Notice of Bed-Hold Policy Before and Upon Transfer
Notice Requirements

1. All **facilities** must have **policies** that address **holding** a resident's bed during periods of absence, **such as** during hospitalization or therapeutic leave.
2. Facilities **must** provide **written** information about these policies to residents **prior to and upon transfer** for such absences.
3. These provisions **require** facilities to issue **two notices** related to bed-hold policies.
4. The **first notice** could be given well in advance of any transfer, i.e., information provided in the admission packet.
5. The **second notice** must be **provided** to the resident, and if applicable the resident's representative, **at the time of transfer**, or in cases of **emergency** transfer, **within 24 hours**.

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F626 – Permitting Residents to Return to the Facility

1. **The intent of F626** is to **ensure** that facilities **develop** and **implement policies** that **address** bed-hold and **return** to the facility for **all** residents.
2. **Specifically**, residents who are **hospitalized** or on **therapeutic leave** are **allowed** to **return** for skilled nursing or nursing facility care or services.
3. **In situations** where the facility **intends** to discharge the resident, the facility **must comply** with Transfer and Discharge Requirements at F622, F623, and F624, and the **resident** must be **permitted** to **return** and **resume** residence in the facility while an **appeal** is pending.

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F626 – Permitting Residents to Return to the Facility
Not Permitting a Resident to Return

1. If a facility does **not** permit a resident who went on therapeutic leave to **return**, the facility must **meet** the requirements for a **facility-initiated discharge** at **F622**.
2. Because the facility **was** able to care for the resident **prior** to therapeutic leave, **documentation** related to the **basis** for discharge must **clearly** show **why** the facility can **no longer care** for the resident.
3. If the facility **determines** the resident will **not** be **returning** to the facility, the facility **must notify** the resident, his or her representative, and the LTC ombudsman in **writing** of the discharge, **including** notification of **appeal** rights.

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F626 – Permitting Residents to Return to the Facility
Not Permitting a Resident to Return-Cont'd

4. If the resident **chooses** to appeal the discharge, the facility **must** allow the resident to **return** to his or her **room** or an **available** bed in the nursing home **during** the **appeal** process, **unless** there is **evidence** that the resident's **return** would **endanger** the health or safety of the **resident** or **other** individuals in the facility.

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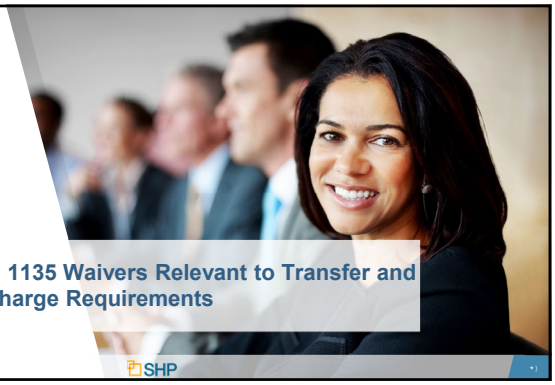

CMS 1135 Waivers Relevant to Transfer and Discharge Requirements

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STRATEGIC HEALTHCARE PROGRAMS

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Resident Transfer and Discharge	CMS is **waiving** requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and §483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) (**with some exceptions**) to allow a long-term care (LTC) facility to **transfer or discharge** residents to another LTC facility **solely for the following cohorting purposes**: 1. **Transferring** residents **with symptoms** of a respiratory infection or **confirmed** diagnosis of COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents; 2. **Transferring** residents **without** symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19, as well as providing treatment or therapy for other conditions as required by the resident's plan of care, or 3. **Transferring** residents **without** symptoms of a respiratory infection to another facility that **agrees** to accept each specific resident to **observe** for any signs or symptoms of a respiratory infection over 14 days. **Exceptions to Resident Transfer and Discharge Notices** These requirements are only waived in cases where the **transferring** facility receives confirmation that the receiving facility agrees to accept the resident to be transferred or discharged. Confirmation may be in writing or verbal. If verbal, the transferring facility needs to document the date, time, and person that the receiving facility communicated agreement. **EXCEPTIONS Continued on NEXT Page**			

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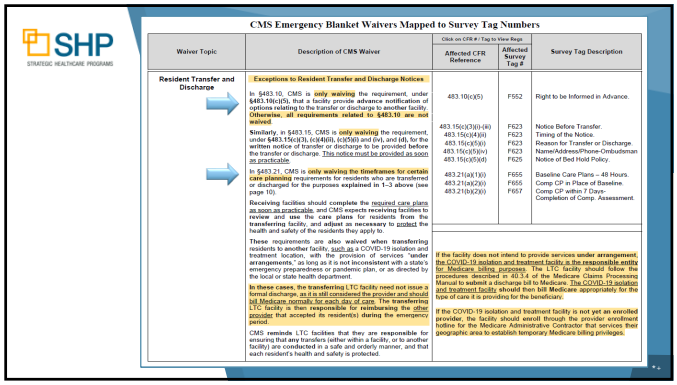
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CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers
Waiver Topic
Description of CMS Waiver
Click on CFR # / Tag to View Regs
Affected CFR Reference
Affected Survey Tag #
Survey Tag Description
Resident Transfer and Discharge
Exceptions to Resident Transfer and Discharge Notices
In §483.10, CMS is only waiving the requirement, under §483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to §483.10 are not waived.
Similarly, in §483.15, CMS is only waiving the requirement, under §483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable.
In §483.21, CMS is only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above (see page 10).
Receiving facilities should complete the required care plans as soon as practicable, and CMS expects receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents they apply to.
These requirements are also waived when transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements," as long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.
In these cases, the transferring LTC facility need not issue a formal discharge, as it is still considered the provider and should bill Medicare normally for each day of care. The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period.
CMS reminds LTC facilities that they are responsible for ensuring that any transfers (either within a facility, or to another facility) are conducted in a safe and orderly manner, and that each resident's health and safety is protected.
483.10(c)(5)
F552
Right to be Informed in Advance.
483.15(c)(3)(i)-(iii)
483.15(c)(4)(ii)
483.15(c)(5)(i)
483.15(c)(5)(iv)
483.15(c)(5)(d)
F623
F623
F623
F623
F625
Notice Before Transfer.
Timing of the Notice.
Reason for Transfer or Discharge.
Name/Address/Phone-Ombudsman
Notice of Bed Hold Policy.
483.21(a)(1)(i)
483.21(a)(2)(i)
483.21(b)(2)(i)
F655
F656
F657
Baseline Care Plans – 48 Hours.
Comp CP in Place of Baseline.
Comp CP within 7 Days-Completion of Comp. Assessment.
If the facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary.
If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.

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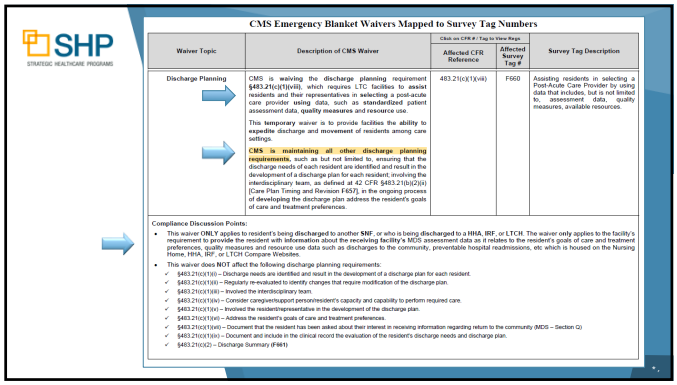
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STRATEGIC HEALTHCARE PROGRAMS
CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers
Waiver Topic
Description of CMS Waiver
Click on CFR # / Tag to View Regs
Affected CFR Reference
Affected Survey Tag #
Survey Tag Description
Discharge Planning
CMS is waiving the discharge planning requirement §483.21(c)(1)(viii), which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use.
This temporary waiver is to provide facilities the ability to expedite discharge and movement of residents among care settings.
CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident, involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(iv) [Care Plan Timing and Revision F657], in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences.
483.21(c)(1)(viii)
F660
Assisting residents in selecting a Post-Acute Care Provider by using data that includes, but is not limited to, assessment data, quality measures, available resources.
Compliance Discussion Points:
This waiver ONLY applies to resident's being discharged to another SNF, or who is being discharged to a HHA, IRF, or LTCH. The waiver only applies to the facility's requirement to provide the resident with information about the receiving facility's MDS assessment data as it relates to the resident's goals of care and treatment preferences, quality measures and resource use data such as discharges to the community, preventable hospital readmissions, etc which is housed on the Nursing Home, HHA, IRF, or LTCH Compare Websites.
This waiver does NOT affect the following discharge planning requirements:
§483.21(c)(1)(i) – Discharge needs are identified and result in the development of a discharge plan for each resident.
§483.21(c)(1)(ii) – Regularly re-evaluated to identify changes that require modification of the discharge plan.
§483.21(c)(1)(iii) – Involved the interdisciplinary team.
§483.21(c)(1)(iv) – Consider caregiver/support person/resident's capacity and capability to perform required care.
§483.21(c)(1)(v) – Involved the resident/representative in the development of the discharge plan.
§483.21(c)(1)(vi) – Address the resident's goals of care and treatment preferences.
§483.21(c)(1)(vii) – Document that the resident has been asked about their interest in receiving information regarding return to the community (MDS – Section Q)
§483.21(c)(1)(ix) – Document and include in the clinical record the evaluation of the resident's discharge needs and discharge plan.
§483.21(c)(2) – Discharge Summary (F461)

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Use of the Discharge and Hospitalization CE Pathways and Care Area Probes
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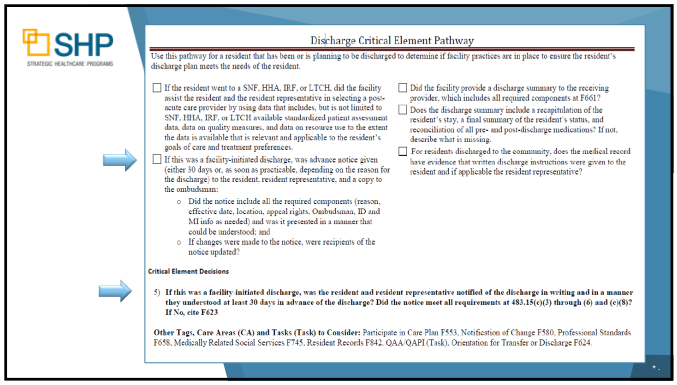
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STRATEGIC HEALTHCARE PROGRAMS
Discharge Critical Element Pathway
Use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident's discharge plan meets the needs of the resident.
If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences.
If this was a facility-initiated discharge, was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident, resident representative, and a copy to the ombudsman:
Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and
If changes were made to the notice, were recipients of the notice updated?
Did the facility provide a discharge summary to the receiving provider, which includes all required components at F661?
Does the discharge summary include a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications? If not, describe what is missing.
For residents discharged to the community, does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?
Critical Element Decisions
5) If this was a facility-initiated discharge, was the resident and resident representative notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)? If No, cite F623
Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Participate in Care Plan F553, Notification of Change F580, Professional Standards F658, Medically Related Social Services F745, Resident Records F842, QAA/QAPI (Task), Orientation for Transfer or Discharge F624.

