F628
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§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.

(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.

§483.15(c)(3) Notice before transfer.

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

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

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

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

§483.15(c)(4) Timing of the notice.

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

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

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

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

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

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

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

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

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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

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

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

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

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

§483.15(c)(6) Changes to the notice.

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

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

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

§483.15(d) Notice of bed-hold policy and return—

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

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and

(iv) The information specified in paragraph (e)(1) of this section.

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

§483.21(c)(2) Discharge Summary

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

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

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

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

INTENT

The intent of this tag is to ensure the facility adheres to all of the applicable components of the process for transferring or discharging a resident which include documentation and information conveyed to the receiving provider, the notice of transfer or discharge, notice of bed-hold policy, and completing the discharge summary.

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).

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

"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.

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

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

"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 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

§483.15(c)(2) **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, 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.

§483.15(c)(3) **Notice of Transfer or Discharge and Ombudsman Notification**

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

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a

representative of the Office of the State LTC Ombudsman. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the ombudsman only needed to occur as soon as practicable.

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

Emergency Transfers--When a resident is temporarily transferred on an emergency basis to an acute care facility a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer, according to 42 CFR §483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices at §483.15(c)(5).

§483.15(c)(5) **Contents of the Notice**

The facility's notice must include all of the following at the time notice is provided:

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

For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice must include the name, mailing and e-mail addresses and phone number of the state agency responsible for the

protection and advocacy for these populations.

§483.15(c)(4) **Timing of the Notice**

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

- The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge;
- An immediate transfer or discharge is required by the resident's urgent medical needs; or
- A resident has not resided in the facility for 30 days.

In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.

§483.15(c)(6) **Changes to the Notice**

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. For significant changes, such as a change in the transfer or discharge destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30 day advance notification and permit adequate time for discharge planning. Surveyors should be aware that if a change in destination indicates that the original basis for discharge has changed, a new notice is required and additional appeal rights may exist for the resident. This situation may require further investigation to determine whether the facility is in compliance with the Transfer and Discharge requirements at 42 CFR 483.15(c).

Example: A facility determines it cannot meet a resident's needs and arranges for discharge to another nursing home which can meet the resident's needs. Before the discharge occurs, the receiving facility declines to take the resident and the discharging facility changes the destination to a setting that does not appear to meet the resident's ongoing medical needs. This could indicate that the basis for discharge has changed and would require further investigation.

NOTE: Federal regulations at 42 CFR Part 431, Subpart E, Fair Hearings for Applicants and Beneficiaries, address the requirements for States to implement a fair hearing process.

§483.15(c)(8) **Notice in Advance of Facility Closure:**

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

§483.15(d) **Notice of Bed-Hold Policy**

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

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

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

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

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

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

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

As stated above, a participating facility must provide notice to its residents and if applicable, their representatives, of the facility's bed-hold policies, as stipulated in each State's plan. This notice must be provided prior to and upon transfer and must include information on how long a

facility will hold the bed, how reserve bed payments will be made (if applicable), and the conditions upon which the resident would return to the facility. These conditions are:

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

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

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

§483.21(c)(2) Discharge Summary

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 or physicians/practitioners to whom the discharge summary is provided.

Content of the Discharge Summary

§483.21(c)(2)(i) 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.

§483.21(c)(2)(ii) **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.

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.

§483.21(c)(2)(iii) **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.

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 a *blood thinning medication*. 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 *their blood thinning medication*.

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 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). *The recapitulation contained all other required components.* This resulted in no negative impact to the resident.