Transfer, Notice, and Discharge
Tool – Transfer and Discharge Policy and Procedure Checklist
§483.15
F620, F621, F622, F623 F624, F625, and F626

Suggested Checklist Admission, Transfer, and Discharge Policy and Procedure	
Requirement	**Recommended Actions**
F620 Admissions Policy	
§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.	☐ Ensure the policy contains provisions to permit residents to remain in the facility unless: ➢ The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; ➢ 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; ➢ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; ➢ The health of individuals in the facility would otherwise be endangered; ➢ 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 ➢ The facility ceases to operate.

	☐ Ensure the policy contains prohibitions against: ➢ The waiver of rights to Medicare or Medicaid. ➢ The waiver of potential facility liability for losses of personal property. ☐ Review, and revise if necessary, facility policies to safeguard residents' personal possessions to include: ➢ A process for documenting high value personal property (cash, valuable, and medical/assistive devices brought in by residents. ➢ 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. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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.	☐ Ensure the policy contains prohibitions against: ➢ Requesting or requiring a third-party guarantee of payment as a condition of admission or expedited admission, or continued stay. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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, —	☐ Ensure the policy contains prohibitions against: ➢ Charging, soliciting, accepting, or receiving any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility for a person eligible for Medicaid.

(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.	☐ Ensure the policy contains the acceptability of: ➢ Charging a Medicaid eligible resident 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 continue stay on the request for and receipt of such additional services. ➢ Soliciting, accepting, or receiving 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. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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.	☐ Ensure the policy contains any State specific admissions standards related to individuals entitled to Medicaid and that the stricter requirement (federal or state) will be followed. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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.	☐ Ensure the policy contains how residents or potential residents will be notified of: ➢ Special facility characteristics. ➢ Service limitations. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.

§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.	☐ Ensure the policy contains how residents or potential residents will be notified of: ➢ The facility's physical configuration, including the various locations that comprise the composite distinct part. ➢ The policies that apply to room changes between its different locations (See F621 below). ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
F621 Equal Practices Regardless of Payment Source	
§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);	☐ Ensure the policy contains how residents or potential residents will be notified that: ➢ The facility does not distinguish between residents based on their source of payment when providing services that are required to be provided under the law and that are based upon the individual needs as determined by assessments and care plans. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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	☐ Ensure the policy contains: ➢ The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). ➢ The facility may charge the resident for requested services that are more expensive than or in excess of covered services. ➢ Residents may be charged any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the provisions of F571 and F582. ➢ Residents must be told in advance when changes will occur in their bills, and

	providers must fully inform the resident of the services and related changes. ☐ Review, and revise if necessary, admissions packet/admissions agreement to include these items.
§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.	**See immediately above.**
§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.	☐ Only if applicable. Refer to F560 which addresses the resident's right to refuse transfer/room change.
F622 Transfer and Discharge Requirements	
§483.15(c) Transfer and discharge **§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	☐ Review, revise, and implement Transfer and Discharge Policies and Procedures in accordance with the new Requirements of Participation. ☐ Ensure the policy contains provisions to permit residents to remain in the facility unless: ➢ The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; ➢ 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; ➢ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; ➢ The health of individuals in the facility would otherwise be endangered; ➢ 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

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.	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 ➢ The facility ceases to operate. ☐ Review and revise as necessary resident rights information provided to residents and representatives to ensure the resident's right related to discharge are reflected. ☐ Review and revise as necessary staff education for orientation and annual training to reflect the resident rights information and policies and procedures for involuntary discharges.
§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	☐ Review, revise, and implement a policy and procedure for documentation of transfers and discharges. The policy must include: ➢ Documentation is required for all voluntary and involuntary transfers and discharges. ➢ Documentation is made in the resident's medical record by the resident's physician for transfers when a resident's needs cannot be met or the resident's health has improved so that the resident does not need the services of the facility. ➢ Documentation must be made by a physician when the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident or the health of individuals in

receiving facility to meet the need(s).

(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.

the facility would otherwise be endangered.

- Documentation by the physician must include:
  1.) The basis for transfer
  2.) The specific resident need(s) that cannot be met and the facility's attempts to meet the need(s)
  3.) The services available at the receiving facility that can meet the resident's need(s)

☐ Provide education for physicians caring for residents in the facility about new requirements for discharge documentation.

☐ Review and revise as necessary the health record structure to include a location for discharge documentation from physicians.