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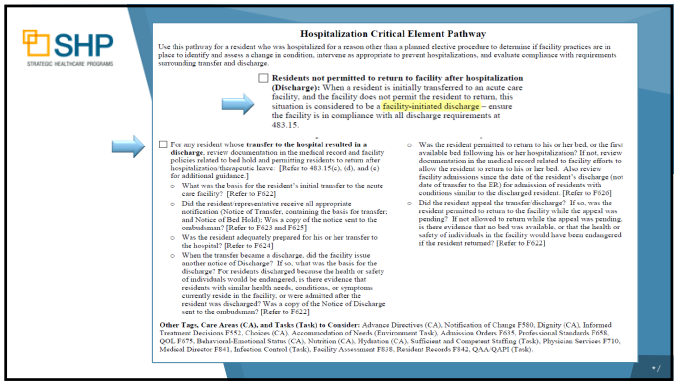
SHP
STRATEGIC HEALTHCARE PROGRAMS
Hospitalization Critical Element Pathway
Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.
Residents not permitted to return to facility after hospitalization (Discharge): When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is considered to be a facility-initiated discharge – ensure the facility is in compliance with all discharge requirements at 483.15.
For any resident whose transfer to the hospital resulted in a discharge, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave. [Refer to 483.15(c), (d), and (e) for additional guidance.]
What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]
Did the resident/representative receive all appropriate notification (Notice of Transfer, containing the basis for transfer; and Notice of Bed Hold); Was a copy of the notice sent to the ombudsman? [Refer to F623 and F625]
Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624]
When the transfer became a discharge, did the facility issue another notice of Discharge? If so, what was the basis for the discharge? For residents discharged because the health or safety of individuals would be endangered, is there evidence that residents with similar health needs, conditions, or symptoms currently reside in the facility, or were admitted after the resident was discharged? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to F622]
Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to F626]
Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to F622]
Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

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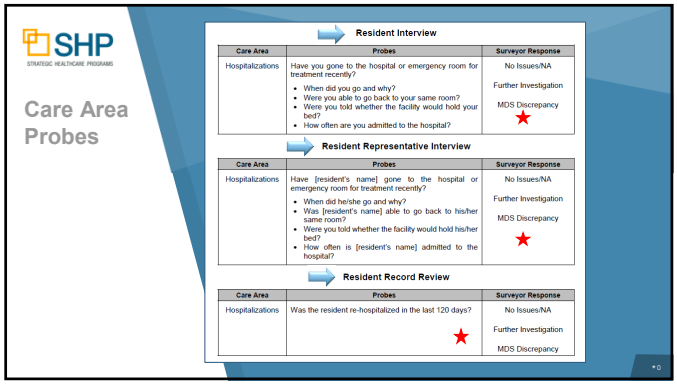
SHP
STRATEGIC HEALTHCARE PROGRAMS
Care Area Probes
Resident Interview
Care Area | Probes | Surveyor Response
Hospitalizations | Have you gone to the hospital or emergency room for treatment recently?
• When did you go and why?
• Were you able to go back to your same room?
• Were you told whether the facility would hold your bed?
• How often are you admitted to the hospital? | No Issues/NA
Further Investigation
MDS Discrepancy
Resident Representative Interview
Care Area | Probes | Surveyor Response
Hospitalizations | Have [resident's name] gone to the hospital or emergency room for treatment recently?
• When did he/she go and why?
• Was [resident's name] able to go back to his/her same room?
• Were you told whether the facility would hold his/her bed?
• How often is [resident's name] admitted to the hospital? | No Issues/NA
Further Investigation
MDS Discrepancy
Resident Record Review
Care Area | Probes | Surveyor Response
Hospitalizations | Was the resident re-hospitalized in the last 120 days? | No Issues/NA
Further Investigation
MDS Discrepancy

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TEAMTSI
now a part of SHP

Compliance with Facility-Initiated Transfer & Discharge Requirements

We want to hear from you!
- Questions
- Comments

Team TSI Support
support@teamtsi.com
Direct: (256) 878-2121
Toll Free: (800) 765-8998

Hugh Heaton
Regs-In-A-Flash, LLC
whheaton@regsinaflash.com
(256) 281-6433

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Compliance with Facility Initiated Transfer and Discharge Requirements

Handout #2

Survey Tags Relevant to Facility-Initiated Transfers and Discharges

Provided Courtesy Of

TEAMTSI
now a part of SHP

Regs-In-A-Flash, LLC

W. H. Heaton

Effective November 28, 2017

F620 - Admissions Policy

Old Tag Number: F208

§483.15(a) Admissions policy.

§483.15(a)(1) The facility must establish and implement an admissions policy.

***§483.15*(a)(2) The facility must—**

(i) Not *request or* require residents or potential residents to waive their rights *as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights* to Medicare or Medicaid; and

(ii) Not *request or* require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

***§483.15*(a)*(3)* The facility must not *request or* require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may *request and* require *a resident representative* who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.**

***§483.15*(a)*(4)* In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—**

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term ''nursing facility services'' so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

***§483.15*(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.**

Effective November 28, 2017

***§483.15*(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.**

§483.15*(a)*(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15*(a)*(7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.

DEFINITIONS/ACRONYMS

"Composite distinct part": *A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as that term is defined in §413.65(a)(2) of this chapter. Additional requirements specific to SNF/NF composite distinct parts are found at §483.5.*

"Campus": *Campus is defined in §413.65(a)(2) and means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.*

"Distinct part": *A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

Effective November 28, 2017

GUIDANCE

§483.15(a)(1) and (2) Admissions Policy/Preconditions of Admission

All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the admissions policy must comply with the provisions at §483.15(c)(1) which stipulate the limited conditions for transfer or discharge. The provisions at §§483.15 (a)(2) –(5), further prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, under §§483.15(a)(6) – (7), the admissions policy must identify information that must be disclosed to residents and potential residents, such as notice of special facility characteristics, any service limitations of the facility, if applicable. Additionally, it requires that the facility's admission agreement disclose its physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part (see additional guidance below). The facility must also have a process for how it will disclose required information to residents and potential residents.

The provision*s at §§483.15(a)(2)(i) and (ii)* prohibit both direct and indirect request*s to residents or potential residents to waive any rights under the LTC requirements and under applicable federal, state, local licensing or certification laws, including but not limited to the* waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, *would* require residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver *would* include, *for example*, requiring the resident to pay private rates for a specified period of time, such as two years (*e.g.,* "private pay duration of stay contract") before Medicaid will be accepted as a payment source for the resident.

Facilities must not seek or receive any kind of assurances that residents *or potential residents* are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Lastly, residents must not be asked to waive facility responsibility for the loss of their personal property or be unable to use personal property because it is only permitted in the facility if safeguarded by the facility in a manner that makes the property essentially inaccessible to the resident. These waivers effectively take away the residents' right to use personal possessions and relieve facilities from their responsibility to exercise due care with respect to residents' personal property. Compliance requires facilities to develop policies and procedures to safeguard residents' personal possessions without effectively prohibiting a resident's use of personal possessions. This provision is not intended to make facilities automatically liable for every loss regardless of whether or not the facility is aware of the extent of personal property brought into the facility. Examples of reasonable facility policies may include 1) establishing a process to document high value personal property (particularly cash, valuables, and medical/assistive devices) brought in by residents; and 2) establishing a process to work with residents and their representatives/family to ensure safety as well as availability to the resident of cash and/or items over a certain dollar value, including medical/assistive devices. For concerns related to whether the facility takes reasonable care to protect each resident's property from loss or theft or the resident's right to be free from misappropriation of property, see F584, §483.10(i) Safe Environment and F602, §483.12 Misappropriation of Resident Property.

Effective November 28, 2017

§483.15(a)(3) Third Party Guarantee of Payment

The facility *must* not *request or* require a third *party* to accept personal responsibility for paying the facility bill out of his or her own funds *as a condition of admission, expedited admission, or continued stay in the facility*. However, *the facility may request and require a resident representative with legal access to the resident's funds available to pay for facility care to access and* use the resident's money *or other assets* to pay for care, *as authorized by law*. *The facility may request and require this representative to sign a contract, without incurring personal liability, to provide the facility with payment from the resident's income or assets.* A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.

§483.15(a)(4)(i) and (ii), Medicaid – Preconditions for Admission

The *requirements at §483.15(a)(4)(i) and (ii) apply* only to *individuals eligible for Medicaid and therefore to* Medicaid certified nursing facilities *(NFs) or dually-certified SNF/NFs*.
Facilities may not charge for any service that is included in the definition of "nursing facility services" *which are* required to be provided as part of the daily rate *(See also §483.10(f)(11)(i))* .
Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes*, but is not limited to,* deposits from residents *who are eligible for Medicaid* or their families, or any promise to pay private rates for a specified period of time.

NOTE: This regulation does not preclude a facility from charging a deposit fee to, or requiring a promissory note from, an individual whose stay is <u>not</u> covered by Medicaid. In instances where the deposit fee is refundable and remains as funds of the resident, the facility must have a surety bond that covers the deposit amount*-- (See also §483.10(f)(10)(vi)).*

A nursing facility is permitted to charge an applicant or resident *for services, while his or her* Medicaid eligibility is pending. *This charge may be* in the form of a deposit prior to admission and/or payment after admission. *Subject to the rules of the State in which the facility is located,* Medicaid eligibility will be made retroactive up to 3 months before the month of application if the applicant would have been eligible had he or she applied in any of the retroactive months.

***NOTE**: A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending (See F622, Transfer and Discharge Requirements).*

Effective November 28, 2017

In addition, the nursing facility must accept as payment in full the amounts determined by the state for all dates the resident was both Medicaid eligible and a nursing facility resident. Therefore, a nursing facility that charged a recipient for services between the first month of eligibility established by the state and the date notice of eligibility was received is obligated to refund, *within 30 days from receipt of funds from a third party payor*, any payments received for that period less the state's determination of any resident's share of the nursing facility's costs for that same period. A nursing facility must prominently display written information in the facility and provide explanation to applicants or residents *in a manner they can understand* about applying for Medicaid, including how to use Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Under the post-eligibility process, if the resident *who is eligible for Medicaid* has income and is required to make a monthly payment to the nursing facility (which is a portion of the Medicaid payment amount), then the nursing facility is permitted to retain the amount it is legally owed. However, the nursing facility must not charge any administrative fees.

A nursing facility may charge a beneficiary *who receives Medicaid* for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a "nursing facility" service;
- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

§483.15(a)(5) State/Local Jurisdiction Admission Standards

Surveyors are expected to refer to state and/or local laws and regulations on admissions standards to prohibit discrimination against individuals entitled to Medicaid as applicable.

§483.15(a)(6) Facility Special Characteristics

Facilities may choose to offer specialized care or services, such as a rehabilitation, dementia, or a mechanical ventilation unit. To enable potential residents and resident representatives to make informed decisions in choosing a facility for admission, facilities must inform residents and resident representatives and potential residents or representatives of any special characteristics or service limitations the facility may have prior to admission. For example, a facility may have a religious affiliation that guides its practices and routines which must be communicated to any potential resident.

Likewise, if a facility has limitations in the type of medical care it can provide, this information must be communicated prior to admission. For example, if the need for a specific type of care or service becomes necessary, knowledge of service limitations may make the need for transfer or discharge more predictable and understandable for the resident and/or his or her representative.

Effective November 28, 2017

Disclosure of facility special characteristics does not relieve a facility of its responsibility to provide required nursing and other services for which it is licensed and certified to provide. To see the required services, refer to sections 1819(a) and 1819(b)(4)(A), and sections 1919(a) and 1919(b)(4)(A) of the Act.

§483.15(a)(7) Composite Distinct Part

If a facility does not have a composite distinct part, this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a composite distinct part according to §483.5(c), consult with the CMS Regional Office for clarification.

Prior to admission, facilities that have areas that meet the definition of a composite distinct part must disclose in their admission agreements to residents:

- *A description of the facility's physical configuration, including the locations for each part that comprise the composite distinct part.*
- *Policies governing room changes between its different locations.*

***NOTE**: If there is a deficiency specific to the requirement at §483.10(g)(15), do not cite at §483.10(g)(15), F580, but cite here at F620, regarding admission policies.*

INVESTIGATIVE PROTOCOL

Objectives

The objectives of this protocol are to determine whether the facility has failed to comply with the regulations at §§483.15(a)(1) – (7) above, regarding admission policies and payment.

Use

Use this protocol when concerns regarding admissions procedures arise during record review, interviews and/or in response to complaints.

PROCEDURES

Record Reviews

Review the facility admissions package, including admissions policies, and contracts to determine if they contain any of, but not limited to, the following:

- *Requirements or requests for residents to waive:*
  - *their rights to current or future enrollment in Medicare or Medicaid*
  - *claims of liability against the facility for loss of personal property*

Effective November 28, 2017

- *Requirements or requests for a third party guarantee of payment as a condition of admission or expedited admission.*
- *Requirements for payment for services which are covered under Medicaid as a condition of admission, or continued stay.*

In addition, if the facility has any special characteristics or service limitations, review the admissions package to determine if they are and have been disclosed to residents and their representative prior to admission. For composite distinct part facilities, determine if the facility discloses and has disclosed its various locations that make up the composite distinct parts and its policies for room changes between its different locations.

For concerns regarding a facility charging for services that may be covered by the State Medicaid plan, surveyors are expected to review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services.

Interviews

Ask resident and/or their representative if there were any preconditions or requirements for admission, such as a third party guarantee of payment, or requests for gifts, money, donations or other considerations.

Ask resident and/or their representative if there were any other preconditions or requirements, or limitations in care that they did not expect or know about prior to admission.
Ask resident and/or their representative if they were required to waive:

- *Their rights to Medicare or Medicaid, or future enrollment in either; and/or*
- *Claims of liability against the facility for loss of personal property.*

Interview staff about information that is provided to potential residents to help them make informed decisions.

