F660

§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.

INTENT §483.21(c)(1)

This requirement intends to ensure that the facility has a discharge planning process in place which 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 §483.21(c)(1) "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.*

"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).* **Effective November 28, 2017**

GUIDANCE §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;*
- *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-Initiatives-Patient-AssessmentInstruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html.

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 **Effective November 28, 2017** *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).

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.*

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The listing of potential providers and data compiled must be relevant to the resident's needs, and be aligned with the resident's goals of care and treatment preferences. Facilities must also comply with Section 1128B of the Social Security Act (the Federal Anti-Kickback statute) when making referrals to other provider types. Section 1128B "prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a Federal health care program,"
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-IntegrityEducation/Downloads/fwa-laws-resourceguide.pdf.

In order to emphasize 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).
POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION F624: *For concerns related to the immediate orientation and preparation necessary for a transfer which does not require discharge planning, such as transfers to a hospital emergency room or therapeutic leave.*

Summary of Investigative Procedures
Use the Community Discharge Critical Element (CE) Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement to develop and implement an effective discharge planning process.
Briefly review the most recent comprehensive assessments, comprehensive care plan (specifically the discharge care plan), progress notes, and orders to identify whether the facility has identified and addressed the resident's goals and discharge needs. This information will guide observations and interviews to be made in order to corroborate concerns identified. If there are concerns related to systematic discharge planning, this may trigger a review of the nursing home's policies and procedures for discharge assessment and care planning.
NOTE*: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*
DEFICIENCY CATEGORIZATION An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to: **Effective November 28, 2017**

• The 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. 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 level 3, actual harm that is not immediate jeopardy include, but are not limited to:

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

- *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.*

Severity Level 1 does not apply for this regulatory requirement. *The failure of the facility to provide appropriate discharge assessment and planning in order to meet the resident's needs* **Effective November 28, 2017** *and goals at the time of discharge from the nursing home and to ensure communication of necessary information for a safe transition of care places the resident at risk for more than minimal harm.*

F661

§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).

(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 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.* **Effective November 28, 2017**

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;*

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- *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 **Effective November 28, 2017**

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:

- o *A recapitulation (containing all required components) of the resident's stay;*
- o *A final summary of the resident's status (that includes the items listed in §483.20(b)(1));*
- o *A reconciliation of all pre and post discharge medications;*
- o *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 examples of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to: **Effective November 28, 2017**

• 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.