☐Review and revise as necessary staff education for orientation and annual training to reflect the resident rights information and policies and procedures for involuntary discharges documentation.

☐ Review and revise as necessary the policy and procedure for referral information sent to the post-discharge provider for voluntary or involuntary discharges or transfers. Ensure that the policy provision of the following information:

- Contact information of the provider caring for the resident.
- Contact information for the resident's representative
- Advance Directive information
- Special instructions for ongoing care or precautions for care
- Comprehensive care plan goals
- The discharge summary
- All other necessary information to provide for continuity of care for the resident.
- Consider these additional documents:
  a. Physician summary orders

	b. Medication administration records c. Treatment records d. The last 15 months of MDS assessments e. The most recent H&P and provider visit notes f. Relevant IDT progress notes ☐ Develop a transfer/discharge checklist for staff use to prepare for voluntary and involuntary transfer and discharge of a resident. ☐ Provide education for nurses, social workers, unit clerks and medical records staff about the transfer and discharge documentation requirements. ☐ Implement a monitoring system to ensure that required and relevant documents are send to post-discharge providers for residents voluntarily and involuntarily transferred and discharged.
F623 Notice Requirements Before Transfer/Discharge	
§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.	☐ Review and revise as necessary the facility policy and procedure for issuing the discharge notice before transfer. Ensure that the policy includes: ➢ The notice will contain the reason for transfer/discharge and the reason for the move. ➢ The notice will be issued in a language and manner the resident and representative can understand. ➢ Notice will be sent to the Long Term Care Ombudsman office. ➢ The reason for the transfer/discharge will be documented in the resident's medical record including the required components of the notice. ➢ Issuance of the notice 30 days in advance of the discharge date or ➢ Notice is issued as soon as practicable if:

	1.) The resident is discharged urgently because the safety of others in the facility is endangered or the health of individuals in the facility would be endangered. 2.) The resident's health improves sufficiently to allow a more immediate transfer or discharge, or an immediate transfer or discharge is required by the resident's urgent medical needs. 3.) The resident has not resided in the facility for 30 days. ➢ If there is a change to any information in the notice prior to the effective date of discharge, the notice will be updated and provided to the required parties.
§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,	See immediately above.

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 Long-Term Care Ombudsman; **(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 **(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.	☐ Review and revise as necessary the facility policy and procedure for issuing the discharge notice before transfer or discharge. Ensure that the policy includes: ➢ The notice will contain the reason for transfer/discharge and the reason for the move. ➢ The notice will be issued in a language and manner the resident and representative can understand. ➢ Notice will be sent to the Long Term Care Ombudsman office. ➢ The reason for the transfer/discharge will be documented in the resident's medical record including the required components of the notice. ➢ Issuance of the notice 30 days in advance of the involuntary discharge date or ➢ Notice is issued as soon as practicable if: 1.) The resident is discharged urgently because the safety of others in the facility is endangered or the health of individuals in the facility would be endangered. 2.) The resident's health improves sufficiently to allow a more immediate transfer or discharge, or an immediate transfer or discharge is required by the resident's urgent medical needs. 3.) The resident has not resided in the facility for 30 days. ➢ If there is a change to any information in the notice prior to the effective date of discharge, the notice will be updated and provided to the required parties. ☐ Ensure the policy includes stipulations that the transfer or discharge notice contains: ➢ The reason for transfer/discharge. ➢ The effective date of transfer/discharge.

	➢ The location to which the resident will be transferred. ➢ A statement of the resident's right to appeal. ➢ The name, mailing address, email address and telephone number of the agency that receives discharge appeal requests. ➢ Information about how to obtain an appeal form and the title of the facility staff who will assist the resident to complete and submit the form. ➢ The name, mailing address, email address and telephone number of the State Long Term Care Ombudsman's office. ➢ For facilities with 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 developmental , or related disabilities; the mailing address , email address and State advocacy agency listing can be found at: Administration for Community Living – US Department of HHS. ➢ For facilities with 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. ☐ Review and revise as necessary the discharge notice form or letter currently used by the facility. Ensure that the required components, as listed above are contained in the notice. ☐ Review and revise staff education for orientation and annual training to reflect the resident rights information and policies and procedures for involuntary discharges,