Effective November 28, 2017

F621 - Equal Practices Regardless of Payment Source

Old Tag Number: F207

§483.15(b) **Equal access to quality care.**

§483.15(b)**(1) A facility must establish, maintain *and implement* identical policies and practices regarding transfer *and* discharge, *as defined in §483.5* and the provision of services for all individuals regardless of source of payment, *consistent with §483.10(a)(2)*;**

§483.15(b)**(2) The facility may charge any amount for services furnished to non- Medicaid residents *unless otherwise limited by state law and* consistent with the notice requirement in *§483.10(g)(18)(i) and (g)(4)(i)* describing the charges; and**

§483.15(b)**(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.**

§483.15(c)(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

DEFINITIONS

"Composite Distinct Part": *A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter. Additional requirements specific to SNF/NF composite distinct parts are found at §483.5.*

"Campus": *Campus is defined in §413.65(a)(2) and means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.*

Effective November 28, 2017

"Distinct Part": *A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

INTENT

To ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source.

GUIDANCE

All *services, including but not limited to* nursing services, specialized rehabilitative services, *behavioral health services,* social services, dietary services, *and* pharmac*y* services, or activities, that are mandated by the law must be provided to residents according to *their* individual needs, as determined by assessments and care plans. "Identical policies and practices" concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

Notice Requirements for Changes to Medicare/Medicaid Coverage

Facilities must inform each resident in writing before or at admission, and periodically during their stay, such as when a change in coverage occurs, of the facility's available services and associated costs. The facility may charge any amount for services furnished to non- Medicaid residents unless otherwise limited by state law. Section 483.10(f)(11) and F571 provide additional information regarding services and charges for which a facility may or may not charge the resident. Pursuant to §483.10(g)(18)(i) and F582, the facility must provide notice of changes in coverage for services to residents as soon as is reasonably possible.

Effective November 28, 2017

Facility Requirements Regarding Room Changes in a Composite Distinct Part

If a facility does not have a composite distinct part this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a distinct or composite distinct part of a larger institution or institutional complex, consult with the CMS Regional Office for clarification.

Room changes within either a composite distinct part SNF or a distinct part SNF are subject to the requirements at §483.10(e)(7) and F560, which address the resident's right to refuse transfer/room change. For concerns regarding the resident's right to refuse such a transfer or room change, refer to 483.10(e)(7) and F560.

PROBES

Determine if residents are grouped in separate wings or floors for reasons other than care needs, *and if the quality of care is different between the different wings/floors*.

Ask nursing home administrator, social worker, charge nurses, unit managers, and/or Director of Nursing:

- *What factors led to decisions to place residents in different wings or floors (or locations if a SNF composed of composite distinct parts)?*
- *Do factors other than medical and nursing needs affect where residents are placed?*

Ask *representatives of the Office of the* State Long-Term Care Ombudsman if *they have information that could indicate the* facility treats residents differently in transfer, discharge and covered services based on source of payment.
If concerns arise regarding equal access to care, ask the resident or representative:

- *Were there any changes to care or services when their payor source changed, for example did they notice fewer staff available to meet their needs when their payor source was due to change or had changed?*
- *Did the resident receive notice of changes in charges for services?*
- *Were they asked to move or were they moved to a different location in the building when their payor source changed?*

Effective November 28, 2017

F622 - Transfer and Discharge Requirements

Old Tag Numbers: F201, F202

***§483.15*(c) Transfer and *d*ischarge-**

§483.15*(c)(1) *Facility requirements-

***(i)* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—**

***(A)* The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**

***(B)* The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;**

(C)* The safety of individuals in the facility is endangered *due to the clinical or behavioral status of the resident;

***(D)* The health of individuals in the facility would otherwise be endangered;**

***(E)* The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility*. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.* For a resident who becomes eligible for Medicaid after admission to a *facility,* the facility may charge a resident only allowable charges under Medicaid; or**

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

***§483.15*(c)(2) Documentation.**

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs *(c)(1)(i)(A)* through *(F)* of this section, *the facility must ensure that the transfer or discharge is documented in* the resident's *medical* record *and appropriate information is communicated to the receiving health care institution or provider.*

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

Effective November 28, 2017

(ii) The documentation *required by paragraph (c)(2)(i) of this section* must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph *(c) (1) (A)* or *(B)* of this section; and

(B) A physician when transfer or discharge is necessary under paragraph *(c)(1)(i)(C) or (D)* of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals;

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

INTENT

To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation. Additionally, these requirements specify the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting.

DEFINITIONS

"Facility-initiated transfer or discharge": *A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.*

"Resident-initiated transfer or discharge": *Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).*

"Transfer and Discharge": *Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

Effective November 28, 2017

GUIDANCE

***NOTE**: The provisions at §§483.15(c)(1)and (2)(i)-(ii), only apply to transfers or discharges that are initiated by the facility, not by the resident. Section 483.15(c)(2)(iii) applies to both facility and resident initiated transfers (for information required at discharge, refer to F661, Discharge Summary).*

These regulations limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from involuntary discharge.

In the following limited circumstances, facilities may initiate transfers or discharges:

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.*
3. *The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.*
5. *The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.*
6. *The facility ceases to operate.*

Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility. See additional guidance at F626, §483.15(e)(1), Permitting Residents to Return. Facility-initiated transfers and discharges must meet all transfer and discharge requirements at §§483.15(c)(1) - (5).

Section 483.15(c)(1)(i) provides that "The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." This means that once admitted, for most residents (other than short-stay rehabilitation residents) the facility becomes the resident's home. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment. (See F838, Facility Assessment). There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Resident-initiated transfers or discharges occur when the resident or, if appropriate, his/her representative has given written or verbal notice of their intent to leave the facility. A resident's expression of a general desire or goal to return to home or to the community or the elopement of a resident who is cognitively-impaired should not be taken as a notice of intent to leave the facility.

Effective November 28, 2017

Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

***NOTE**: In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors would review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return.*
If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs. (See §483.20(b)(2)(ii), F637 for information concerning assessment upon significant change.)

A resident's declination of treatment does not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. The facility must be able to demonstrate that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment, and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others.

Nonpayment as Basis for Discharge

Non-payment for a stay in the facility occurs when:

- *The resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or*
- *After the third party payor denied the claim and the resident refused to pay.*

Effective November 28, 2017

It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third party paperwork. In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf, before discharging the resident. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Additionally, conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Emergent Transfers to Acute Care

Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected.

*Residents who are sent to the emergency room, **must** be permitted to return to the facility, unless the resident meets one of the criteria under which the facility can initiate discharge. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status is not based on his or her condition at the time of transfer) meets one of the criteria at §§483.15(c)(i)(A) through (D).*

483.15(c)(1)(ii) Discharge pending appeal

When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending. Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. Appeal procedures vary by State.

If the resident, or if applicable, their representative, appeals his or her discharge while in a hospital, facilities must allow the resident to return pending their appeal, unless there is evidence that the facility cannot meet the resident's needs, or the resident's return would pose a danger to the health or safety of the resident or others in the facility. If there are concerns related to a facility's determination that it cannot meet a resident's needs, surveyors should assess whether the facility has admitted residents with similar needs. A facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending must not be based on the resident's condition when originally transferred to the hospital.

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Required Documentation

To demonstrate that any of the cirmcumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge.

For circumstances 1 and 2 above for permissible facililty-initiated transfer or discharge, the ***resident's physician*** *must document information about the basis for the transfer or discharge. Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the* ***resident's physician must*** *include:*

- *The specific resident needs the facility could not meet;*
- *The facility efforts to meet those needs; and*
- *The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.*

In circumstances 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

NOTE*: Documentation of the transfer or discharge may be completed by a non-physician practitioner (NPP) in accordance with State law.*

Information Conveyed to Receiving Provider

The regulations at §483.15(c)(2)(iii) address information that must be conveyed to the receiving provider when a resident is transferred or discharged. The specific information which must be conveyed depends upon whether the resident is transferred (expected to return), or is discharged (not expected to return). If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider:

- *Contact information of the practitioner who was responsible for the care of the resident;*
- *Resident representative information, including contact information;*
- *Advance directive information;*
- *Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:*
  - *Treatments and devices (oxygen, implants, IVs, tubes/catheters);*
  - *Precautions such as isolation or contact;*
  - *Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;*
- *The resident's comprehensive care plan goals; and*

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- *All information necessary to meet the resident's needs, which includes, but may not be limited to:*
  - *Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;*
  - *Diagnoses and allergies;*
  - *Medications (including when last received); and*
  - *Most recent relevant labs, other diagnostic tests, and recent immunizations.*
- *Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information).*

***NOTE**: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer.*

For residents being discharged (return not expected), the facility must convey all of the information listed above, along with required information found at §483.21(c)(2) Discharge Summary, F661. Communicating this information to the receiving provider is one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting.

Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. The transferring or discharging facility may transmit the information electronically in a secure manner which protects the resident's privacy, as long as the receiving facility has the capacity to receive and use the information. Communication of this required information should occur as close as possible to the time of transfer or discharge.

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility transfer or discharge requirements.

Summary of Investigative Procedure

*Briefly review the most recent comprehensive assessment, comprehensive care plan, progress notes, and orders to identify the basis for the transfer or discharge; during this review, identify the extent to which the facility has developed and implemented interventions to avoid transferring or discharging the resident, in accordance with the resident's needs, goals for care and professional standards of practice. This information will guide observations and interviews to be made in order to corroborate concerns identified. **NOTE**: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

Effective November 28, 2017

F623 - Notice Requirements Before Transfer/Discharge

Old Tag Number: F203

***§483.15*(c)(3) Notice before transfer.**

Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the *resident's* representative*(s)* of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. *The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.*

(ii) Record the reasons *for the transfer or discharge* in the resident's *medical* record *in accordance with paragraph (c)(2) of this section*; and

(iii) Include in the notice the items described in paragraph *(c)(5)* of this section.

***§483.15*(c)(4) Timing of the notice.**

(i) Except *as* specified in paragraphs *(c)(4)(ii) and (c)(8)* of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph *(c)(1)(i)(C)* of this section;

(B) The health of individuals in the facility would be endangered, under *paragraph (c)(1)(i)(D)* of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph *(c)(1)(i)(B)* of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph *(c)(1)(i)(A)* of this section; or

(E) A resident has not resided in the facility for 30 days.

***§483.15*(c)(5) Contents of the notice. The written notice specified in paragraph *(c)(3)* of this section must include the following:**

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal *rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;*

(v) The name, address *(mailing and email)* and telephone number of *the Office of the* State *L*ong-*T*erm *C*are *O*mbudsman;

(vi) For nursing facility residents with *intellectual and* developmental disabilities *or related disabilities,* the mailing *and email* address and telephone number of the agency responsible for the protection and advocacy of individuals *with developmental disabilities* established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act *of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.);* and

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(vii) For nursing facility residents *with a* mental *disorder or related disabilities*, the mailing *and email* address and telephone number of the agency responsible for the protection and advocacy of individuals *with a mental disorder* established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

DEFINITIONS

"Facility-initiated transfer or discharge": *A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.*

"Resident-initiated transfer or discharge": *Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).*

"Transfer and Discharge": *Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

GUIDANCE

The requirements at 483.15(c)(3)-(6) only apply to facility-initiated transfers and discharges, not resident-initiated transfers and discharges. This guidance will address the requirement to send a notice in situations where the facility initiates a transfer or discharge, including discharges that occur while the resident remains in the hospital after emergency transfer.

Facility-initiated transfers and discharges generally occur when the facility determines it should not, or cannot provide needed care or services to a resident in accordance with F622, Transfer and Discharge Requirements. Whether or not a resident agrees with the facility's decision, the requirements at 483.15(c)(3)-(6) apply whenever a facility initiates the transfer or discharge.

Effective November 28, 2017

A resident-initiated transfer or discharge is one in which the resident has provided written or verbal notice of their intent to leave the facility, which is documented in the resident's record. A resident's expression of a general desire to return home or to the community or elopement of a resident who is cognitively impaired should not be taken as a notice of intent to leave. When a resident initiates his or her transfer or discharge, the medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or if appropriate his/her representative, containing details of discharge planning, and arrangements for post-discharge care (See F660, Discharge Planning Process). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident initiated. Therapeutic leave is a type of resident-initiated transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.

Notice of Transfer or Discharge and Ombudsman Notification

For facility-initiated transfer or discharge of a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state.

