State Operations Manual

Appendix PP – Guidance to Surveyors for Long-Term Care Facilities

§483.15 Admission, Transfer, and Discharge Rights

Effective: November 28, 2017

- *Evaluation of whether the alleged victim feels safe and if the he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.;*
- *Immediate assessment of the alleged victim and provision of medical treatment as necessary;*
- *Immediate notification of the alleged victim's practitioner and the family or responsible party;*
- *Removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents;*
- *Notification of the alleged violation to other agencies or law enforcement authorities; and*
- *Whether administrative staff, including the administrator, were informed and involved as necessary in the investigation.*

Corrective Actions
As a result of a facility's investigation, if an alleged violation is verified, the facility must take appropriate corrective action to protect residents. The facility should oversee the implementation of corrective action and evaluate whether it is effective. While some corrective actions may be limited in scope, facilities should determine whether more systemic actions may be necessary to prevent recurrence of the situation. In addition, the Quality Assessment & Assurance committee should monitor the reporting and investigation of the alleged violations, including assurances that residents are protected from further occurrences and that corrective actions are implemented as necessary.

Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602 and F603.

KEY ELEMENTS OF NONCOMPLIANCE
*To cite deficient practice at F610, the surveyor's investigation will generally show that the facility failed to do **any** one or more of the following:*

- *Initiate an investigation of an alleged violation of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source; **or***
- *Complete a thorough investigation of the alleged violation; **or***
- *Maintain documentation that an alleged violation was thoroughly investigated; **or***
- *Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation of an alleged violation is in progress; **or***
- *Take corrective action following an investigation of an alleged violation, if the allegation was verified.*

F620
§483.15(a) Admissions policy.
§483.15(a)(1) The facility must establish and implement an admissions policy.

***§483.15*(a)(2) The facility must—**

(i) Not *request or* require residents or potential residents to waive their rights *as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights* to Medicare or Medicaid; and

(ii) Not *request or* require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

***§483.15*(a)*(3)* The facility must not *request or* require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may *request and* require *a resident representative* who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.**

***§483.15*(a)*(4)* In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—**

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term ''nursing facility services'' so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

***§483.15*(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.**

§483.15*(a)*(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15*(a)*(7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.

DEFINITIONS/ACRONYMS

"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) of this chapter. 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.*

"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 this paragraph and of paragraph (b)(2) of this section, 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 of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

GUIDANCE

§483.15(a)(1) and (2) Admissions Policy/Preconditions of Admission

All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the admissions policy must comply with the provisions at §483.15(c)(1) which stipulate the limited conditions for transfer or discharge. The provisions at §§483.15 (a)(2) –(5), further prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, under §§483.15(a)(6) – (7), the admissions policy must identify information that must be disclosed to residents and potential residents, such as notice of special facility characteristics, any service limitations of the facility, if applicable. Additionally, it requires that the facility's admission agreement disclose its physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part (see additional guidance below). The facility must also have a process for how it will disclose required information to residents and potential residents.

The provision*s at §§483.15(a)(2)(i) and (ii)* prohibit both direct and indirect request*s to residents or potential residents to waive any rights under the LTC requirements and under applicable federal, state, local licensing or certification laws, including but not limited to the* waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, *would* require residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver *would* include, *for example*, requiring the resident to pay private rates for a specified period of time, such as two years (*e.g.*, "private pay duration of stay contract") before Medicaid will be accepted as a payment source for the resident.

