F622
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§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.

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

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

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

"Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. *(See §483.5).* Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

GUIDANCE

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

Surveyors must determine whether a transfer or discharge is resident- or facility-initiated. *The determination that a transfer or discharge is facility-initiated does not equate to noncompliance if the requirements in this regulatory section are met.*

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.

For resident-initiated 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 (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

NOTE: *Situations in which residents sign out of the facility, or leave Against Medical Advice (AMA) should be thoroughly investigated to determine if the discharge is facility- or resident-initiated. If evidence reveals that a resident or resident representative was forced, pressured, or intimidated into leaving AMA, the discharge would be considered a facility-initiated discharge, requiring further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F623. See additional guidance on AMA discharges at F660 and guidance on Abuse, Neglect and Exploitation at F600.*

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

In certain cases, residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge and the requirements at §§483.15(c)(1) and (c)(2)(i)-(ii) apply to ensure the discharge is not involuntary. These situations may require further investigation to ensure that discrimination based on payment source has not occurred in accordance with §483.10(a)(2) (F550). Additionally, in cases where the resident does not appear to object to the discharge, or has not appealed it, the discharge could still be a facility-initiated discharge and be thoroughly investigated to determine if resident-, or facility-initiated.

These regulations limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from facility-initiated transfers and discharges *which violate federal regulations.*

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.

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 *requirements at §483.70(e)* (*see also* F838, Facility Assessment). *For residents the facility has admitted,* §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, residents have a right to remain in the facility unless the discharge or transfer meets one of the specified exceptions in §§483.15(c)(1)(i)(A)-(F). Discharging a resident is a violation of this right unless the facility can demonstrate that one of the limited circumstances listed above is met. For example, if a resident whose stay is being paid for under Medicaid is discharged from the facility, but he or she wants to stay in the facility and still meets a state's requirements for a nursing home level of care, this would be a facility-initiated discharge.*

Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility. See additional guidance at F626, §483.15(e)(1), Permitting Residents to Return. Facility-initiated transfers and discharges must meet *the* transfer and discharge requirements at §§483.15(c)(1) - (5) *by having a valid basis for the transfer or discharge*. There may be rare situations, such as when a *serious* crime *(e.g., attempted murder or rape)* has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

NOTE: In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors would review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return.

If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs. (See §483.20(b)(2)(ii), F637, for information concerning assessment upon significant change.)

A resident's declination of treatment does not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. The facility must be able to demonstrate that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment, *(§483.10(c)(5) and (6), F552 and F578)* 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 *(§483.15(c)(2)(i)(B) and see also §§483.20 Resident Assessment and 483.35 Nursing Services).*

Nonpayment as Basis for Discharge
Non-payment for a stay in the facility occurs when *the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and also may apply:*

- *When t*he resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or
- After the third party *payer (including Medicare or Medicaid)* denied the claim and the resident refused to pay *for his/her stay*.

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. *In situations where a resident's Medicare coverage may be ending, the facility must comply with the requirements at §483.10(g)(17) and (18), F582. If the resident continues to need long-term care services, the facility, under the requirements above, should offer the resident the ability to remain, which may include:*

- *Offering the resident the option to remain in the facility by paying privately for a bed;*
- *Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:*
  - *if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and*
  - *if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.*

The resident cannot be discharged for nonpayment while a determination on the resident's Medicaid eligibility is pending.

NOTE:*Surveyors should be aware of a facility's Medicare and Medicaid certification status and/or the presence of a distinct part as this can affect whether a resident's discharge for non-payment is justified and is a relevant part of the investigation.*

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.

Emergency Transfers to Acute Care

*When*r esidents are sent emergently to *an acute care setting, these scenarios* are considered facility-initiated transfers, *NOT discharges,* because the resident's return is generally expected.

Residents who are sent *emergently to an acute care setting, such as a hospital*,**must**be permitted to return to the facility (*§483.15(e)(1),*F626). 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 at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria at §483.15(c)(1)(i)(A) through (D). Additionally, the resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that the failure to transfer or discharge would pose. (§483.15(c)(1)(ii)).*

NOTE*: Residents who are sent to the acute care setting for routine treatment/planned*

procedures must also be allowed to return to the facility (See F626, Permitting Residents to Return to Facility).

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

When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending.

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

§483.15(c)(2) **Required Documentation**

To demonstrate that any of the circumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge.

For circumstances 1 and 2 *listed* above for 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 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

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

Information Conveyed to Receiving Provider

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

- Contact information of the practitioner who was responsible for the care of the resident;
- Resident representative information, including contact information;
- Advance directive information;
- *All* special instructions and/or precautions for ongoing care, as appropriate *such as*:

- Treatments and devices (oxygen, implants, IVs, tubes/catheters);
- *Transmission-based* precautions such as contact, *droplet, or airborne*;
- 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 *other* information necessary to meet the resident's needs, which includes, but may not be limited to:
  - Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;
  - Diagnoses and allergies;
  - Medications (including when last received); and
  - Most recent relevant labs, other diagnostic tests, and recent immunizations.

- Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information).

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

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

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

INVESTIGATIVE PROTOCOL

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

Summary of Investigative Procedure

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

Outcome Severity Guide).

Deficiency Categorization
In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Psychosocial Outcome Severity Guide, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html, select the Survey Resources download and select the Psychosocial Outcome Severity Guide from the list of resources.

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

- *Facility initiated a discharge on the basis that the resident's health had improved, however, the resident and her family disagreed and filed an appeal. The facility did not allow the resident to remain in the facility while the appeal was pending and dropped her off at her daughter's home. The resident's daughter previously stated she could not care for her mother at her home where needed medical equipment and wound care was not available. The resident developed sepsis from inadequate wound management, and remains hospitalized post-amputation of the infected limb.*

- *A facility initiated a discharge based on the facility's inability to meet a resident's needs. However, upon complaint investigation, it was determined by interview and record review that, while the resident was depressed and had challenging behavior requiring staff attention, he did not have needs which could not be met in that facility, and there was evidence that the facility was caring for other residents with similar challenging behaviors. The resident was discharged to the street and found by a passerby in the street, rolled up in a tarp, and in a health condition requiring immediate medical attention.*

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

- *The facility failed to allow a resident to remain in the facility after his skilled rehabilitation ended and while his application for Medical Assistance was pending. The resident consequently was discharged to another facility that was located further from the resident's family, resulting in the resident expressing persistent sadness and withdrawal from social activities.*

- *A facility initiated a resident's discharge after the resident attempted to hit a staff member during morning care over several days. The facility discharged the resident claiming the resident was a danger to others. Upon investigation of a complaint, it was determined the facility had been failing to provide the resident with pain medication prior to morning care in accordance with the care plan. Evidence also showed the resident had never attempted to hit staff when pain was managed according to the care plan, therefore the resident was not actually a danger to others. There was also no*

documentation of the facility's attempts to meet the resident's needs or what services the new receiving facility had in order to meet the resident's needs. During an interview with the resident, the surveyor found the resident was not happy in the new facility and was no longer participating in activities or therapy, resulting in a significant decreased ability to perform ADLs.

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

- *A facility transferred a resident to the hospital emergently due to a change in condition. The facility failed to provide the hospital with contact information for the practitioner responsible for the resident's care leading to a delay in admitting the resident.*

An example of Severity Level 1 noncompliance: The failure to permit the resident to remain in the facility, document the resident's transfer or discharge, and communicate necessary information to the receiving provider places the resident at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.