Facility-Initiated Transfers and Discharges

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the ***transfer*** *notice to the ombudsman only needed to occur as soon as practicable as described below.*

For any other types of facility-initiated discharges, the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the ombudsman must be sent at the same time notice is provided to the resident and resident representative.

Effective November 28, 2017

***Emergency Transfers**--When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.*

Resident-Initiated Transfers and Discharges

A resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. The medical record must contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility. While a resident's expression of a general desire or goal to return home or to the community or the elopement of a resident who is cognitively impaired should be taken into consideration for the purposes of discharge planning and community placement, it should not be taken as notice of intent to leave the facility and does not constitute a resident-initiated transfer or discharge. For resident-initiated transfers or discharges, sending a copy of the notice to the ombudsman is not required because the notice requirement does not apply to resident-initiated transfers or discharges.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated. If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

Contents of the Notice

The facility's notice must include *the following:*

- The *specific* reason for the *transfer or* discharge, *including the basis per §§483.15(c)(1)(i)(A)-(F)*;
- The effective date of the *transfer or* discharge;
- The location to which the resident is to be *transferred or* discharged;
- An explanation of the right to appeal to the State;
- *The name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests;*
- *Information on how to request an appeal hearing;*
- *Information on obtaining assistance in completing and submitting the appeal hearing request; and*
- The name, address, and phone number of the *representative of the Office of the* State Long-Term Care ombudsman.

Effective November 28, 2017

For residents with intellectual and developmental *disabilities and/or mental illness*, *the notice must include* the name, *mail and e-mail* address*es* and phone number of the *state protection and advocacy* agency responsible for advocating for these *populations.*

Timing of the Notice

Generally, this notice must be provided at least 30 days prior to the *transfer or discharge*. Exceptions to the 30-day requirement apply when the *transfer or discharge* is effected because:

- *The resident's welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or*
- *The health or safety of others in the facility is e*ndangered.

In these cases, the notice must be provided as soon as practicable *and* ***notice to the ombudsman*** *in these situations can be sent when practicable, such as a list of residents on a monthly basis.*

Changes to the Notice

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents *and their representatives* are aware of and can respond appropriately. *For significant changes, such as a change in the destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date, in order to provide 30 day advance notification.*

Notice in Advance of Facility Closure:

Refer to 483.70(l), F845 for guidance related to evaluating Notice in Advance of Facility Closure.

Effective November 28, 2017

F624 - Preparation for Safe/Orderly Transfer/Discharge

Old Tag Number: F204

***§483.15(*c)(7) Orientation for *t*ransfer or *d*ischarge.**

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. *This orientation must be provided in a form and manner that the resident can understand.*

DEFINITIONS

"Transfer and Discharge": *Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

GUIDANCE

The guidance at this tag generally addresses the immediate orientation and preparation necessary for a transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate discharge where a complete discharge planning process is not practicable.

For concerns related to how the facility planned for a discharge that meets a resident's health and safety needs, as well as their preferences and goals in circumstances which permit a complete discharge planning process, please refer to F660, Discharge Planning.

Sufficient preparation *and orientation* means the facility informs the resident where he or she is going, and takes steps under its control to *minimize anxiety*.

Examples of preparation and orientation may include explaining to a resident why they are going to the emergency room or other location or leaving the facility; working with family or resident's representative to assure that the resident's possessions (as needed or requested by the resident) are not left behind or lost; and ensuring that staff handle transfers and discharges in a manner that minimizes anxiety or depression and recognizes characteristic resident reactions identified by the resident's assessment and care plan.

Effective November 28, 2017

The facility must orient and prepare the resident regarding his or her transfer or discharge in a form and manner that the resident can understand. The form and manner of this orientation and preparation must take into consideration factors that may affect the resident's ability to understand, such as educational level, language and/or communication barriers, and physical and mental impairments. The facility must also document this orientation in the medical record, including the resident's understanding of the transfer or discharge.

Other tags for consideration would be:

- *F622, Transfer and Discharge Requirements, specifically the clinical information that must be conveyed to the receiving provider, if the transfer or discharge is to another healthcare setting; and*
- *F843, Transfer Agreement, for concerns related to timely transfer to the acute care facility.*

PROCEDURES

- *Review nursing notes and any other relevant documentation to see if appropriate orientation and preparation of the resident prior to transfer and discharge has occurred.*
- *Through record review and interviews, determine if the resident received sufficient preparation prior to transfer or discharge, and if they understood the information provided to them.*
- *Were the resident's needed/requested possessions transferred with the resident to the new location?*
- *Ask resident or his or her representative if they understand why the transfer or discharge occurred.*

Effective November 28, 2017

F625 - Notice of Bed Hold Policy Before/Upon Transfer

Old Tag Number: F205

***§483.15(*d) Notice of *b*ed-*h*old policy and *return*—**

***§483.15*(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or *the* resident *goes* on therapeutic leave, the nursing facility must provide written information to the resident *or resident representative* that specifies—**

(i) The duration of the *state* bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii)* The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph *(e)(1)* of this section, permitting a resident to return; *and
(iv) The information specified in paragraph (e)(1) of this section.

***§483.15*(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and *the resident representative* written notice which specifies the duration of the bed-hold policy described in paragraph *(d)(1)* of this section.**

INTENT

To ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility.

DEFINITIONS

"Bed-hold": *Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.*

"Reserve Bed Payment": *Payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility.*

"Therapeutic Leave": *Absences for purposes other than required hospitalization.*

Effective November 28, 2017

GUIDANCE

Notice of Bed-Hold Policy

All facilities must have policies that address holding a resident's bed during periods of absence, such as during hospitalization or therapeutic leave. Additionally, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source.

These *provisions* require *facilities to issue* two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, *i.e., information provided in the admission packet.* Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change.

The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative.
The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed.

When a resident residing in a skilled nursing facility under Medicare is hospitalized or takes therapeutic leave, Medicare will not pay to hold the bed. Facility policies may allow the resident to pay privately to hold his or her bed. While the provisions of this requirement specifically address bed-hold under Medicaid law, facilities must make all residents aware in writing of their policies related to holding beds during absences from the facility.

***NOTE**: Residents not covered by Medicare or Medicaid, may be permitted to privately provide reserve bed payments.*

Medicaid law requires each state Medicaid plan to address bed-hold policies for hospitalization and periods of therapeutic leave. State plans vary in payment for and duration of bed-holds. However, federal regulations do not require states to pay nursing facilities for holding beds while the resident is away from the facility. In general, the State plan sets the length of time, if any, that the state will pay the facility for holding a bed for a Medicaid-eligible resident. It is the responsibility of the survey team to know the bed-hold policies of their State Medicaid plan.

Additionally, §483.15 (e)(1) and F626 require facilities to permit residents to return to the facility immediately to the first available bed in a semi-private room.

Effective November 28, 2017

As stated above, a participating facility *must* provide notice to its residents *and if applicable, their representatives,* of the facility's bed-hold policies*, as stipulated in each State's plan. This notice must be provided* prior to *and upon* transfer *and must include information on how long a facility will hold the bed, how reserve bed payments will be made (if applicable), and the conditions upon which the resident would return to the facility. These conditions are:*

- *The resident requires the services which the facility provides; and*
- *The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.*

Bed-hold for days of absence in excess of the State's bed-hold limit *is* considered *a* non-covered service which means that the resident could use his/her own income to pay for the bed-hold. However, if a resident does not elect to pay to hold *his or her* bed, *the resident will be permitted to return* to the next available bed, *consistent with the requirements at §483.15(e).*

The provision at §483.15(d)(1)(ii) references regulations for Medicaid Payments for Reserving Beds in Institutions (§447.40), which state "Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient's plan of care." This means that therapeutic leave of absence must be consistent with the resident's goals for care, be assessed by the comprehensive assessment, and incorporated into the comprehensive care plan, and cannot be a means of involuntarily discharging the resident.

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility requirements for bed-hold.

Summary of Investigative Procedure

If concerns arise regarding notice of bed-hold, review the medical record for evidence of whether a notice of bed-hold was provided both (1) prior to and (2) upon transfer. Look for documentation such as a copy of the dated notice(s), progress notes, transfer checklist(s), or other evidence that the notice was given. Additionally, ask to review facility policies on bed-hold. Review the facility's admission packet to determine if notice of bed-hold is given at admission. If not, determine how the facility notifies residents prior to transfer.

Ask the resident, or if applicable, the resident's representative(s), whether they received the bed-hold notice and understand the facility's bed-hold policy. If not, determine how the facility notifies residents of this information prior to transfer.

Effective November 28, 2017

F626 - Permitting Residents to Return to Facility

Old Tag Number: F206

***§483.15*(e)(1) Permitting resident*s* to return to facility.**

A facility must establish and follow a written policy *on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.*

***(i) A* resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, *returns to the facility to their previous room if available or* immediately upon the first availability of a bed in a semi-private room if the resident—**

(A) Requires the services provided by the facility; and

(B) Is eligible for *Medicare skilled nursing facility services or* Medicaid nursing facility services.

(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

INTENT

*To ensure that facilities develop and implement policies that address bed-hold and return to the facility for all residents. Specifically, residents who are hospitalized or on therapeutic leave are allowed to return for skilled nursing or nursing facility care or services. In situations where the facility intends to discharge the resident, the facility must comply with Transfer and Discharge Requirements at §483.15(c), **and** the resident must be permitted to return and resume residence in the facility while an appeal is pending.*

DEFINITIONS

***"Bed-hold":** Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.*

***"Composite Distinct Part":** A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as that term is defined in §413.65(a)(2). Additional requirements specific to SNF/NF composite distinct parts are found at §483.5.*

***"Campus":** Campus is defined in §413.65(a)(2) and means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly*

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contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

"Distinct Part": *A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

"Therapeutic Leave": *Absences for purposes other than required hospitalization.*

GUIDANCE §483.15 (e)

Facilities must develop *and implement* policies *for bed-hold and* permit*ting residents to return following* hospitalization or therapeutic leave. *These policies must address how the facility will allow residents to return when their hospitalization or therapeutic leave has exceeded the bed-hold period allowed by the State Medicaid plan. Duration of and payment for bed-hold for residents eligible for Medicaid vary by State. The policy must also address how residents who pay privately, or receive Medicare, may pay to reserve their bed.*

NOTE*: These requirements also apply to a resident who was receiving Medicaid at the time of his or her hospitalization, and returns needing skilled nursing (Medicare) care or services.*

Residents must be permitted to return to their previous room, if available, or to the next available bed in a semi-private room, providing the resident:

- *Still requires the services provided by the facility; and*
- *Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.*

Medicaid-eligible residents must be *permitted to return* to the first available bed even if the residents have outstanding Medicaid balances.

Composite Distinct Part

If a facility does not have a composite distinct part this provision does not apply. If there are concerns as to whether or not a facility is appropriately certified as a distinct or composite distinct part, consult with the CMS Regional Office for clarification.

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When a resident is returning to a composite distinct part, he/she must be allowed to return to an available bed in the particular location of the composite distinct part in which he/she resided previously, or the next available bed in that location.

Not Permitting Residents to Return

Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in §483.15(c)(1)(ii). A facility must not discharge a resident unless:

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the services of the facility.*
3. *The resident's clinical or behavioral status endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status endangers the health of individuals in the facility.*
5. *The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility.*
6. *The facility ceases to operate.*

For concerns related to a facility not permitting a resident to return, the surveyor should investigate to determine if the basis for discharge meets one of the requirements above (See F622, §483.15(c)(1)(ii)).

As noted at 483.15(c)(2)(i)(B), when the facility transfers or discharges a resident for the resident's welfare, or because the resident's needs cannot be met in the facility, the medical record must contain documentation of the specific resident needs that cannot be met, facility attempts to meet those needs, and the service available at the receiving facility to meet the needs. Resident decisions to refuse care should not be considered a basis for transfer or discharge unless the refusal poses a risk to the resident's or other individuals' health and/or safety. In situations where a resident's choice to refuse care or treatment poses a risk to the resident's or others' health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate (See F656, 483.21(b)(1)(ii), Comprehensive Care Plans.)

If unable to resolve situations where a resident's refusal for care poses a risk to the resident's or others' health or safety, the facility administration, nursing and medical director may wish to convene an ethics meeting, which includes legal consultation, in order to determine if the facility can meet the resident's needs, or if the resident should be transferred or discharged.