Facilities must not seek or receive any kind of assurances that residents *or potential residents* are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Lastly, residents must not be asked to waive facility responsibility for the loss of their personal property or be unable to use personal property because it is only permitted in the facility if safeguarded by the facility in a manner that makes the property essentially inaccessible to the resident. These waivers effectively take away the residents' right to use personal possessions and relieve facilities from their responsibility to exercise due care with respect to residents' personal property. Compliance requires facilities to develop policies and procedures to safeguard residents' personal possessions without effectively prohibiting a resident's use of personal possessions. This provision is not intended to make facilities automatically liable for every loss regardless of whether or not the facility is aware of the extent of personal property brought into the facility. Examples of reasonable facility policies may include 1) establishing a process to document high value personal property (particularly cash, valuables, and medical/assistive devices) brought in by residents; and 2) establishing a process to work with residents and their representatives/family to ensure safety as well as availability to the resident of cash and/or items over a certain dollar value, including medical/assistive devices. For concerns related to whether the facility takes reasonable care to protect each resident's property from loss or theft or the resident's right to be free from misappropriation of property, see F584, §483.10(i) Safe Environment and F602, §483.12 Misappropriation of Resident Property.

§483.15(a)(3) Third Party Guarantee of Payment

The facility *must* not *request or* require a third *party* to accept personal responsibility for paying the facility bill out of his or her own funds *as a condition of admission, expedited admission, or continued stay in the facility*. However, *the facility may request and require a resident representative with legal access to the resident's funds available to pay for facility care to access and* use the resident's money *or other assets* to pay for care, *as authorized by law*. *The facility may request and require this representative to sign a contract, without incurring personal liability, to provide the facility with payment from the resident's income or assets.* A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.

§483.15(a)(4)(i) and (ii), Medicaid – Preconditions for Admission

The *requirements at §483.15(a)(4)(i) and (ii) apply* only to *individuals eligible for Medicaid and therefore to* Medicaid certified nursing facilities *(NFs) or dually-certified SNF/NFs*.
Facilities may not charge for any service that is included in the definition of "nursing facility services" *which are* required to be provided as part of the daily rate *(See also §483.10(f)(11)(i))* .
Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes*, but is not limited to,* deposits from residents *who are eligible for Medicaid* or their families, or any promise to pay private rates for a specified period of time.

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NOTE: This regulation does not preclude a facility from charging a deposit fee to, or requiring a promissory note from, an individual whose stay is not covered by Medicaid. In instances where the deposit fee is refundable and remains as funds of the resident, the facility must have a surety bond that covers the deposit amount-- *(See also §483.10(f)(10)(vi)).*

A nursing facility is permitted to charge an applicant or resident *for services, while his or her* Medicaid eligibility is pending. *This charge may be* in the form of a deposit prior to admission and/or payment after admission. *Subject to the rules of the State in which the facility is located,* Medicaid eligibility will be made retroactive up to 3 months before the month of application if the applicant would have been eligible had he or she applied in any of the retroactive months.

***NOTE**: A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending (See F622, Transfer and Discharge Requirements).*

In addition, the nursing facility must accept as payment in full the amounts determined by the state for all dates the resident was both Medicaid eligible and a nursing facility resident. Therefore, a nursing facility that charged a recipient for services between the first month of eligibility established by the state and the date notice of eligibility was received is obligated to refund*, within 30 days from receipt of funds from a third party payor*, any payments received for that period less the state's determination of any resident's share of the nursing facility's costs for that same period. A nursing facility must prominently display written information in the facility and provide explanation to applicants or residents *in a manner they can understand* about applying for Medicaid, including how to use Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Under the post-eligibility process, if the resident *who is eligible for Medicaid* has income and is required to make a monthly payment to the nursing facility (which is a portion of the Medicaid payment amount), then the nursing facility is permitted to retain the amount it is legally owed. However, the nursing facility must not charge any administrative fees.

A nursing facility may charge a beneficiary *who receives Medicaid* for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a "nursing facility" service;
- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

§483.15(a)(5) State/Local Jurisdiction Admission Standards

Surveyors are expected to refer to state and/or local laws and regulations on admissions standards to prohibit discrimination against individuals entitled to Medicaid as applicable.

§483.15(a)(6) Facility Special Characteristics

Facilities may choose to offer specialized care or services, such as a rehabilitation, dementia, or a mechanical ventilation unit. To enable potential residents and resident representatives to make informed decisions in choosing a facility for admission, facilities must inform residents and

resident representatives and potential residents or representatives of any special characteristics or service limitations the facility may have prior to admission. For example, a facility may have a religious affiliation that guides its practices and routines which must be communicated to any potential resident.