	documentation requirements and issuance of the discharge notice. ☐ Develop and implement a monitoring process to ensure that discharge notices are completed with the required information.
§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.	☐ Develop and implement a monitoring process to ensure that a discharge notice is revised if information changes prior to the resident's discharge date and that the revised notice is distributed to the required parties.
§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).	☐ Only if applicable. The facility will need to follow the specific State requirements for facility or unit close as well as State relocation requirements. Review and revise the policy and procedure for issuing a discharge notice to ensure that the policy stipulates that the Administrator will provide written notice of ending closure to the State Survey Agency, The State Long Term Care Ombudsman, the residents and their representatives. Per the regulations - The Administrator will provide an adequate relocation and the plan and to the State Survey Agency, The State Long Term Care Ombudsman, the residents and their representatives.
F624 Preparation for Safe/Orderly Transfer/Discharge	
§483.15(c)(7) Orientation for transfer or discharge. 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.	☐ Review and revise as necessary policies and procedures regarding transfers and discharges even for a hospital emergency room transfer or therapeutic leave to ensure sufficient preparation and orientation has occurred to minimize anxiety as much as possible. ➢ Informing the resident where he/she is going. ➢ Working with family or representative to assure possessions as needed or requested by the resident are not left behind or lost. ➢ Informing the resident in a form and manner the resident can understand. ➢ Documenting in the medical record.

	See F623 above as well.
F625 Notice of Bed Hold Policy Before/Upon Transfer	
§483.15(d) Notice of bed-hold 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.	☐ Review and revise as necessary policies and procedures regarding bed hold and reserve bed payment. ➢ Include this information in the admission packet. ➢ Re-issue this information if the policy changes under the State plan or the facility procedures.
§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.	☐ Review and revise as necessary policies and procedures regarding bed hold and reserve bed payment. ➢ Issuance of the notice to the resident and if applicable to the representative at the time of transfer or in cases of emergency within 24 hours. ➢ Documentation of all attempts to reach the representative. ➢ While Medicare will not pay to hold a bed, facility policy may allow the resident to pay privately to hold his/her bed. ➢ Include state plan information regarding payment for and duration of bed holds. ☐ Review and revise as necessary the bed-hold notice form.

F626 Permitting Residents to Return to Facility	
§483.15(e)(1) Permitting residents 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.	☐ Review and revise as necessary policies and procedures regarding return to the facility for all residents. ➢ 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. ➢ How residents who pay privately or receive Medicare may pay to reserve their bed. ➢ 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: 1.) Still requires the services provided by the facility; and 2.) 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. ➢ Not permitting a resident to return following hospitalization or therapeutic leave requires the facility to meet the limited requirements for a facility-initiated discharge.
§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.	☐ Only if applicable.

The areas below serve as a cross reference for facility leaders to conduct addition policy and procedure review across departments to incorporate the changes set forth in the requirements of participation related to Admissions, Transfers, and Discharges at §483.15. This listing is not all encompassing; however, it should serve as a resource for leaders as they update their internal policies, procedures, and operational processes.

Resident Bill of Rights
Resident Handbook
Discharge Policy
Discharge Summary
Admission Agreement
Discharge transfer and referral policy
Grievance
Grievance Official Role and Responsibility
Social Services
Medical Director – Role and Responsibility
Resident Rights Postings
Appeal Process with Agency and State Contacts
New Employee Orientation for social worker, nurse leaders, staff nurses, unit clerk and medical records staff
Medical records policies for physician discharge note and discharge notice
Facility Wide Resource Assessment – Phase II
Quality Assurance and Performance Improvement

Transfer, Notice, and Discharge
Overview
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Preface

F620

All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the policy must identify the limited conditions for transfer or discharge. Second, requirements of participation prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, 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. Also, the facility's admission agreement must disclose the facility's physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part. The facility must also have a process for how it will disclose required information to residents and potential residents.

Regulations prohibit both direct and indirect requests to residents or potential residents to waive any rights under the long term care (LTC) requirements and under applicable federal, state, and 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.

Regulations do not preclude a facility from charging a deposit fee to, or requiring a promissory note from, an individual whose stay is not 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.

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.

A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending.

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.

F621

All services, including but not limited to nursing services, specialized rehabilitative services, behavioral health services, social services, dietary services, and pharmacy 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.

Facility Requirements Regarding Room Changes in a Composite Distinct Part

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.

F622

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.

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.

