§483.15(c) Transfer and discharge-

§483.15(c)(1) Facility requirements-

§483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

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

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

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

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

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

(F)The facility ceases to operate.

§483.15(c)(1)(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.

§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.

§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.

§483.21(c)(1) Discharge Planning Process

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

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

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

§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:

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

INTENT

- *These regulations and guidance address inappropriate discharges and:*
  - Specify the limited conditions under which a skilled nursing facility or nursing facility may transfer or discharge a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation.

- *Ensure policies are developed and implemented which allow residents to return to the facility following hospitalization or therapeutic leave.*

- *Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred.*

- *Ensure the discharge planning process* addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

DEFINITIONS

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

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

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

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

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

distinct part" of §483.5 described above. Requirements specific to distinct part SNFs or NFs are found at §483.5.

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

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

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

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

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

"Therapeutic Leave": Resident 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. (See §483.5). Specifically, transfer refers to the movement of a resident from a bed in one facility to a bed in another 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 facility or other location in the community, when return to the original facility is not expected.

GUIDANCE

Investigating noncompliance with the transfer and discharge requirements begins when conducting offsite preparation. The team coordinator (TC) should contact the local ombudsman and inquire if there are specific residents from whom the ombudsman has received complaints related to inappropriate discharges for review (see Investigative Procedure section below). The TC should also be sure to review complaints and survey history of the facility for indications of noncompliance with the requirements for transfer and/or discharge.

§483.15(c)(1)(i)-(ii) Transfer and Discharge Requirements

Use guidance at this Ftag to determine if noncompliance exists when evidence suggests a facility should not have transferred or discharged a resident at the time of discharge, or at all. These circumstances may include, but are not limited to, the following:

- *When evidence in the medical record does not support the basis for discharge, such as:*
    - *Discharge based on an inability to meet the resident's needs, but there is no evidence of facility attempts to meet the resident's needs, or no*
    - *evidence of an assessment at the time of discharge indicating what needs cannot be met;*
    - *Discharge based on improvement of resident's health such that the services provided by the facility are no longer needed, but documentation shows the resident's health did not improve or actually declined;*
    - *Discharge based on the endangerment of the safety or health of individuals in the facility, but there is no documentation in the resident's medical record that supports this discharge;*
    - *Discharge based on failure to pay, however there is no evidence that the facility offered the resident to pay privately or apply for Medical Assistance or that the resident refused to pay or have paid under Medicare or Medicaid;*
    - *Discharge occurs even though the resident appealed the discharge, the appeal is pending, and there is no documentation to support the failure to discharge would endanger the health and safety of individuals in the facility.*
- *When evidence in the medical record shows a resident was not permitted to return following hospitalization or therapeutic leave, and there is no valid basis for discharge.*
- *There is no evidence that the facility considered the care giver's availability, capacity, and/or capability to perform needed care to the resident following discharge.*
- *The post-discharge plan of care did not address resident limitations in ability to care for themself.*

These regulations *describe the requirements that must be met in order for* a facility *to* transfer or discharge *a resident*, thus protecting nursing home residents from transfers and discharges which *should not have occurred, and thus* violate federal regulations.

§483.15(c)(1)(i)(A), (C) or (D) - Discharge when Needs Cannot be Met, or when Safety or Health of Individuals is Endangered

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 §483.71 (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 in the regulation is met.

Surveyors must ensure that for discharges related to circumstances *at §483.15(c)(1)(i)(A), (C), or (D)* 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 an acute care facility. *Without an assessment of the resident's status and needs at the time of proposed return to the facility, there can be no determination of (A), the resident's needs cannot be met, or (C) and (D), that the safety or health of individuals would be endangered.*

In situations where a resident's choice to refuse care or treatment poses a risk to the resident's or others' health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate (See F656, §483.21(b)(1)(ii), Comprehensive Care Plans.) 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, and see also §§483.20 Resident Assessment and 483.35 Nursing Services).

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.

§483.15(c)(1)(i)(E) **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 the resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or

- After the third party payor (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.