Likewise, if a facility has limitations in the type of medical care it can provide, this information must be communicated prior to admission. For example, if the need for a specific type of care or service becomes necessary, knowledge of service limitations may make the need for transfer or discharge more predictable and understandable for the resident and/or his or her representative.

Disclosure of facility special characteristics does not relieve a facility of its responsibility to provide required nursing and other services for which it is licensed and certified to provide. To see the required services, refer to sections 1819(a) and 1819(b)(4)(A), and sections 1919(a) and 1919(b)(4)(A) of the Act.

§483.15(a)(7) Composite Distinct Part
If a facility does not have a composite distinct part, this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a composite distinct part according to §483.5(c), consult with the CMS Regional Office for clarification.

Prior to admission, facilities that have areas that meet the definition of a composite distinct part must disclose in their admission agreements to residents:

- *A description of the facility's physical configuration, including the locations for each part that comprise the composite distinct part.*
- *Policies governing room changes between its different locations.*

***NOTE**: If there is a deficiency specific to the requirement at §483.10(g)(15), do not cite at §483.10(g)(15), F580, but cite here at F620, regarding admission policies.*

INVESTIGATIVE PROTOCOL
Objectives
The objectives of this protocol are to determine whether the facility has failed to comply with the regulations at §§483.15(a)(1) – (7) above, regarding admission policies and payment.

Use
Use this protocol when concerns regarding admissions procedures arise during record review, interviews and/or in response to complaints.

PROCEDURES
Record Reviews
Review the facility admissions package, including admissions policies, and contracts to determine if they contain any of, but not limited to, the following:

- *Requirements or requests for residents to waive:*
  - *their rights to current or future enrollment in Medicare or Medicaid*
  - *claims of liability against the facility for loss of personal property*

- *Requirements or requests for a third party guarantee of payment as a condition of admission or expedited admission.*
- *Requirements for payment for services which are covered under Medicaid as a condition of admission, or continued stay.*

In addition, if the facility has any special characteristics or service limitations, review the admissions package to determine if they are and have been disclosed to residents and their representative prior to admission. For composite distinct part facilities, determine if the facility discloses and has disclosed its various locations that make up the composite distinct parts and its policies for room changes between its different locations.

For concerns regarding a facility charging for services that may be covered by the State Medicaid plan, surveyors are expected to review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services.

Interview*s*
Ask resident and/or their representative if there were any preconditions or requirements for admission, such as a third party guarantee of payment, or requests for gifts, money, donations or other considerations.
Ask resident and/or their representative if there were any other preconditions or requirements, or limitations in care that they did not expect or know about prior to admission.
Ask resident and/or their representative if they were required to waive:

- *Their rights to Medicare or Medicaid, or future enrollment in either; and/or*
- *Claims of liability against the facility for loss of personal property.*

Interview staff about information that is provided to potential residents to help them make informed decisions.

F621
***§483.15(b)* Equal access to quality care.**
***§483.15(b)*(1) A facility must establish, maintain *and implement* identical policies and practices regarding transfer *and* discharge, *as defined in §483.5* and the provision of services for all individuals regardless of source of payment, *consistent with §483.10(a)(2)*;**

***§483.15(b)*(2) The facility may charge any amount for services furnished to non- Medicaid residents *unless otherwise limited by state law and* consistent with the notice requirement in *§483.10(g)(18)(i) and (g)(4)(i)* describing the charges; and**

***§483.15(b)*(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.**

§483.15(c)(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides,

unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

DEFINITIONS

"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 defined in §413.65(a)(2) of this chapter. 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.*

"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 this paragraph and of paragraph (b)(2) of this section, 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 of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

INTENT

To ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source.