If a facility does not permit a resident who went on therapeutic leave to return, the facility must meet the requirements for a facility-initiated discharge at F622. Because the facility was able to care for the resident prior to therapeutic leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

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Additionally, facilities must not treat situations where a resident goes on therapeutic leave and returns later than agreed upon, as a resident-initiated discharge. The resident must be permitted to return and be appropriately assessed for any ill-effects from being away from the facility longer than expected, and provide any needed medications or treatments which were not administered because they were out of the building. If a resident has not returned from therapeutic leave as expected, the medical record should show evidence that the facility attempted to contact the resident and resident representative. The facility must not initiate a discharge unless it has ascertained from the resident or resident representative that the resident does not wish to return.

A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:

- *Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.*
- *Ascertain an accurate status of the resident's condition—this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.*
- *Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.*
- *Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:*
  - *Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;*
  - *Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.*

If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

For concerns regarding notification of discharge, and the resident's right to appeal the discharge, refer to the regulation and guidance at §§483.15(c)(3)-(5)(F623).

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INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility requirements to permit residents to return following hospitalization or therapeutic leave.

Summary of Investigative Procedure

If concerns arise regarding facility failure to permit a resident to return, review the medical record for evidence of whether a notice of transfer and discharge and notice of bed-hold were provided. Determine the basis for discharge and how the facility evaluated the resident. The surveyor may have to obtain hospital records for further investigation. Review any other documentation necessary to ascertain the extent to which the facility made efforts to enable the resident to return.

In cases where a facility did not allow a resident to return due to lack of an available bed, the surveyor should review facility admissions beginning with when the resident was ready to return to determine if residents with similar care needs have been admitted. Additionally, if the facility does not readmit the resident due to risk to the health or safety of individuals in the facility, the surveyor should review documentation for how the facility made this determination.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F626, the surveyor's investigation will generally show that the facility failed to:

- *Establish and/or implement a policy that is in accordance with the State Medicaid plan, and addresses returning to the facility following hospitalization or therapeutic leave; or*
- *Ensure that residents whose hospitalization or therapeutic leave exceeds the State's bed-hold period are returned to their previous room and/or the first available bed in a semi-private room; or*
- *Ensure (for a resident not permitted to return) the medical record and notification contain a valid basis for discharge; or*
- *Permit a resident to return to the same composite distinct part in which they previously resided.*

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

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Examples of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or Safety include, but are not limited to:

- *Facility failed to allow a resident to return following therapeutic leave to a family member's home, resulting in the resident being found living on the street, without food or shelter. The medical record did not contain evidence of a valid basis for discharge, and there was no evidence of discharge planning This was cross-referenced and also cited at F622, Transfer and Discharge Requirements, §483.15(c)(1), and F660, Discharge Planning Process, §483.21(c)(1).*
- *Facility failed to allow a resident to return following a hospitalization. The medical record did not accurately evaluate the resident, rather they used the resident's status prior to the transfer as the basis for discharge. This was cross-referenced and also cited at F622, Transfer and Discharge Requirements, §483.15(c)(1).*

Examples of Severity Level 3 Noncompliance: Actual Harm that is not Immediate Jeopardy include, but are not limited to:

- *Facility failed to allow a resident to return to a bed in the same composite distinct part in which they resided previously. The new location was far from the resident's family, resulting in the resident expressing sustained and persistent sadness and withdrawal.*
- *Facility failed to allow a resident to return to the nursing facility, following a hospitalization that exceeded the bed-hold policy (and state plan). The facility discharged the resident on the basis of being unable to meet his needs. The survey team was able to verify that the facility had accepted residents with similar conditions during the timeframe that the resident was ready to return. This resulted in the resident being sent to another facility which was in a location not easily accessible by the resident's family. The resident expressed feelings of depression and loneliness.*

An example of Severity Level 2 Noncompliance: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy includes, but is not limited to:

- *Facility failed to allow a resident to return to his/her previous room (even though it was available) upon return from the hospital, which resulted in no more than minimal harm as the resident adjusted to the new room. This noncompliance has the potential to cause more than minimal psychosocial harm.*

An example of Severity Level 1 noncompliance: No actual harm with potential for minimal harm includes, but is not limited to:

- *A facility which is a composite distinct part permitted a resident to return following hospitalization or therapeutic leave, however, the resident returned to a different location in the composite distinct part even though a bed was available in the same location where the resident had resided prior to transfer. The resident did not express displeasure with the situation.*

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Effective November 28, 2017

F660 - Discharge Planning Process

Old Tag Number: F284

§483.21(c)(1) Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- ***(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.***
- ***(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.***
- ***(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.***
- ***(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.***
- ***(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.***
- ***(vi) Address the resident's goals of care and treatment preferences.***
- ***(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.***
  - ***(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.***
  - ***(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.***
  - ***(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.***
- ***(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.***

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(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

INTENT §483.21(c)(1)

This requirement intends to ensure that the facility has a discharge planning process in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

DEFINITIONS §483.21(c)(1)

"Discharge Planning": *A process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.*

"Home Health Agency (HHA)": *a public agency or private organization (or a subdivision of either) which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home and meets the requirements of sections 1861(o) and 1891 of the Social Security Act.*

"Inpatient Rehabilitation Facility (IRF)": *are freestanding rehabilitation hospitals or rehabilitation units in acute care hospitals that serve an inpatient population requiring intensive services for treatment.*

"Local Contact Agency": *refers to each State's designated community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, such as an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.*

"Long Term Care Hospital (LTCH)": *are certified as acute-care hospitals, but focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.*

"Patient Assessment Data": *standardized, publicly available information derived from a post-acute care provider's patient/resident assessment instrument, e.g., Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS).*

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GUIDANCE §483.21(c)(1)

Discharge Planning

Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team (as defined in §483.21(b)(2)(ii) working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge. It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions. A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition. An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.

The discharge care plan is part of the comprehensive care plan and must:

- *Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;*
- *Address the resident's goals for care and treatment preferences;*
- *Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;*
- *Be re-evaluated regularly and updated when the resident's needs or goals change;*
- *Document the resident's interest in, and any referrals made to the local contact agency;*
- *Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance*

Resident Discharge to the Community

Section Q of the Minimum Data Set (MDS) requires that individuals be periodically assessed for their interest in being transitioned to community living, unless the resident indicates otherwise. See: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html.
For residents who want to be discharged to the community, the nursing home must determine if appropriate and adequate supports are in place, including capacity and capability of the resident's caregivers at home. Family members, significant others or the resident's representative should be involved in this determination, with the resident's permission, unless the resident is unable to participate in the discharge planning process.
Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be transitioned to a community setting of their choice. The nursing home staff is responsible for making referrals to the LCA, if appropriate, under the process that the State has established. Nursing home staff should also make the resident and if applicable, the resident representative aware that the local ombudsman is available to provide information and assist with any transitions from the nursing home.

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For residents who have been in the facility for a longer time, it is still important to inquire, as appropriate, whether the resident would like to talk with LCA experts about returning to the community. New or improved community resources and supports may have become available since the resident was first admitted which may now enable the resident to return to a community setting.

If the resident is unable to communicate his or her preference or is unable to participate in discharge planning, the information should be obtained from the resident's representative.

Discharge planning must include procedures for:

- *Documentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose;*
- *Documentation of the response to referrals; and*
- *For residents for whom discharge to the community has been determined to not be feasible, the medical record must contain information about who made that decision and the rationale for that decision.*

Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:

- *Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;*
- *Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;*
- *Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;*
- *Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.*

As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).

Residents who will be discharged to another SNF/NF, HHA, IRF, or LTCH

If a resident will be discharged to another SNF, an IRF, LTCH, or HHA, the facility must assist the resident in choosing an appropriate post-acute care provider that will meet the resident's needs, goals, and preferences. Assisting the resident means the facility must compile available data on other appropriate post-acute care options to present to the resident. Information the facility must gather about potential receiving providers includes, but is not limited to:

- *Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and*
- *Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.*

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The listing of potential providers and data compiled must be relevant to the resident's needs, and be aligned with the resident's goals of care and treatment preferences.
Facilities must also comply with Section 1128B of the Social Security Act (the Federal Anti-Kickback statute) when making referrals to other provider types. Section 1128B "prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a Federal health care program," https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-laws-resourceguide.pdf.
In order to emphasize resident involvement, facilities are expected to present provider information to the resident and resident representative, if applicable, in an accessible and understandable format. For example, the facility should provide the aforementioned quality data on other post-acute care providers that meet the resident's needs, goals, and preferences, and are within the resident's desired geographic area. Facilities must then assist residents and/or resident representative as they seek to understand the data and use it to help them choose a post-acute care provider, or other setting for discharge, that is best suited to their goals, preferences, needs and circumstances. For residents who are discharged to another SNF/NF, a HHA, IRF, or LTCH the facility must provide evidence that the resident and if applicable, the resident representative was given provider information that includes standardized patient assessment data, and information on quality measures and resource use (where that data is available).

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

F624: *For concerns related to the immediate orientation and preparation necessary for a transfer which does not require discharge planning, such as transfers to a hospital emergency room or therapeutic leave.*

Summary of Investigative Procedures

Use the Community Discharge Critical Element (CE) Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement to develop and implement an effective discharge planning process.

Briefly review the most recent comprehensive assessments, comprehensive care plan (specifically the discharge care plan), progress notes, and orders to identify whether the facility has identified and addressed the resident's goals and discharge needs. This information will guide observations and interviews to be made in order to corroborate concerns identified. If there are concerns related to systematic discharge planning, this may trigger a review of the nursing home's policies and procedures for discharge assessment and care planning.

NOTE*: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

Effective November 28, 2017

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to:

- *The facility failed to ensure that the post-discharge destination and continuing care provider could meet the resident's needs prior to the discharge of a resident with a feeding tube to a residential group facility. The surveyor discovered that within 24 hours of discharge, the resident was transferred to the hospital for aspiration, was intubated for respiratory distress and diagnosed with brain death. Review of medical records showed no documentation of the resident's tube feeding needs in the discharge plan, or whether the nursing home informed the receiving facility of the presence of the feeding tube and the need for aspiration precautions. It was also unclear whether the nursing home had determined that the receiving facility had the ability to care for a resident with a feeding tube prior to placement of the individual.*

Examples of level 3, actual harm that is not immediate jeopardy include, but are not limited to:

- *The facility failed to develop and/or implement a discharge care plan for a resident who had expressed a desire to return home as soon as possible once she completed rehabilitation for a fractured hip. The medical record revealed the therapist had discontinued the active treatment one week ago. The resident stated and the medical record verified that the facility had not developed plans for her care after her discharge and had not contacted any community providers to assist in her discharge. She indicated that she has not slept well due to worrying about returning to her home and paying the rent while in the facility. The resident's home was over an hour away. She stated she was depressed over having to remain in the nursing home, and spent most of the day in her room as it was too far for her friends to visit.*
- *A facility failed to develop discharge plans to meet the needs and goals of each resident, resulting in significant psychosocial harm, when the facility determined it would be closing, necessitating the discharge of all residents. The facility notified residents and resident representatives it would assist with relocation. Interviews with residents and observations showed residents were agitated, fearful, and in tears over the impending move. Residents indicated they were not asked their preferences and many would be relocated far away from family. Residents also indicated they were not given opportunities to provide input into the discharge planning process, specifically regarding discharge location. Record review showed no evidence of interaction with residents or resident representatives related to discharge planning. This was cross-referenced and cited at F845, Facility Closure.*

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An example of Level 2, no actual harm with potential for than more than minimal harm that is not immediate jeopardy, includes, but is not limited to:

- *Facility failed to develop a discharge care plan that addressed all of the needs for a resident being discharged home. Specifically, the care plan did not address the resident's need for an oxygen concentrator at home. After the resident was discharged to his home, a family member had to contact the physician to obtain the order and make arrangements for delivery of the equipment. Although there was a delay in obtaining the oxygen concentrator, the resident did not experience harm, however this four-hour delay had a potential for compromising the residents' ability to maintain his well-being.*

Severity Level 1 does not apply for this regulatory requirement. *The failure of the facility to provide appropriate discharge assessment and planning in order to meet the resident's needs and goals at the time of discharge from the nursing home and to ensure communication of necessary information for a safe transition of care places the resident at risk for more than minimal harm.*

Effective November 28, 2017

F661 - Discharge Summary

Old Tag Numbers: F283, F284

§483.21(c)(2) Discharge Summary

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

(i)* A recapitulation of the resident's stay *that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

***(ii)* A final summary of the resident's status to include items in paragraph *(b)(1) of §483.20,* at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.**

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv)* A post-discharge plan of care that is developed with the participation of the resident and, *with the resident's consent, the resident representative(s)*, which will assist the resident to adjust to his or her new living environment. *The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

INTENT of §483.*21(c)(2)*

To ensure the facility communicates necessary information to the resident, continuing care provider and other authorized persons at the time of an anticipated discharge.