The facility must ensure that for discharges related to circumstances 1, 3, or 4 above, it 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.

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. 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.

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.

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. 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.

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.

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 and meets one of the criteria at §483.15(c)(i)(A) through (D).

> **(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.**]**

Required Documentation

To demonstrate that any of the circumstances permissible for a facility to initiate a transfer or discharge as specified in A – F 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 A and B above for permissible facility-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 C and D above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

Documentation of the transfer or discharge may be completed by a non-physician practitioner in accordance with State law.

Information Conveyed to Receiving Provider

The regulations at 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:
  o Treatments and devices (oxygen, implants, IVs, tubes/catheters);
  o Precautions such as isolation or contact;
  o Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;
- The resident's comprehensive care plan goals; and
- All information necessary to meet the resident's needs, which includes, but may not be limited to:
  o Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;
  o Diagnoses and allergies;
  o Medications (including when last received); and
  o Most recent relevant labs, other diagnostic tests, and recent immunizations.
- Additional information, if any, outlined in the transfer agreement with the acute care provider.

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.

F623

The requirements at 483.15(c) (3)-(6) only apply to facility-initiated transfers and discharges, not resident-initiated transfers and discharges, and include 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. 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.

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. 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.

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. 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.

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. 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.

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.

For residents with intellectual and developmental disabilities and/or mental illness, the notice must include the name, mail and e-mail addresses 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 endangered.

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.

F624

The guidance at F624 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.

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.

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.

F625

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.

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, F626 requires facilities to permit residents to return to the facility immediately to the first available bed in a semi-private room.

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.

F626

Facilities must develop and implement policies for bed-hold and permitting 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.

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

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.

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.

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.

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:
  o 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;
  o 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.

Definitions

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

Campus: 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.

Composite distinct part: A distinct part consisting of two or more noncontiguous components that are not located within the same campus.

Discharged: The resident is not expected to return to the facility.

Distinct part: A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it. 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.

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.

Identical policies and practices: Facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

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.

Resident representative: The term resident representative may mean any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Resident-initiated transfer or discharge: The resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility.

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

Therapeutic Leave: Absences for purposes other than required hospitalization.

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.

Transferred: The resident is expected to return to the facility.

Overview of Regulatory Requirements for This Policy

F620 Admissions Policy

§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.

§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.

F621 Equal Practices Regardless of Payment Source

§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.

F622 Transfer and Discharge Requirements

§483.15(c) Transfer and discharge

§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).

(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.

F623 Notice Requirements Before Transfer/Discharge

§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 Long-Term Care Ombudsman;

(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

(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).

F624 Preparation for Safe/Orderly Transfer/Discharge

§483.15(c)(7) Orientation for transfer or discharge. 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.

F625 Notice of Bed Hold Policy Before/Upon Transfer

§483.15(d) Notice of bed-hold 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.

F626 Permitting Residents to Return to Facility

§483.15(e)(1) Permitting residents 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.

Admission, Transfer, and Discharge Policy and Procedures

Policy

Federal requirements of participation in the Medicare and Medicaid programs require a nursing facility to establish and to implement a policy addressing resident admission to the facility as well as the limited conditions for transfer or discharge from the facility.

The facility cannot require that residents or potential residents waive their rights to Medicare or Medicaid, nor can it require an oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Residents (and if appropriate, their representative(s)) have the right to be informed of these policies at the time of admission, transfer, and/or discharge. Additionally, written communication at the time of admission, re-admission, transfer, or discharge will be provided to ensure a safe and orderly process.

Procedure

A. Admission

1.) The facility will not request or require residents or potential residents to waive their rights as set forth in federal, state, or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid.
2.) The facility will not request or require written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.
3.) The facility will not ask residents 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.
4.) The facility will 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.
5.) 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.
6.) In the case of a person eligible for Medicaid, the nursing facility will 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.
7.) The 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.
8.) The 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.

9.) The nursing facility will disclose and will provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

10.) The nursing facility will disclose its physical configuration, including the various locations that comprise a composite distinct part, and will specify the policies that apply to room changes between its different locations.

B. Equal Access to Quality Care

1.) The facility will establish, will maintain, and will implement identical policies and practices regarding transfer and discharge and the provision of services for all individuals regardless of source of payment.

2.) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the federal and state notification requirements describing those charges.

C. Transfer and Discharge

1.) The facility will 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.