GUIDANCE

All *services, including but not limited to* nursing services, specialized rehabilitative services, *behavioral health services,* social services, dietary services, *and* pharmac*y* services, or activities, that are mandated by the law must be provided to residents according to *their* individual needs, as determined by assessments and care plans. "Identical policies and practices" concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

Notice Requirements for Changes to Medicare/Medicaid Coverage

Facilities must inform each resident in writing before or at admission, and periodically during their stay, such as when a change in coverage occurs, of the facility's available services and associated costs. The facility may charge any amount for services furnished to non- Medicaid

residents unless otherwise limited by state law. Section 483.10(f)(11) and F571 provide additional information regarding services and charges for which a facility may or may not charge the resident. Pursuant to §483.10(g)(18)(i) and F582, the facility must provide notice of changes in coverage for services to residents as soon as is reasonably possible.

Facility Requirements Regarding Room Changes in a Composite Distinct Part
If a facility does not have a composite distinct part this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a distinct or composite distinct part of a larger institution or institutional complex, consult with the CMS Regional Office for clarification.

Room changes within either a composite distinct part SNF or a distinct part SNF are subject to the requirements at §483.10(e)(7) and F560, which address the resident's right to refuse transfer/room change. For concerns regarding the resident's right to refuse such a transfer or room change, refer to 483.10(e)(7) and F560.

PROBES
Determine if residents are grouped in separate wings or floors for reasons other than care needs, *and if the quality of care is different between the different wings/floors*.
Ask nursing home administrator, social worker, charge nurses, unit managers, and/or Director of Nursing:

- *What factors led to decisions to place residents in different wings or floors (or locations if a SNF composed of composite distinct parts)?*
- *Do factors other than medical and nursing needs affect where residents are placed?*

Ask *representatives of the Office of the* State Long-Term Care Ombudsman if *they have information that could indicate the* facility treats residents differently in transfer, discharge and covered services based on source of payment.
If concerns arise regarding equal access to care, ask the resident or representative:

- *Were there any changes to care or services when their payor source changed, for example did they notice fewer staff available to meet their needs when their payor source was due to change or had changed?*
- *Did the resident receive notice of changes in charges for services?*
- *Were they asked to move or were they moved to a different location in the building when their payor source changed?*

F622
***§483.15*(c) Transfer and *d*ischarge-**
***§483.15*(c)(1) *Facility requirements*-**

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

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

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

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

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

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

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15**(c)(2) Documentation.**

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs ***(c)(1)(i)(A)*** **through** ***(F)*** **of this section,** ***the facility must ensure that the transfer or discharge is documented in*** **the resident's** ***medical*** **record** ***and appropriate information is communicated to the receiving health care institution or provider.***

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation ***required by paragraph (c)(2)(i) of this section*** **must be made by—**

(A) The resident's physician when transfer or discharge is necessary under paragraph ***(c) (1) (A)*** **or** ***(B)*** **of this section; and**

(B) A physician when transfer or discharge is necessary under paragraph ***(c)(1)(i)(C) or (D)*** **of this section.**

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals;

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

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INTENT

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

DEFINITIONS

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

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

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

GUIDANCE

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

These regulations limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from involuntary discharge.

*In the following limited circumstances, facilities may initiate transfers or discharges**:***

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.*
3. *The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.*
5. *The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.*
6. *The facility ceases to operate.*

Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility. See additional guidance at F626, §483.15(e)(1), Permitting Residents to Return. Facility-initiated transfers and discharges must meet all transfer and discharge requirements at §§483.15(c)(1) - (5).

Section 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, for most residents (other than short-stay rehabilitation residents) the facility becomes the resident's home. 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. (See F838, Facility Assessment). There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Resident-initiated transfers or discharges occur when the resident or, if appropriate, his/her representative has given written or verbal notice of their intent to leave the facility. A resident's expression of a general desire or goal to return to home or to the community or the elopement of a resident who is cognitively-impaired should not be taken as a notice of intent to leave the facility.

Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

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

***NOTE**: In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors would review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return.*
If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the

facility to meet the resident's needs. (See §483.20(b)(2)(ii), F637 for information concerning assessment upon significant change.)

A resident's declination of treatment does not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. The facility must be able to demonstrate that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment, 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.