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, *the survey team should investigate to determine if* the discharge *violates these requirements,* is *inappropriate and should not have occurred. Additionally, t*hese situations may require further investigation to ensure that discrimination based on payment source has not occurred in accordance with §483.10(a)(2) (F550).

NOTE: Situations in which residents sign out of the facility, or leave Against Medical Advice (AMA) should be thoroughly investigated to determine if the resident or resident representative was forced, pressured, or intimidated into leaving AMA. *Additionally,* the discharge would *require* further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F62*8*. See additional guidance *at* Abuse, Neglect and Exploitation at F600.

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.

Successful Appeals on Discharges

For residents who have appealed their discharge and obtained a favorable ruling from the hearing, the resident or their representative may choose to report the discharge as a complaint to the State Survey Agency based on the favorable appeal ruling. However, the State Survey Agency cannot take a survey action, such as citing noncompliance exclusively based on the ruling of the hearing. Rather, the State Survey Agency must triage the complaint and conduct a survey in accordance with the timelines specified in Section 5079.9 of Chapter 5 of the State Operations Manual. During the survey, surveyors must investigate compliance with the applicable regulations, such as the discharge requirements in this F-tag. Surveyors should also consider compliance with §483.70(b), Compliance with Federal, State, and local laws and professional standards at F836. If noncompliance is found, cite the appropriate tag and level of scope and severity. Also, if the resident's discharge location is to a setting that does not meet their health or safety needs, the facility's plan of correction should state that the facility will either, 1) Re-admit the resident until a safe and compliant discharge can be done, or 2) Coordinate a transfer of the resident to another setting where they will be safe. See the Deficiency Categorization section towards the end of this guidance for more information.

§483.15(c)(2) Required Documentation *in the Resident's Medical Record*
To demonstrate that any of the circumstances permissible for a facility to transfer or discharge as specified in *the regulations* have occurred, the medical record must show documentation of the basis for transfer or discharge.

For circumstances *where the discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs or the resident's health has improved sufficiently so that the resident no longer needs the care of the facility,* the **resident's physician** must document information about the basis for the transfer or discharge. Additionally, *if the facility*

determines it cannot 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 *situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility,* 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.

§483.15(d)(1) – (e)(1)-(2) Bed Hold and Permitting Residents to Return

Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. **These policies apply to all residents, regardless of their payment source.** The facility policies must provide that residents who seek to return to the facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period or when state law does not provide for bed-holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident:

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

The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements at 42 CFR 483.15(c).

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

Emergency Transfers to Acute Care

When residents are sent emergently to an acute care setting, these scenarios are considered 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. In a situation where the facility discharge*s the resident* while

he or she 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 *the* 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)).

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 *her* 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 from the hospital the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility. If the facility is unable to provide the treatments, medications, and services needed, the facility may not be able to meet the resident's needs. For example, a resident now requires ventilator care or dialysis, and the nursing home is unable to provide this same level of care.

- Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:

    - Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;

    - Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

§483.15(e)(1)(ii) **Not Permitting Residents to Return**

Not permitting a resident to return following hospitalization or therapeutic leave constitutes a discharge and requires a facility to meet the requirements as outlined in §483.15(c)(1)(ii).

Because the facility was able to care for the resident prior to *the hospitalization or* therapeutic

leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

If the facility does not permit a resident's return to the facility (i.e., discharge*s the resident*) based on inability to meet the resident's needs, documentation must be in accordance with requirements at §483.15(c)(2)(i)(B). The facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. (§483.15(c)(3) and (5)(iv)) 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 documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

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

In cases where a facility did not allow a resident to return due to lack of an available bed, the surveyor should review facility admissions beginning with when the resident was ready to return to determine whether the facility held the resident's bed in accordance with its bed-hold policies, or, if the resident's stay outside of the facility exceeded the bed-hold period, whether there was an available bed at the time the resident sought return to the facility. If there was not an available bed at the time the resident sought return to the facility, the surveyor should determine whether or not the resident was allowed to return to the first available bed in a semi-private room.