2.) The facility will not transfer or discharge the resident while an appeal is pending when a resident exercises his or her right to appeal a transfer or discharge notice from the facility unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.

3.) Facility staff continually monitor a resident's health and well-being and the care provided to meet their needs.

a.) If a transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, facility staff will notify the resident, resident representative, and physician or physician extender.

b.) If 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, facility

staff will carry out the discharge plan, incorporating whenever possible and practical the goals identified at time of admission or modified during the course of stay at the facility.

c.) If the health or safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, facility staff will notify the resident, resident representative, and physician or physician extender.

4.) The facility will make every effort to assist a resident to collect payment for services provided. This includes gathering and submitting information required by Medicare, Medicaid, and other third-party payers.

5.) If the resident (or if appropriate, resident representative) has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility, facility staff may issue a notice of discharge whenever the outstanding bill is _____ days in arrears.

a.) 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.

b.) For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6.) If the facility ceases to operate, all residents will receive a notice of discharge.

D. Timing and Content of the Notice of Transfer or Discharge

1.) Notice must be made to the resident and resident representative as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered,

(B) The health of individuals in the facility would be endangered,

(C) The resident's health improves sufficiently to allow a more immediate transfer,

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, or

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

2.) Except as specified immediately above, the notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged.

3.) The facility will notify the ombudsman of any facility-initiated transfer or discharge as per federal and state requirements.

a.) A 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.

b.) 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.

4.) The written notice must include the following:

a.) The reason for transfer or discharge;

b.) The effective date of transfer or discharge;

c.) The location to which the resident is transferred or discharged;

d.) 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;

e.) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

f.) 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; and

g.) 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.

5.) 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.

6.) 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.

7.) If a resident chooses to leave the facility against medical advice (AMA), include documentation of the following:

a.) Capacity. This term refers to the resident's medical ability to make a decision. Documenting that the resident "understood" offers little protection, while documenting the ability to carry on a conversation and demonstrate reason provides a much more compelling example of their capacity to make decisions.

b.) Signs and Symptoms. The resident and provider need to agree on both the individual's symptoms and also the providers concerns.

c.) Extent of Care and Services. Document what has been done as well as the limitations that still exist.

d.) Current Plan of Care. Document that you have reviewed their current plan of care and need for services, treatment, *etc.*

e.) Risks of Foregoing Services. Document discussion of potential risks.

f.) Alternatives and Options. Document if other options or alternatives were discussed and the individual's response.

g.) Explicit Statement of AMA and About What the Resident is Refusing. Document a specific statement about AMA discharge and what the resident is specifically refusing.

h.) Questions, Follow-up, Medicines, Instructions. When patients leave AMA, providers should do whatever is possible to limit potential negative outcomes. All questions should be answered.

E. Preparation for Safe/Orderly Transfer/Discharge

1.) The facility will provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

2.) This orientation must be provided in a form and manner that the resident can understand.

F. Notice of Bed Hold Policy Before/Upon Transfer

1.) Before the nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility will provide written information to the resident or resident representative that specifies—
   a.) 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;
   b.) The reserve bed payment policy in the state plan if any;
   c.) The nursing facility's policies regarding bed-hold periods and permitting a resident to return:
      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 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 for transfer and discharge noted above.

G. Permitting Residents to Return to the Facility

1.) 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.

2.) If the facility 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 federal requirements and not discharge a resident unless:
   a. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.
   b. The resident's health has improved sufficiently so that the resident no longer needs the services of the facility.
   c. The resident's clinical or behavioral status endangers the safety of individuals in the facility.
   d. The resident's clinical or behavioral status endangers the health of individuals in the facility.
   e. The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility.
   f. The facility ceases to operate.

References

CMS Manual System Services (DHHS) Pub. 100 Centers for Medicare & Medicaid -07 State Operations Services (CMS) Provider Certification Transmittal 169- Advanced Copy
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Medicaid Bed-Hold Policies by State (September 2012)
http://ltcombudsman.org/uploads/files/library/state-bedhold-chart-oct2012.pdf

The Proper Way to Go Against Medical Advice
https://www.aliem.com/2014/proper-way-to-go-against-medical-advice/

Sample Notices

The following are samples and must include state specific requirements,
State agency contact and reviewed with facility counsel

THIRTY DAY DISCHARGE NOTICE

<<Date>>

<<Resident/Legal Representative>>
<<ADDRESS>>
<<CITY, STATE, ZIP>>

Dear _____:

This letter serves as a notice of discharge from ***(insert name and location of facility)*** . The reason for this notice and your upcoming discharge is due to ***(insert reason for transfer/discharge as approved by primary physician) .***

The anticipated date of your discharge is ___ (DATE) ___. A discharge planning conference will be held prior to your discharge to ensure a smooth transition to your new living setting. The location to which you'll be moving is ___ (LOCATION) ___.