Nonpayment as Basis for Discharge
Non-payment for a stay in the facility occurs when:

- *The resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or*
- *After the third party payor denied the claim and the resident refused to pay.*

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. 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.

Emergent Transfers to Acute Care
Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected.

*Residents who are sent to the emergency room, **must** be permitted to return to the facility, unless the resident meets one of the criteria under which the facility can initiate discharge. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status is not based on his or her condition at the time of transfer) meets one of the criteria at §§483.15(c)(i)(A) through (D).*

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. Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. Appeal procedures vary by State.

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.

Required Documentation

To demonstrate that any of the cirmcumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge.

*For circumstances 1 and 2 above for permissible facililty-initiated transfer or discharge, the **resident's physician** must document information about the basis for the transfer or discharge. Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the **resident's physician must** include:*

- *The specific resident needs the facility could not meet;*
- *The facility efforts to meet those needs; and*
- *The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.*

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

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

Information Conveyed to Receiving Provider

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

- *Contact information of the practitioner who was responsible for the care of the resident;*
- *Resident representative information, including contact information;*
- *Advance directive information;*
- *Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:*
  - *Treatments and devices (oxygen, implants, IVs, tubes/catheters);*
  - *Precautions such as isolation or contact;*
  - *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 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 required information found at §483.21(c)(2) Discharge Summary, F661. Communicating this information to the receiving provider is one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting.

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

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

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

F623
***§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** ***L*****ong-***T***erm** ***C*****are** ***O*****mbudsman;**

(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.**

Effective November 28, 2017

§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).

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

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

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

GUIDANCE
The requirements at 483.15(c)(3)-(6) only apply to facility-initiated transfers and discharges, not resident-initiated transfers and discharges. This guidance will address the requirement to send a notice in situations where the facility initiates a transfer or discharge, including discharges that occur while the resident remains in the hospital after emergency transfer.

Facility-initiated transfers and discharges generally occur when the facility determines it should not, or cannot provide needed care or services to a resident in accordance with F622, Transfer and Discharge Requirements. Whether or not a resident agrees with the facility's decision, the requirements at 483.15(c)(3)-(6) apply whenever a facility initiates the transfer or discharge.

A resident-initiated transfer or discharge is one in which the resident has provided written or verbal notice of their intent to leave the facility, which is documented in the resident's record. A resident's expression of a general desire to return home or to the community or elopement of a resident who is cognitively impaired should not be taken as a notice of intent to leave. When a resident initiates his or her transfer or discharge, the medical record should contain

documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or if appropriate his/her representative, containing details of discharge planning, and arrangements for post-discharge care (See F660, Discharge Planning Process). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident initiated. Therapeutic leave is a type of resident-initiated transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.

Notice of Transfer or Discharge and Ombudsman Notification
For facility-initiated transfer or discharge of a resident, 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 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. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state.

Facility-Initiated Transfers and Discharges
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, 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 as described below.*

For any other types of facility-initiated 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, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable, 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.*

Resident-Initiated Transfers and Discharges

A resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. The medical record must contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility. While a resident's expression of a general desire or goal to return home or to the community or the elopement of a resident who is cognitively impaired should be taken into consideration for the purposes of discharge planning and community placement, it should not be taken as notice of intent to leave the facility and does not constitute a resident-initiated transfer or discharge. For resident-initiated transfers or discharges, sending a copy of the notice to the ombudsman is not required because the notice requirement does not apply to resident-initiated transfers or discharges.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated. If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

Contents of the Notice

The facility's notice must include *the following:*

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

For residents with intellectual and developmental *disabilities and/or mental illness, the notice must include* the name, *mail and e-mail* address*es* and phone number of the *state protection and advocacy* agency responsible for advocating for these *populations.*

Timing of the Notice

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

- *The resident's welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or*
- *The health or safety of others in the facility is e*ndangered.

