§483.15(c) Transfer and discharge-

§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)(ii)(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.

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 circumstances 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 facility-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
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§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.