DEFINITIONS §483.21(c)(2)

***"Anticipated Discharge"**: A discharge that is planned and not due to the resident's death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation).*

***"Continuing Care Provider"**: The entity or person who will assume responsibility for the resident's care after discharge. This includes licensed facilities, agencies, physicians, practitioners, and/or other licensed caregivers.*

***"Recapitulation of Stay"**: A concise summary of the resident's stay and course of treatment in the facility.*

***"Reconciliation of Medications":** A process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.*

Effective November 28, 2017

GUIDANCE §483.*21(c)(2)*

Overview

The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge. A discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care.

In the case of discharge to a non-institutional setting such as the resident's home, provision of a discharge summary, with the resident's consent, to the resident's community-based physicians/practitioners allows the resident to receive continuous and coordinated, person-centered care.

For residents who are being discharged from the facility to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care. The medical record must identify the receiving facilities for which or physicians/practitioners to whom the discharge summary is provided.

Content of the Discharge Summary

Recapitulation of Resident's Stay

Recapitulation of the resident's stay describes the resident's course of treatment while residing in the facility. The recapitulation includes, but is not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results.

Final Summary of Resident Status

In addition to the recapitulation of the resident's stay, the discharge summary must include a final summary of the resident's status which includes the items from the resident's most recent comprehensive assessment identified at §483.20(b)(1)(i) – (xviii) Comprehensive Assessment. This is necessary to accurately describe the current clinical status of the resident. Items required to be in the final summary of the resident's status are:

- *Identification and demographic information;*
- *Customary routine;*
- *Cognitive patterns;*
- *Communication;*
- *Vision;*
- *Mood and Behavior patterns;*
- *Psychosocial well-being;*
- *Physical functioning and structural problems;*

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- *Continence;*
- *Disease diagnoses and health conditions;*
- *Dental and nutritional status*
- *Skin condition;*
- *Activity pursuit;*
- *Medications;*
- *Special treatments and procedures;*
- *Discharge planning (as evidenced by most recent discharge care plan);,*
- *Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and*
- *Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.*

***NOTE**: In addition to the above, pursuant to §483.15(c)(2)(iii), the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility:*

- *Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident;*
- *Resident representative information, if applicable, including contact information;*
- *Advance directive information;*
- *All special instructions or precautions for ongoing care, as appropriate;*
- *Comprehensive care plan goals; and*
- *All other necessary information, including a copy of the resident's discharge summary, consistent with 483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.*

For concerns related to the above, see guidance at F622, §483.15(c)(2)(iii).

Timing of the Discharge Summary

*The discharge summary contains necessary medical information that the facility must furnish **at the time the resident leaves the facility**, to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary may be furnished in either hard copy or electronic format, if the provider assuming responsibility for the resident's care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident. The medical record must contain the discharge summary information and identify the recipient of the summary.*

***NOTE:** In situations where there is no continuing care provider (e.g., resident has no primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider.*

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Reconciliation of Medications Prior to Discharge

A resident's discharge medications may differ from what the resident was receiving while residing in the facility. Facility staff must compare the medications listed in the discharge summary to medications the resident was taking while residing in the nursing home. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes. For example, a resident who was receiving rehabilitative services may have required antibiotic

therapy postoperatively but does not need to continue the antibiotic at home. The discontinuation of the medication should be documented in the discharge summary.

Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative must accurately reflect the reconciled medication list in the discharge summary.

Post-Discharge Plan of Care

The post-discharge plan of care details the arrangements that facility staff have made to address the resident's needs after discharge, and includes instructions given to the resident and his or her representative, if applicable. The post-discharge plan of care must be developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the resident's representative. At the resident's request, a representative of the local contact agency may also be included in the development of the post-discharge plan of care. The post-discharge plan of care should show what arrangements have been made regarding:

- *Where the resident will live after leaving the facility;*
- *Follow-up care the resident will receive from other providers, and that provider's contact information;*
- *Needed medical and non-medical services (including medical equipment);*
- *Community care and support services, if needed; and*
- *When and how to contact the continuing care provider.*

Instructions to residents discharged to home

For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. These instructions must be discussed with the resident and resident representative and conveyed in a language and manner they will understand.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F661, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- *Prepare a discharge summary that includes all of the following:*
  - *A recapitulation (containing all required components) of the resident's stay;*
  - *A final summary of the resident's status (that includes the items listed in §483.20(b)(1));*

Effective November 28, 2017

- *A reconciliation of all pre and post discharge medications;*
- *A discharge plan of care (containing all required components);* ***or***

- *Reconcile the resident's pre-discharge medications with his/her post-discharge medications;* ***or***
- *Convey the discharge summary to the continuing care provider or receiving facility at the time of discharge*

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to:

- *A resident experienced a stroke during the SNF stay and was started on Coumadin. The resident was then discharged to another facility but the discharge summary did not include the new orders for Coumadin and PT/INR monitoring. The receiving facility did not start the resident on Coumadin and the resident experienced another stroke.*

An example of level 3, actual harm that is not immediate jeopardy includes, but is not limited to:

- *Review of a discharge summary for a discharged resident showed that the discharge summary did not contain necessary information about the resident's wound care care needs and arrangements for wound care after discharge. Investigation showed that the resident did not receive appropriate wound care at home because details of wound care received in the facility were not conveyed in the discharge summary. The facility's failure to provide instructions for the care of the wound in the discharge summary information caused the resident's wound to worsen at home resulting in readmission to a hospital.*

An example of Level 2, no actual harm with potential for than more than minimal harm that is not immediate jeopardy, includes, but is not limited to:

- *A resident was discharged to another facility closer to her family. The transferring facility did not send a complete discharge summary to the receiving facility until one week after the resident was admitted to the new facility. The receiving facility had to take additional time and use multiple sources to verify medications and other medical orders while waiting for a complete discharge summary. This placed the resident at risk for more than minimal harm due to the potential for inaccuracies in medication and other orders while waiting for a complete discharge summary.*

An example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, includes, but is not limited to:

- *The failure of the facility to provide in its recapitulation of the resident's stay, the most recent laboratory results (which were normal). This resulted in no negative impact to the resident.*

Psychosocial Outcome Severity Guide

Clarification of Terms

"Anger" refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

"Apathy" refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

"Anxiety" refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper-vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

"Dehumanization" refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.

"Depressed mood" (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

"Humiliation" refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

Purpose

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag. The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome. The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome. For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, *as demonstrated by fear, agitation, and/or isolation*. In this case, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency.

Overview

Psychosocial outcomes (*e.g.*, *changes in* mood and/*or* behavior) may result from a facility's noncompliance with any regulatory requirement. *A* resident may *have* experienced *(or may have the potential or likelihood to experience)* a negative physical outcome *and/*or a negative psychosocial outcome *resulting from facility noncompliance*.

Psychosocial and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level should reflect the most significant negative outcome or highest level of harm/potential harm.

The presence of a given affect (i.e., behavioral manifestation of mood) does not necessarily indicate a psychosocial outcome that is the direct result of noncompliance. A resident's reactions and responses (or lack thereof) also may be affected by *his/her* pre-existing psychosocial issues, illnesses, medication side effects, and/or other factors. Because many nursing home residents have sadness, anger, loss of self-esteem, etc. in reaction to normal life experiences, the survey team must determine that the *negative* psychosocial outcome is a result of the noncompliance and not a pre-existing condition for the resident.

Psychosocial outcomes *may be the result of* facility noncompliance with any regulation. This also includes psychosocial outcomes resulting from facility failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, leading to continuation or worsening of the condition.

Instructions

This Guide is designed to be used separately for each resident included in the deficiency. Each resident's psychosocial response to the noncompliance is the basis for determining psychosocial severity of a deficiency. To determine severity, use the information gathered through the investigative process. Compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) and mood before and after the noncompliance.

If the survey team determines that a facility's noncompliance has resulted in a negative psychosocial outcome to one or more residents, the team should use this Guide to evaluate the severity of the outcome for each resident identified in the deficiency. The team should determine severity based *primarily* on the resident's response, *or if appropriate, apply the reasonable person concept to the deficient practice.*

Application of the Reasonable Person Concept

There are circumstances in which the survey team *should* apply the "reasonable person concept" to determine severity of the deficiency, *such as when a resident's psychosocial outcome may not be readily determined through the investigative process*.

To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance).

NOTE: The reasonable person concept described in this Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes. Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate and is expressly precluded.

Use the reasonable person concept *to determine* a resident's psychosocial outcome, *which* may not be readily determined. *For example:*

- When *a resident may not be able to express their feelings,* there is no discernable response, or when circumstances *may not permit* the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

- When *a* resident's reaction to a deficient practice is markedly incongruent *(or different)* with the level of reaction a reasonable person would have to the deficient practice.

Severity Levels

The following are *examples of severity* levels of negative psychosocial outcomes that *could have* developed, continued, or worsened as a result of *a* facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation *has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.* Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level four* include, but are not limited to:

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).

- Sustained and intense crying, moaning, screaming, or combative behavior.

- Expressions (verbal and/or non-verbal) of severe, unrelenting, excruciating, and unrelieved pain; pain has become all-consuming and overwhelms the resident.

- Recurrent (i.e., more than isolated or fleeting) debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of a specific staff member).

- Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persists regardless of whether the precipitating event(s) has ceased and has resulted in a potentially life-threatening consequence.

- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, impairment, or death to self or others.

- *Extreme changes in social patterns, such as sustained isolation from staff, friends and family for a prolonged period of time.*

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level three* include, but are not limited to:

- Significant decline in former social patterns that does not rise to a level of immediate jeopardy.

- Persistent depressed mood that may be manifested by verbal and nonverbal symptoms such as:
    - Social withdrawal; *apathy*; irritability; anxiety; hopelessness; tearfulness; crying; moaning;
    - Loss of interest or ability to experience or feel pleasure nearly every day for much of the day;
    - Psychomotor agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a bothered or sad expression;
    - Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering);

- Verbal agitation (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), accompanied by sad facial expressions;
- Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care);
- Markedly diminished ability to think or concentrate;
- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead" or "my family would be better off without me").

- Expressions (verbal and/or non-verbal) of persistent pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, weight loss and/or diminished appetite. Pain or physical distress has become a central focus of the resident's attention, but it is not all-consuming or overwhelming (as in Severity Level 4).

- Chronic or recurrent fear/anxiety that has compromised the resident's well-being and that may be manifested as avoidance of the fear-inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization (as in Severity Level 4).

- Ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists regardless of whether the precipitating, dehumanizing event(s) or situation(s) has ceased. The*se* feelings do not result in a life-threatening consequence.
- Sustained distress (e.g., agitation indicative of under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something).
- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, screaming, or cursing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level two* include but are not limited to:

- Intermittent sadness, as reflected in facial expression and/or demeanor, tearfulness, crying, or verbal/vocal agitation (e.g., repeated requests for help, moaning, and sighing).

- Feelings and/or complaints of discomfort or moderate pain. The resident may be irritable and/or express discomfort.

- Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well- being.

- Feeling of shame or embarrassment without a loss of interest in the environment and the self.

- Complaints of boredom and/or reports that there is nothing to do, accompanied by expressions of periodic distress that do not result in maladaptive behaviors (e.g., verbal or physical aggression).

- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm
Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the *following* areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome. *Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:*

483.10 Resident Rights
F557, Respect, Dignity/Right to Have Personal Property;
F558, Reasonable Accommodation of Needs/Preferences;

483.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;
F602 Free from Misappropriation/Exploitation;
F603, Free from Involuntary Seclusion;
F604, Right to be Free from Physical Restraints;
F605, Right to be Free from Chemical Restraints;
F606, Not Employ/Engage Staff with Adverse Actions;
F607, Develop/Implement Abuse/Neglect, etc. Policies;
F608, Reporting of Reasonable Suspicion of a Crime;
F609, Reporting of Alleged Violations;
F610, Investigate/Prevent/Correct Alleged Violations;

483.21 Comprehensive Resident Centered Care Plans

F656, Develop/Implement Comprehensive Care Plan;
F657, Care Plan Timing and Revision;

483.24 Quality of Life

F675, Quality of Life

F679, Activities Meet Interest/Needs of Each Resident;

483.40 Behavioral Health Services

F740, Behavioral Health Services;
F741, Sufficient/Competent Staff – Behavioral Health Needs;
F742, Treatment/Services for Mental/Psychosocial Concerns;
F743, No Pattern of Behavioral Difficulties Unless Unavoidable;
F745, Provision of Medically Related Social Services;

483.45 Pharmacy Services

F757, Drug Regimen is Free From Unnecessary Drugs; and
F758, Free from Unnecessary Psychotropic Medications/PRN Use.