In these cases, the notice must be provided as soon as practicable *and* ***notice to the ombudsman*** *in these situations can be sent when practicable, such as a list of residents on a monthly basis.*

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 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.*

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

F624
***§483.15(*c)(7) Orientation for *t*ransfer or *d*ischarge.**
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.*

DEFINITIONS
"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. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

GUIDANCE
The guidance at this tag generally addresses the immediate orientation and preparation necessary for a transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate discharge where a complete discharge planning process is not practicable.

For concerns related to how the facility planned for a discharge that meets a resident's health and safety needs, as well as their preferences and goals in circumstances which permit a complete discharge planning process, please refer to F660, Discharge Planning.

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.

Other tags for consideration would be:

- *F622, Transfer and Discharge Requirements, specifically the clinical information that must be conveyed to the receiving provider, if the transfer or discharge is to another healthcare setting; and*
- *F843, Transfer Agreement, for concerns related to timely transfer to the acute care facility.*

PROCEDURES

- *Review nursing notes and any other relevant documentation to see if appropriate orientation and preparation of the resident prior to transfer and discharge has occurred.*
- *Through record review and interviews, determine if the resident received sufficient preparation prior to transfer or discharge, and if they understood the information provided to them.*
- *Were the resident's needed/requested possessions transferred with the resident to the new location?*
- *Ask resident or his or her representative if they understand why the transfer or discharge occurred.*

F625
***§483.15(*d) Notice of *b*ed-*h*old 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.

Effective November 28, 2017

***§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.**

INTENT

To ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility.

DEFINITIONS

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

"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.*

GUIDANCE

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, §483.15 (e)(1) and F626 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 involuntarily discharging the resident.

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community 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 for bed-hold.

Summary of Investigative Procedure

If concerns arise regarding notice of bed-hold, review the medical record for evidence of whether a notice of bed-hold was provided both (1) prior to and (2) upon transfer. Look for documentation such as a copy of the dated notice(s), progress notes, transfer checklist(s), or other evidence that the notice was given. Additionally, ask to review facility policies on bed-hold. Review the facility's admission packet to determine if notice of bed-hold is given at admission. If not, determine how the facility notifies residents prior to transfer.

Ask the resident, or if applicable, the resident's representative(s), whether they received the bed-hold notice and understand the facility's bed-hold policy. If not, determine how the facility notifies residents of this information prior to transfer.

F626
***§483.15*(e)(1) Permitting resident*s* 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.

INTENT
*To ensure that facilities develop and implement policies that address bed-hold and return to the facility for all residents. Specifically, residents who are hospitalized or on therapeutic leave are allowed to return for skilled nursing or nursing facility care or services. In situations where the facility intends to discharge the resident, the facility must comply with Transfer and Discharge Requirements at §483.15(c), **and** the resident must be permitted to return and resume residence in the facility while an appeal is pending.*

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). 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.

"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 this paragraph and of paragraph (b)(2) of this section, 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 of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.*

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

GUIDANCE §483.15 (e)

Facilities must develop *and implement* policies *for bed-hold and* permit*ting residents to return following* hospitalization or therapeutic leave. *These policies must address how the facility will allow residents to return when their hospitalization or therapeutic leave has exceeded the bed-hold period allowed by the State Medicaid plan. Duration of and payment for bed-hold for residents eligible for Medicaid vary by State. The policy must also address how residents who pay privately, or receive Medicare, may pay to reserve their bed.*

NOTE*: These requirements also apply to a resident who was receiving Medicaid at the time of his or her hospitalization, and returns needing skilled nursing (Medicare) care or services.*

Residents must be permitted to return to their previous room, if available, or to the next available bed in a semi-private room, providing the resident:

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

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

Composite Distinct Part

If a facility does not have a composite distinct part this provision does not apply. 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 Regional Office for clarification.

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.

Not Permitting Residents to Return

Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in §483.15(c)(1)(ii). A facility must not discharge a resident unless:

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the services of the facility.*
3. *The resident's clinical or behavioral status endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status endangers the health of individuals in the facility.*
5. *The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility.*
6. *The facility ceases to operate.*

For concerns related to a facility not permitting a resident to return, the surveyor should investigate to determine if the basis for discharge meets one of the requirements above (See F622, §483.15(c)(1)(ii)).