When a facility alleges they cannot meet the resident's needs and does not allow a resident to return, the surveyor should 1) investigate why the resident's needs cannot be met; and 2) review facility admissions to determine if residents with similar care needs have been admitted or permitted to remain, which could indicate the facility has the capability to meet the needs of the resident who is not being allowed to return and demonstrates noncompliance with this requirement**.**

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 discharge *the resident* unless it has ascertained from the resident or resident representative that the *he or she* does not wish to return.

NOTE: In reviewing complaints for 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.

Composite Distinct Part

If a facility does not have a composite distinct part, §483.15(e)(2) does not apply. 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.
NOTE: If there are concerns as to whether or not a facility is appropriately certified as a distinct or composite distinct part, consult with the CMS Location for clarification.

§483.15(c)(7) Preparation for Transfer or Discharge

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.

§483.21(c)(1) Discharge Planning

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

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

- Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;

- Address the resident's goals for care and treatment preferences;

- Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;

- Be re-evaluated regularly and updated when the resident's needs or goals change;

- Document the resident's interest in, and any referrals made to the local contact agency; *and*

- Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance.

Resident Discharge to the Community

Section Q of the Minimum Data Set (MDS) requires that individuals be periodically assessed for their interest in being transitioned to community living, unless the resident indicates otherwise. See: *https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.*

For residents who want to be discharged to the community, the nursing home must determine if appropriate and adequate supports are in place, including capacity and capability of the resident's caregivers at home. Family members, significant others or the resident's representative should be involved in this determination, with the resident's permission, unless the resident is unable to participate in the discharge planning process.

Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be transitioned to a community setting of their choice. The nursing home staff is responsible for making referrals to the LCA, if appropriate, under the process that the State has established. Nursing home staff should also make the resident and if applicable, the resident representative aware that the local ombudsman is available to provide information and assist with any transitions from the nursing home.

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

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

Discharge planning must include procedures for:

- Documentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose;

- Documentation of the response to referrals; and

- For residents for whom discharge to the community has been determined to not be feasible, the medical record must contain information about who made that decision and the rationale for that decision.

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

- Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;

- Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;

- Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;

- Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.

As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).
Note: These situations only apply when a resident expresses their wishes to be discharged earlier than outlined in the care plan. These situations do not apply if a facility offers to discharge a resident to a location which does not meet their health and/or safety needs, and the resident agrees (this would constitute noncompliance).

§483.21(c)(1)(viii) **Residents who will be discharged to another SNF/NF, HHA, IRF, or LTCH**

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

- Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and

- Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.

To ensure resident involvement, facilities are expected to present provider information to the resident and resident representative, if applicable, in an accessible and understandable format. For example, the facility should provide the aforementioned quality data on other post-acute care providers that meet the resident's needs, goals, and preferences, and are within the resident's desired geographic area. Facilities must then assist residents and/or resident representative as they seek to understand the data and use it to help them choose a post-acute care provider, or other setting for discharge, that is best suited to their goals, preferences, needs and circumstances. For residents who are discharged to another SNF/NF, a HHA, IRF, or LTCH the facility must provide evidence that the resident and if applicable, the resident representative was given provider information that includes standardized patient assessment data, and information on quality measures and resource use (where that data is available).

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.

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 requirements *on when a facility can transfer or discharge a resident and ensuring the transfer or discharge meets the resident's health and/or safety needs.*

Summary of Investigative Procedure

*Use Offsite Preparation information from the Ombudsman to identify residents or resident representatives (for residents already discharged) who may have concerns with inappropriate discharges. For any residents with concerns, b*riefly review the most recent comprehensive assessment, comprehensive care plan (specifically the discharge care plan), progress notes, and orders to*:*

- *I*dentify the basis for the transfer or discharge,

- *Determine* whether the facility has identified and addressed the resident's goals and discharge needs*;*

- *Determine if the resident was appropriately oriented, prepared, and understood the information provided to him or her.*

*D*uring this review, identify the extent to which the facility has developed and implemented interventions 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.

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.