Compliance with Facility Initiated Transfer and Discharge Requirements

Handout #3

Critical Element Pathways and Care Area Probes Relevant to Facility-Initiated Transfers and Discharges

Provided Courtesy Of

TEAMTSI now a part of SHP

Discharge Critical Element Pathway

Use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident's discharge plan meets the needs of the resident.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – Discharge Status (A2100), C – Cognitive Patterns, G – Functional Status, and Q – Participation in Assessment and Goal Setting.
- ☐ Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- ☐ Pertinent diagnoses.
- ☐ Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).

Observations:

- ☐ Does staff provide care for the resident as listed in the discharge plan? If not, what is different?
- ☐ How are staff providing education regarding care and treatments in the care plan?
- ☐ How does the resident perform tasks or demonstrate understanding after staff provides education?

Resident, Resident Representative, or Family Interview:

- ☐ What are your discharge plans?
- ☐ What has the facility discussed with you about returning to the community or transitioning to another care setting?
- ☐ Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?
- ☐ What was your involvement in the development of your discharge plan?
- ☐ What has the facility talked to you about regarding post-discharge care?
- ☐ Ask about any discrepancies between the resident's discharge plan and the facility's discharge plan.
- ☐ If discharge is planned:
  - How did the facility involve you in selecting the new location? Did you have a trial visit, if feasible? How did it go;
  - How were your goals, choices, and treatment preferences taken into consideration;
  - What are your plans for post-discharge care (e.g., self-care, caregiver assistance);
  - What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable; and
  - What discharge instructions (e.g., medications, rehab, durable medical equipment needs, labs, contact info for home health, wound treatments) has the facility discussed with you? Were you given a copy of the discharge instructions? If applicable, did the facility have you demonstrate how to perform a specific procedure so that you can do it at home?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- ☐ What is the process for determining whether a resident can be discharged back to the community? How do you involve the resident or resident representative in the discharge planning? Do you make referrals to the Local Contact Agency when the resident expresses an interest in being discharged?
- ☐ How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated?
- ☐ What is the resident's discharge plan, including post-discharge care?
- ☐ Why is the resident being discharged (i.e., for the resident's welfare and the resident's needs cannot be met in the facility, because the resident no longer required services provided by the facility, because the health or safety of the individual was endangered, or due to non-payment)?
- ☐ For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? What does the new facility offer that can meet the resident's needs that you could not offer?
- ☐ Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible?
- ☐ What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location?
- ☐ For discharge summary concerns are noted, interview staff responsible for the discharge summary.
- ☐ How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?

Record Review:

- ☐ Did the facility ask the resident about their interest in receiving information regarding returning to the community? If not, why not?
- ☐ If the resident wants to return to the community, was there a referral to the local contact agency or other appropriate entities?
- ☐ If referrals were made, did the facility update the discharge plan in response to information received?
- ☐ If the resident cannot return to the community, who made the determination and why?
- ☐ Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs?
- ☐ Does the care plan adequately address the resident's discharge planning? Does it address identified needs, measureable goals, resident and/or resident representative involvement, treatment preferences, education, and post-discharge care? Has the care plan been revised to reflect any changes in discharge planning?
- ☐ Who from the IDT was involved in the ongoing process of developing the discharge plan?
- ☐ What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate?
- ☐ Is there documentation of the specific needs that could not be met, the attempts the facility made to meet the resident's needs, and the specific services the new facility will provide to meet the resident's needs?

Discharge Critical Element Pathway

- ☐ If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences.
- ☐ If this was a facility-initiated discharge, was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident, resident representative, and a copy to the ombudsman:
  - o Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and
  - o If changes were made to the notice, were recipients of the notice updated?
- ☐ Did the facility provide a discharge summary to the receiving provider, which includes all required components at F661?
- ☐ Does the discharge summary include a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications? If not, describe what is missing.
- ☐ For residents discharged to the community, does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

Critical Element Decisions:

1) Did the facility:
   - o Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support;
   - o Document that the resident was asked about their interest in receiving information about returning to the community;
   - o Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital); and/or

   If No, cite F660

2) Did the facility:
   a. Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
   b. Develop a post-discharge plan of care, including discharge instructions?

   If No, cite F661

Discharge Critical Element Pathway

3) Does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., for the resident's welfare, the resident's needs could not be met in the facility, the resident no longer required services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates)?
   If No, cite F622

4) Was required discharge information documented in the resident's record and communicated to the receiving facility?
   If No, cite F622

5) If this was a facility-initiated discharge, was the resident and resident representative notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)?
   If No, cite F623

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Participate in Care Plan F553, Notification of Change F580, Professional Standards F658, Medically Related Social Services F745, Resident Records F842, QAA/QAPI (Task), Orientation for Transfer or Discharge F624.

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive MDS/CAAs for Sections B – Hearing, Speech, and Vision, C – Cognitive Patterns, E – Behavior, G – Functional Status, I – Active Diagnoses, J – Health Conditions-Pain, Falls, N – Medications, and O – Special Treatments, Procedures, and Programs.
- ☐ Physician's orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).
- ☐ Pertinent diagnoses.
- ☐ Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident's hospitalization.
- ☐ Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident's needs, goals, preferences, and assessment).

Observations:

- ☐ Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
  - o Physical distress;
  - o Mental status changes;
  - o A change in condition; and/or
  - o Pain?
- ☐ If symptoms are exhibited, what does staff do?
- ☐ Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

- ☐ Why were you sent to the hospital? Has your condition improved? If not, do you know why it's not getting better?
- ☐ When did you start to feel different, sick, or have a change in condition?
- ☐ Do you feel staff responded as quickly as they could have when you had a change in condition?
- ☐ Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?
- ☐ Do you have pain? If so, what does staff do for your pain?
- ☐ Has your health declined since you were in the hospital? If so, what has staff done?
- ☐ What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).

Hospitalization Critical Element Pathway

- ☐ Were you notified immediately about your change in condition and need for potential hospitalization?
- ☐ Were you involved in the development of the care plan and goals regarding your care before and after you got back from the hospital?
- ☐ Do the interventions reflect your choices and preferences?
- ☐ Did you refuse care related to the symptoms which led to your hospitalization? If so, what was your reason for refusing care? Did the staff provide you with other options for treatment or provide you with education on what might happen if you did not follow the treatment plan?
- ☐ Has your hospitalization caused you to be less involved in activities you enjoy?
- ☐ Since your hospitalization, have you had a change in your mood or ability to function? If so, what has staff done?
- ☐ Did you receive a notice of transfer or discharge from the facility?
- ☐ Did the facility give you information about holding your bed for you while you were at the hospital?
- ☐ Were you allowed to return to the facility and to your previous room? If not, do you know why not?

Staff Interviews (Nursing Aides, Nurses, DON, Practitioner):

- ☐ Are you familiar with the resident's care?
- ☐ When did the hospitalization occur? What was the cause (e.g., pain, infection, mental status change, or fall)?
- ☐ Do you have a structured process for identifying and addressing a resident's change in condition (e.g., facility developed tool, Interventions to Reduce Acute Care Transfers [INTERACT])?
- ☐ Prior to the hospitalization, did the resident have a change or decline in condition? If so, when? How often did you assess the resident? Where is it documented?
- ☐ If the resident had a change in condition, who did you notify (e.g., practitioner or representative) and when?
- ☐ Prior to or after the hospitalization, did the resident refuse any treatment? What do you do if the resident refuses?
- ☐ Is the resident at risk for additional hospitalizations?
- ☐ Since the resident returned from the hospital, has the resident had a change or decline in condition? If so, what interventions are in place to address the problem(s)?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ How did you involve the resident/representative in decisions regarding treatments?
- ☐ If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current care plan.
- ☐ Ask about identified concerns.

Hospitalization Critical Element Pathway

Record Review:

- ☐ Was the cause of the hospitalization assessed, monitored, and documented timely (e.g., nursing notes, EMT records, hospital discharge summaries, H&P, progress notes/vital signs)?
- ☐ Did the facility adequately identify and address the resident's change in condition?
- ☐ Were changes in the resident's status or other risks associated with the hospitalization identified as soon as possible?
- ☐ Were changes in the resident's status related to the hospitalization communicated to staff, practitioner, resident and representative immediately after they were identified?
- ☐ Was the transfer to the hospital necessary (e.g., the resident's needs couldn't be met after facility attempts to address the needs, or the health or safety of individuals in the facility would be endangered if the resident stayed in the facility)?
- ☐ Did the facility send all necessary clinical information to the hospital (i.e., practitioner and representative's contact info, advance directive, special instructions or precautions for ongoing care, care plan goals, and all other information needed to care for the resident). Refer to 483.15(c)(2)(iii) for additional guidance on what must be conveyed.
- ☐ Did the appropriate practitioner document the basis for the transfer? [F622, 483.15(c)(2)(ii)]
- ☐ Was the resident/representative provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand?
- ☐ Did the notice meet all the notice requirements at 483.15(c)(3)?
- ☐ Did the resident/representative receive the notice of Bed Hold per 483.15(d)?
- ☐ Did the facility assess and monitor the resident's response to interventions?
- ☐ Did the facility identify necessary changes in interventions to prevent further hospitalizations?
- ☐ Does the resident have a medical condition or receive medications that require monitoring? If so, did the monitoring take place and was it documented (e.g., blood glucose monitored and treated appropriately)?
- ☐ Were there any medication changes that were pertinent to the hospitalization?
- ☐ Were any laboratory results pertinent to the hospitalization?
- ☐ Review facility policies and procedures relevant to the resident's hospitalization (e.g., policy on changes in condition).
- ☐ Review the facility's admission information provided during the Entrance Conference regarding bed holds and transfers.
- ☐ Ensure the resident was provided the policy on returning to the facility in the same room, if possible, and bed holds.
- ☐ Could the transfer to the hospital have been avoided (e.g., had the change in condition been identified and addressed earlier, the condition would not have declined to the point where the resident required a transfer)?
- ☐ **Residents not permitted to return to facility after hospitalization (Discharge):** When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is considered to be a facility-initiated discharge – ensure the facility is in compliance with all discharge requirements at 483.15.

Hospitalization Critical Element Pathway

☐ For any resident whose **transfer to the hospital resulted in a discharge**, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave: [Refer to 483.15(c), (d), and (e) for additional guidance.]

- What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]
- Did the resident/representative receive all appropriate notification (Notice of Transfer, containing the basis for transfer; and Notice of Bed Hold); Was a copy of the notice sent to the ombudsman? [Refer to F623 and F625]
- Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624]
- When the transfer became a discharge, did the facility issue another notice of Discharge? If so, what was the basis for the discharge? For residents discharged because the health or safety of individuals would be endangered, is there evidence that residents with similar health needs, conditions, or symptoms currently reside in the facility, or were admitted after the resident was discharged? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to F622]
- Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to F626]
- Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to F622]

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care to prevent the hospitalization, that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice??
If No, cite the relevant outcome tag in Quality of Life, Quality of Care, or if no specific outcome tag, cite F684

2) Was the basis for the resident's transfer/discharge consistent with the requirements at 483.15(c)(1)? Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements at 483.15(c)(2)(i)-(ii)? Is there evidence that the information conveyed to the receiving provider met the requirements at 483.15(c)(2)(III)? Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
If No to any of these questions, cite F622

Hospitalization Critical Element Pathway

3) Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?

AND/OR

For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?
If No, cite F623

4) Was the resident sufficiently prepared and oriented for their transfer to the hospital?
If No, cite F624

5) Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
If No, cite F625

6) Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
If No, cite F626

7) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident?Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

8) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

9) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637

Hospitalization Critical Element Pathway

NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change status.

10) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status) ?
If No, cite F641

11) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

12) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

Care Area Probes Relative to Transfers and Discharges

During the resident **initial pool interview** and **sample pool investigative process**, surveyors will ask these questions to determine if there are compliance issues with **facility-initiated** transfers and discharges.