As noted at 483.15(c)(2)(i)(B), when the facility transfers or discharges a resident for the resident's welfare, or because the resident's needs cannot be met in the facility, the medical record must contain documentation of the specific resident needs that cannot be met, facility attempts to meet those needs, and the service available at the receiving facility to meet the needs. Resident decisions to refuse care should not be considered a basis for transfer or discharge unless the refusal poses a risk to the resident's or other individuals' health and/or safety. 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.)

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.

If a facility does not permit a resident who went on therapeutic leave to return, the facility must meet the requirements for a facility-initiated discharge at F622. Because the facility was able to care for the resident prior to therapeutic leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

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 initiate a discharge unless it has ascertained from the resident or resident representative that the resident does not wish to return.

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 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 what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital 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.*

If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. 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 evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

For concerns regarding notification of discharge, and the resident's right to appeal the discharge, refer to the regulation and guidance at §§483.15(c)(3)-(5)(F623).

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community 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 to permit residents to return following hospitalization or therapeutic leave.

Summary of Investigative Procedure

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 if residents with similar care needs have been admitted. Additionally, if the facility does not readmit the resident due to risk to the health or safety of individuals in the facility, the surveyor should review documentation for how the facility made this determination.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F626, the surveyor's investigation will generally show that the facility failed to:

- *Establish and/or implement a policy that is in accordance with the State Medicaid plan, and addresses returning to the facility following hospitalization or therapeutic leave; or*
- *Ensure that residents whose hospitalization or therapeutic leave exceeds the State's bed-hold period are returned to their previous room and/or the first available bed in a semi-private room; or*
- *Ensure (for a resident not permitted to return) the medical record and notification contain a valid basis for discharge; or*
- *Permit a resident to return to the same composite distinct part in which they previously resided.*

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

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

- *Facility failed to allow a resident to return following therapeutic leave to a family member's home, resulting in the resident being found living on the street, without food or shelter. The medical record did not contain evidence of a valid basis for discharge, and there was no evidence of discharge planning This was cross-referenced and also cited at F622, Transfer and Discharge Requirements, §483.15(c)(1), and F660, Discharge Planning Process, §483.21(c)(1).*

- *Facility failed to allow a resident to return following a hospitalization. The medical record did not accurately evaluate the resident, rather they used the resident's status prior to the transfer as the basis for discharge. This was cross-referenced and also cited at F622, Transfer and Discharge Requirements, §483.15(c)(1).*

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

- *Facility failed to allow a resident to return to a bed in the same composite distinct part in which they resided previously. The new location was far from the resident's family, resulting in the resident expressing sustained and persistent sadness and withdrawal.*
- *Facility failed to allow a resident to return to the nursing facility, following a hospitalization that exceeded the bed-hold policy (and state plan). The facility discharged the resident on the basis of being unable to meet his needs. The survey team was able to verify that the facility had accepted residents with similar conditions during the timeframe that the resident was ready to return. This resulted in the resident being sent to another facility which was in a location not easily accessible by the resident's family. The resident expressed feelings of depression and loneliness.*

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:

- *Facility failed to allow a resident to return to his/her previous room (even though it was available) upon return from the hospital, which resulted in no more than minimal harm as the resident adjusted to the new room. This noncompliance has the potential to cause more than minimal psychosocial harm.*

An example of Severity Level 1 noncompliance: No actual harm with potential for minimal harm includes, but is not limited to:

- *A facility which is a composite distinct part permitted a resident to return following hospitalization or therapeutic leave, however, the resident returned to a different location in the composite distinct part even though a bed was available in the same location where the resident had resided prior to transfer. The resident did not express displeasure with the situation.*

F635
§483.20(a) Admission orders
At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

INTENT §483.20(a)
To ensure *each* resident receives necessary care and services *upon admission*.

GUIDANCE **§483.20(a)**
"Physician orders for immediate care" are those written *and/or verbal* orders facility staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission *to the facility*. These orders should, at a minimum, include dietary, *medications*