F661

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§483.21(c)(2) Discharge Summary

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

- ***(i)*** **A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.**
- ***(ii)*** **A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.**
- ***(iii)*** **Reconciliation of all pre-discharge medications with the resident's postdischarge medications (both prescribed and over-the-counter).**
- ***(iv)*** **A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The postdischarge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.**

INTENT of §483.21(c)(2)

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

DEFINITIONS §483.21(c)(2)

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

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

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

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

GUIDANCE §483.21(c)(2)

Overview

The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the

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

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

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

Content of the Discharge Summary

Recapitulation of Resident's Stay

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

Final Summary of Resident Status

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

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and Behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnoses and health conditions;
- Dental and nutritional status
- Skin condition;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge planning (as evidenced by most recent discharge care plan);,

- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and
- Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.

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

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

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

Timing of the Discharge Summary

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

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

Reconciliation of Medications Prior to Discharge

A resident's discharge medications may differ from what the resident was receiving while residing in the facility. Facility staff must compare the medications listed in the discharge summary to medications the resident was taking while residing in the nursing home. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes. For example, a resident who was receiving rehabilitative services may have required antibiotic therapy postoperatively but does not need to continue the antibiotic at home. The discontinuation of the medication should be documented in the discharge summary.

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

Post-Discharge Plan of Care

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

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

Instructions to residents discharged to home

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

KEY ELEMENTS OF NONCOMPLIANCE

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

- Prepare a discharge summary that includes all of the following:
  - A recapitulation (containing all required components) of the resident's stay; ○ A final summary of the resident's status (that includes the items listed in §483.20(b)(1));
  - A reconciliation of all pre and post discharge medications; ○ A discharge plan of care (containing all required components); **or**
- Reconcile the resident's pre-discharge medications with his/her post-discharge medications; **or**
- Convey the discharge summary to the continuing care provider or receiving facility at the time of discharge

DEFICIENCY CATEGORIZATION

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

- A resident experienced a stroke during the SNF stay and was started on Coumadin. The resident was then discharged to another facility but the discharge summary

did not include the new orders for Coumadin and PT/INR monitoring. The receiving facility did not start the resident on Coumadin and the resident experienced another stroke.

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

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

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

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

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

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