You have a right to relocation assistance and to be prepared for and oriented to being discharged. A separate notice will be provided inviting you, your representative and others to a discharge planning conference. In addition, you have a right to contact an advocate to discuss this notice, and to seek assistance.

You may call or write an Ombudsman (for persons over age 60) or a representative from _____ (for persons under age 60) to discuss this notice and help you understand your rights:

<<Insert Name and Contact of Long Term Care Ombudsman>>

<<Insert Name and Contact of all other appropriate advocacy representatives per State requirements and disability>>

If you wish to appeal this discharge decision, you may appeal your relocation or discharge plan by:

- Writing a letter, within _____ *(per State requirements)* days of having received this notice, to the regional office of the <<insert State Agency information>> asking for a review of the discharge/transfer notice and stating why this plan should not take place.

- Send a copy of the appeal letter to the administrator of this facility.
- Within _____ days of having received your written appeal, the facility must provide written justification for the discharge to the _____.
    - You may not be discharged, if you've filed a written appeal within _____ days of receiving this notice, until the _____ has completed its review and notified both you and the facility of its decision, within fourteen (14) days of having received written justification from the facility.
    - You may appeal the decision of the _____ in writing, to the _____within five (5) days after having received the decision by the _____.

The name/address/phone number for the regional office of the _____ Department of Health Services

<<Insert name and contact information for State Department of HSS Representative>>>

The name/address/phone number of this facility's administrator is:
<<insert Name and Contact information>>>

The name/address/phone number of _____ – Division of Hearing and Appeals is:
<<insert contact information >>>

We will continue to work very closely with you to assure that your relocation goes as smoothly as possible and that your questions and concerns will be addressed. Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility. Thank you.

Sincerely,

Sample - Formal Discharge Planning Conference Notice

FORMAL DISCHARGE PLANNING CONFERENCE NOTICE

<<Date>>

<<Resident/Legal Representative>>
<<ADDRESS>>
<<CITY, STATE, ZIP>>

Dear _____:

This letter serves as a notice of a formal discharge planning conference at <<Insert Name of Facility and address>>

The purpose of this meeting is to finalize plans for your relocation to _____ on _____ (Date).

At this meeting, the kinds of assistance to be provided to you in moving yourself, your belongings and funds will be discussed as well as making provisions for your continuing to receive medications and treatments in accordance to your plan of care. This meeting should result in the development of a post-discharge plan of care that includes instructions for your continued care in order to assist you in adjusting to a new living environment.

At the time of your discharge and upon your consent, a summary of your status will be made available to authorized persons and agencies. A final statement of any funds or property that has been held by this facility for you will be prepared.

FORMAL DISCHARGE PLANNING CONFERENCE
The meeting is scheduled for (DATE) at (TIME) located in _____.
You will be meeting with : _____.

You may invite, or decline to have present, any person of your choosing at this meeting. I recommend involving your friends/family members, your county care manager, as appropriate, your physician and an Ombudsman. <<insert State specific information>>

You may file a complaint about this discharge or discharge process by contacting the regional office of the Department of Health Services_____ by contacting:

<<Insert Contact Information>>

We will continue to work very closely with you to assure that your relocation goes as smoothly as possible and that your questions and concerns will be addressed. Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility.

Sincerely,

SAMPLE

NOTICE OF WAIVER OF THE 30 DAY TIME PERIOD FOR A DISCHARGE

_____ I, ____ (RESIDENT'S NAME/DECISION-MAKER) ____, have been informed of my right to receive a written notice of discharge at least 30 days before the anticipated date of that discharge. I choose to/circumstances dictate that I leave the facility before the 30 day period has lapsed and I waive my right to receive notice within that time frame.

_____ I have received a written notice of discharge on __ (DATE) __. This notice states the reason for my being discharged, and the location to and date upon which I am to relocate. This notice informs me of and instructs me in how to file an appeal of this discharge/relocation decision. This notice provides me with contact information for the regulatory agency with which I can file an appeal and for advocacy organizations that can assist me in an appeal.