Violations of the requirements at F627, Inappropriate Discharges, would generally be cited at the severity level of Harm (Level 3) or Immediate Jeopardy (Level 4) when using the reasonable person approach in considering psychosocial outcomes as well as the likelihood for serious physical harm resulting from an unsafe discharge. See State Operations Manual Appendix Q and the Psychosocial Outcome Severity Guide located in the Survey Resources zip file located at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes) for additional information about psychosocial/mental harm and using the reasonable person concept.

***NOTE:** For citations at **any** level of scope and severity, if the discharged resident's health and/or safety is threatened in the setting they are currently located, the facility's plan of correction should state that the facility will either, 1) Re-admit the resident until a safe and compliant discharge can be done, or 2) Coordinate a transfer of the resident to another setting where they will be safe. The facility should not be determined in substantial compliance until one of these two items is complete (and all other noncompliance has been corrected). If the resident's needs are being met in their current location, the plan of correction should include specifics on how the facility will prevent inappropriate noncompliant discharges in the future.*

Additionally, for situations in which residents' discharge locations did not meet their health and/or safety needs,, enforcement should be implemented immediately. For example, a discretionary denial of payment for new admissions should be imposed to go into effect within 2 or 15 days (as appropriate) and remain in effect until a return to substantial compliance as evidenced by either, 1) the resident is readmitted and not discharged unless a safe and compliant discharge is done, or 2) the facility coordinates a discharge to another setting where their needs will be met.

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

- *A facility discharged a resident* on the basis that the resident's health had improved *so that the resident no longer needed the services provided by the facility*, 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*, thus creating an inappropriate discharge for this resident, which did not meet her health needs.*

- A facility discharge*d a resident* based on the facility's inability to meet *the* 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*s* 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

behaviors. The resident was discharged to *an unsafe setting, or in a manner, that placed the resident at risk for serious harm (e.g., the resident still has medical needs, but they cannot be supported in the setting they were discharged to).*

- *A f*acility failed to allow a resident *requiring the facility's services* to return following therapeutic leave to a family member's home. *Additionally, when the facility refused to allow him to return, they took no steps to comply with the discharge requirements for notice and appeal rights. This resulted* in *an inappropriate discharge.* The resident *was* found living on the street, without *the needed care and* adequate food and shelter, and susceptible to serious *injury*.

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

Examples of 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 discharge*d* a resident 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 *their prescribed* 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.

- Facility failed to allow a resident to return to an available bed in the same location of the composite distinct part in which they resided previously. The new location was not on the same campus where the resident previously resided, and was farther from the resident's family, resulting in the resident expressing sustained and persistent sadness and withdrawal.

- After transfer to a*n acute care facility*, a facility failed to allow a resident to return to the facility where the resident had lived for several months *saying they could not meet the resident's needs. Review of the resident's records did not show the resident had any new needs after hospitalization that could not be met by the facility. As a* result, the resident *was* transferred from the hospital to a different nursing home 40 minutes away, where he did not know anyone, and where he developed increased anxiety and depression.

- The facility failed to develop and/or implement a discharge care plan for a resident who had expressed a desire to return home as soon as possible once she completed rehabilitation for a fractured hip. The medical record revealed the therapist had discontinued the active treatment one week ago. The resident stated and the medical record verified that the facility had not developed plans for her care after her discharge and had not contacted any community providers to assist in her discharge. She indicated that she has not slept well due to worrying about returning to her home and paying the rent while in the facility. The resident's home was over an hour away. She stated she was depressed over having to remain in the nursing home, and spent most of the day in her room as it was too far for her friends to visit.

- A facility failed to develop discharge plans to meet the needs and goals of each resident, resulting in significant psychosocial harm, when the facility determined it would be closing, necessitating the discharge of all residents. The facility notified residents and resident representatives it would assist with relocation. Interviews with residents and observations showed residents were agitated, fearful, and in tears over the impending move. Residents indicated they were not asked their preferences and many would be relocated far away from family. Residents also indicated they were not given opportunities to provide input into the discharge planning process, specifically regarding discharge location. Record review showed no evidence of interaction with residents or resident representatives related to discharge planning. This was cross-referenced and cited at F845, Facility Closure.

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.

- Facility failed to develop a discharge care plan that addressed all of the needs for a

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

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.