Resident Interview

Care Area	Probes	Surveyor Response
Hospitalizations	Have you gone to the hospital or emergency room for treatment recently? • When did you go and why? • Were you able to go back to your same room? • Were you told whether the facility would hold your bed? • How often are you admitted to the hospital?	No Issues/NA Further Investigation MDS Discrepancy

Resident Representative Interview

Care Area	Probes	Surveyor Response
Hospitalizations	Have [resident's name] gone to the hospital or emergency room for treatment recently? • When did he/she go and why? • Was [resident's name] able to go back to his/her same room? • Were you told whether the facility would hold his/her bed? • How often is [resident's name] admitted to the hospital?	No Issues/NA Further Investigation MDS Discrepancy

Resident Record Review

Care Area	Probes	Surveyor Response
Hospitalizations	Was the resident re-hospitalized in the last 120 days?	No Issues/NA Further Investigation MDS Discrepancy

Source: Surveyor Care Area Interview Probes Worksheet.

Compliance with Facility Initiated Transfer and Discharge Requirements

Handout #4

CMS Emergency Waivers Relevant to Facility-Initiated Transfers and Discharges

Provided Courtesy Of

TEAMTSI
now a part of SHP

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Resident Transfer and Discharge	CMS is **waiving** requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and §483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) (with some exceptions) to allow a long term care (LTC) facility to **transfer or discharge** residents to another LTC facility **solely for the following cohorting purposes**: 1. **Transferring** residents with **symptoms** of a respiratory infection or **confirmed** diagnosis of COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents; 2. **Transferring** residents **without** symptoms of a respiratory infection or confirmed to **not** have COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19, as well as providing treatment or therapy for other conditions as required by the resident's plan of care, or 3. **Transferring** residents **without** symptoms of a respiratory infection to another facility that **agrees** to accept each **specific** resident to **observe** for any signs or symptoms of a respiratory infection over 14 days. **Exceptions to Resident Transfer and Discharge Notices** These requirements are **only** waived in cases where the **transferring** facility receives **confirmation** that the **receiving** facility **agrees** to **accept** the resident to be transferred or discharged. Confirmation may be in **writing** or **verbal**. If verbal, the transferring facility needs to **document** the date, time, and person that the **receiving** facility communicated agreement. **EXCEPTIONS Continued on NEXT Page**			

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Resident Transfer and Discharge	**Exceptions to Resident Transfer and Discharge Notices** In §483.10, CMS is **only waiving** the requirement, under **§483.10(c)(5),** that a facility provide **advance notification** of **options relating** to the transfer or discharge to **another** facility. **Otherwise**, **all requirements related to §483.10 are not waived**. **Similarly**, in §483.15, CMS is **only waiving** the requirement, under **§483.15(c)(3), (c)(4)(ii), (c)(5)(i)** and **(iv),** and **(d),** for the **written notice** of transfer or discharge to be provided **before** the transfer or discharge. This notice must be provided as soon as practicable. In §483.21, CMS is **only waiving** the **timeframes** for **certain care planning** requirements for residents who are transferred or discharged for the purposes **explained in 1–3 above** (see page 10). **Receiving** facilities should **complete** the required care plans as soon as practicable, and CMS expects **receiving** facilities to **review** and **use** the **care plans** for residents **from** the **transferring** facility, and **adjust** as **necessary** to protect the health and safety of the residents they apply to. **These** requirements are **also waived when transferring** residents to **another** facility, such as a COVID-19 isolation and treatment location, with the provision of services "**under arrangements**," as long as it is **not inconsistent** with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department. **In these cases**, the **transferring** LTC facility need **not** issue a formal discharge, as it is still considered the provider and should bill Medicare normally for each day of care. The **transferring** LTC facility is then **responsible** for **reimbursing** the other provider that accepted its resident(s) **during** the emergency period. CMS **reminds** LTC facilities that they are **responsible** for ensuring that **any** transfers (either within a facility, or to another facility) are **conducted** in a safe and orderly manner, and that each resident's health and safety is protected.	483.10(c)(5)	F552	Right to be Informed in Advance.
		483.15(c)(3)(i)-(iii)	F623	Notice Before Transfer.
		483.15(c)(4)(ii)	F623	Timing of the Notice.
		483.15(c)(5)(i)	F623	Reason for Transfer or Discharge.
		483.15(c)(5)(iv)	F623	Name/Address/Phone-Ombudsman
		483.15(c)(5)(d)	F625	Notice of Bed Hold Policy.
		483.21(a)(1)(i)	F655	Baseline Care Plans – 48 Hours.
		483.21(a)(2)(i)	F655	Comp CP in Place of Baseline.
		483.21(b)(2)(i)	F657	Comp CP within 7 Days-Completion of Comp. Assessment.
	If the facility does **not** intend to provide services **under arrangement**, the COVID-19 isolation and treatment facility is the **responsible entity** for Medicare billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to **submit** a discharge bill to Medicare. The COVID-19 isolation and treatment facility **should** then **bill Medicare** appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is **not yet an enrolled provider**, the facility should **enroll** through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.			

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Discharge Planning	CMS is **waiving** the **discharge planning** requirement **§483.21(c)(1)(viii)**, which requires LTC facilities to **assist** residents and their representatives in **selecting** a post-acute care provider **using** data, such as **standardized** patient assessment data, **quality measures** and **resource** use. This **temporary** waiver is to provide facilities the **ability** to **expedite** discharge and **movement** of residents among care settings. **CMS is maintaining all other discharge planning requirements,** such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii) [Care Plan Timing and Revision **F657**], in the ongoing process of **developing** the discharge plan address the resident's goals of care and treatment preferences.	483.21(c)(1)(viii)	F660	Assisting residents in selecting a Post-Acute Care Provider by using data that includes, but is not limited to, assessment data, quality measures, available resources.

Compliance Discussion Points:

- This waiver **ONLY** applies to resident's being **discharged** to another **SNF**, or who is being **discharged** to a **HHA**, **IRF**, or **LTCH**. The waiver **only** applies to the facility's requirement to **provide** the resident with **information** about the **receiving facility's** MDS assessment data as it relates to the resident's goals of care and treatment preferences, quality measures and resource use data such as discharges to the community, preventable hospital readmissions, etc which is housed on the Nursing Home, HHA, IRF, or LTCH Compare Websites.
- This waiver does **NOT** affect the following discharge planning requirements:
  - ✓ §483.21(c)(1)(i) – Discharge needs are identified and result in the development of a discharge plan for each resident.
  - ✓ §483.21(c)(1)(ii) – Regularly re-evaluated to identify changes that require modification of the discharge plan.
  - ✓ §483.21(c)(1)(iii) – Involved the interdisciplinary team.
  - ✓ §483.21(c)(1)(iv) – Consider caregiver/support person/resident's capacity and capability to perform required care.
  - ✓ §483.21(c)(1)(v) – Involved the resident/representative in the development of the discharge plan.
  - ✓ §483.21(c)(1)(vi) – Address the resident's goals of care and treatment preferences.
  - ✓ §483.21(c)(1)(vii) – Document that the resident has been asked about their interest in receiving information regarding return to the community (MDS – Section Q)
  - ✓ §483.21(c)(1)(ix) – Document and include in the clinical record the evaluation of the resident's discharge needs and discharge plan.
  - ✓ §483.21(c)(2) – Discharge Summary **(F661)**

Compliance with Facility Initiated Transfer and Discharge Requirements

Handout #5

S&C Letter 18-08

Facility Initiated Discharges that Violate Federal Regulations

Provided Courtesy Of

TEAMTSI now a part of SHP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-08-NH

DATE: **December 22, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations

Memorandum Summary

- **Federal regulations allow facilities to initiate discharges of residents only in specific instances.** Despite these protections, discharges which violate Federal regulations continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs.

- **The Centers for Medicare & Medicaid Services (CMS) has begun an initiative to examine and mitigate facility-initiated discharges that violate federal regulations.** CMS is examining State survey agency's intake and triage practices for these type of discharge complaints, developing examples of inappropriate and appropriate discharges for surveyors, identifying best practices for nursing homes, developing training and evaluating enforcement options for these types violations.

- **Civil Money Penalty (CMP) Reinvestment Projects Assistance**. CMS is encouraging States to pursue CMP-funded projects that may help prevent facility initiated discharges that violate federal regulations.

Background

Federal regulations governing long term care facilities provide many protections for all nursing home residents, including the right to remain in the facility unless a limited set of circumstances apply:

> §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
> (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.

Facilities are required to determine their capacity and capability to care for the residents they admit, so in the absence of atypical changes in residents' conditions, it should be rare that facilities who properly assess their capacity and capability of caring for a resident then discharge that resident based on the inability to meet their needs.

Occurrence of Facility initiated Discharges/Evictions

Facility-initiated discharges continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs. In FY 2015, ''discharge/eviction'' was the most frequent nursing facility complaint category processed by the Long-Term Care Ombudsman Programs nationally.

Discharges which violate federal regulations are of great concern because in some cases they can be unsafe and/or traumatic for residents and their families. These discharges may result in residents being uprooted from familiar settings; termination of relationships with staff and other residents; and residents may even be relocated long distances away, resulting in fewer visits from family and friends and isolation of the resident. In some cases, residents have become homeless or remain in hospitals for months.

The reasons for non-compliant discharges can vary. Analysis of federal deficiencies indicate that some discharges are driven by payment concerns, such as when Medicare or private pay residents shift to Medicaid as the payment source. The most commonly reported reason that residents are discharged is due to behavioral, mental, and/or emotional expressions or indications of resident distress. Sometimes facilities discharge residents while the resident is hospitalized for health concerns unrelated to the behaviors that form the alleged basis for the discharge.

CMS is evaluating facility initiated discharge issues in nursing homes and considering a variety of interventions, including surveyor and provider training, intake and triage training, CMP-funded projects that may help prevent facility initiated discharges that violate federal regulations, and enforcement.

CMP Proposals Encouraged

CMS is encouraging States to consider CMP reinvestment proposals that would utilize funds to prevent improper facility initiated discharges.

Please see S&C 12-13-NH for information on how to submit proposals for CMP funds (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter12_13.pdf).

Such proposals may include but are not limited to the following:

- Projects designed to educate residents and their families on their rights in relation to facility initiated discharge;

- Projects creating teams of health professionals who could provide immediate support to facilities around the state to reduce risk of harm to self or others when a resident is exhibiting expressions or indications of distress. Such support may include consultation, resident assessments, and/or creating a more person-centered plan of care. This may be accomplished through in-person consultation or remotely with telemedicine;

- Projects designed to educate facility staff on best practices for engaging residents and families in collaborative strategies such as person-centered environments and care plans to reduce resident distress; and/or

- Formation and support of a collaborative group focusing on nursing home issues such as resident placement or transitional care, residents expressing or indicating distress, or medically complex residents such as those with dementia or delirium. Group members may consist of nursing homes, ombudsman, local hospitals, providers of long term services and supports, the regional QIN-QIO, and other stakeholders who have a vested interest in the protection and quality of care nursing home residents receive. Appropriate use of CMP funds for this project may include but are not limited to a meeting space, facilitator, or administrative support for the group. Examples of organizations that could qualify include but are not limited to consumer advocacy organizations, resident or family councils, professional or state nursing home associations, private contractors, etc. We note that funds cannot be used to supplant activities that are already required or funded. For example, it may be appropriate for representatives from QIN-QIO or ombudsman organizations to participate in activities related to these projects, but their specific engagement shouldn't be funded through CMP funds.

Transfer of Cases to the RO

As part of the effort to fully address facility initiated discharges that violate federal regulations, CMS will review deficiencies precipitated by facility-initiated discharges. Unless directed otherwise by the CMS Regional Office (CMS RO), State survey agencies must transfer any case involving facility initiated discharge violations to the CMS RO for review where there is placement in a questionable or unsafe setting, where residents remain hospitalized, where there is a facility pattern, or other circumstances that the RO may identify of cases they would like transferred. This does not change any other enforcement policies that identify cases that must be transferred to the RO. Following review, the ROs may take enforcement action if they deem it is proper.

Tags related to facility-initiated discharges include:

- F177/F560: Right to Refuse Certain Transfers
- F208/F620: Admissions Policy
- F201/F622: Transfer/Discharge Requirements (Basis for Transfer/Discharge of Resident)
- F202/F622: Transfer/Discharge Requirements (Documentation for Transfer/Discharge of Resident)
- F203/F623: Notice Requirements Before Transfer/Discharge
- F204/F624: Preparation for Safe/Orderly Transfer/Discharge
- F205/F625: Notice of Bed Hold Policy Before/Upon Transfer
- F206/F626: Permitting Residents to Return to Facility

Contact: For questions or concerns, please contact NHSurveydevelopment@cms.hhs.gov.

Effective Date: Immediately. This memorandum should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management