_____ I have been informed of my right to receive discharge planning and to have a discharge planning conference scheduled at least 14 days before the anticipated date of discharge. I choose to leave the facility before the 14 day period has lapsed and I waive my right to the formal discharge planning conference that adheres to these timelines. I understand I will receive discharge and relocation assistance as mandated in state and federal regulations.

_____ I have been informed of my right to receive a written notice of this discharge planning conference within 7 days before that conference. I choose to leave the facility before the 14 day period has lapsed and waive my right to receive written notice of this formal discharge planning conference.

_____ _____

Signature – Resident or Agent Date

_____ _____

Signature – Facility Representative Date

Transfer, Notice, and Discharge
Tool – Discharge Audit

Discharge Audit	
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: o How did the facility involve you in selecting the new location? Did you have a trial visit, if feasible? How did it go; o How were your goals, choices, and treatment preferences taken into consideration; o What are your plans for post-discharge care (e.g., self-care, caregiver assistance); o 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 o 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?

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, 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?

	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:	
	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, possible cite at F660**
	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, possible cite at F661**
	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, possible cite at F622**

	Was required discharge information documented in the resident's record and communicated to the receiving facility? **If No, possible cite at F622**
	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, possible cite at 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.	

Adapted from Discharge Critical Element Pathway Form CMS 20132 (5/2017)

Transfer, Notice, and Discharge Tool – Hospitalization Audit

Hospitalization Audit	
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: Auditor 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?
	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 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).
	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.
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.
	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.] o What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]

	o 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] o Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624] o 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] o 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] o 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 Decisions:	
	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, potential cite for the relevant outcome tag at Quality of Life, Quality of Care, or if no specific outcome tag, potential cite at F684**
	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, potential cite at F622**
	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, potential cite at F623**

	Was the resident sufficiently prepared and oriented for their transfer to the hospital? **If No, potential cite at F624**
	Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment? **If No, potential cite at F625**
	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, potential cite at F626**
	For newly admitted residents, 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, potential cite at F655**
	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, potential cite at 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.**
	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, potential cite at F637** **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.**
	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, potential cite at F641**
	Did the facility develop and implement a comprehensive person-centered care plan that includes measurable 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, potential cite at F656 **NA, the comprehensive assessment was not completed.**
	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, potential cite at 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).	

Adapted from Hospitalization Critical Element Pathway Form CMS 20123 (5/2017)

Training Plan: Transfer Discharge Process

Training Name: Transfer Discharge Process – Leadership and IDT		
	❑ Training ❑ Simulation ❑ Workshop ☑ Presentation	
Training Objectives	1. Understand the regulation that guide our practices regarding involuntary transfer and discharge of residents. 2. Understand transfer/discharge notice responsibilities of the facility. 3. Understand facility requirements for promoting resident's rights and assisting with a safe and orderly transfer/discharge.	
Connection to Overall Project Goals	• This training is part of the overall project to educate and support nursing, facility operators and staff regarding the revised requirements of participation for nursing homes as it relates to Transfer and Discharge Process	
Participants: Who should attend?	Social Workers, Nurses and Nurse Leaders, Admissions Staff, Administrator, Business Office Staff (Power Point Presentation with speaker notes)	
	What training should they attend before this one?	• No pre-requisite
	What training should they attend after this?	• Annually or as needed
Facilitators: (How many trainers should participate and whom?)	***One presenter will be needed to facilitate the presentation, discussion and post-test***	
Logistics Requirements	***What is needed?***	
	• Room for training • Projector • Screen or other blank light colored surface	

Training References

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 10/04/16:

https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM), Appendix PP- Revised Regulations and Tags, 11/09/16:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf

POST TEST - TRANSFER DISCHARGE PROCESS

Question: True or False?	Answer
1. A transfer or discharge stands for a room change.	
2. The facility must provide a Notice of Discharge to a resident and resident representative 30 days prior to the discharge.	
3. Prior to discharge, the facility is not responsible for training or orienting the resident to their new setting.	
4. The facility can discharge a resident because their family complains a lot!	
5. The facility must provide a written notice in a manner and language in which it will be understood, 30 days prior to the scheduled discharge.	

Employee Printed Name_____ Date: _____

Employee Signature: _____