Policy and Procedure Manual

Transfer and Discharge Requirements / Documentation

POLICY:

1. It is the policy of \_\_\_\_\_\_\_\_to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

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

(ii) 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;

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

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

(v) 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;

(vi) The facility ceases to operate.

2. If a resident exercises his or her right to appeal a transfer or discharge notice, it is the policy of this facility not to transfer or discharge the resident while the appeal is pending unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility will document the danger that failure to transfer or discharge would pose.

3.  When the facility transfers or discharges a resident under any of the circumstances specified above, it is the policy of this facility to document the resident’s transfer or discharge in the medical record and appropriately communicate the information to the receiving health care institution or provider.

RESPONSIBLE PARTIES:

Physician, Nursing Supervisor, Social Worker, Physical Therapist, Occupational Therapist, Dietary, Recreation

PROCEDURE:

1. The physician with the input with the other members of the interdisciplinary team will assess the resident’s care requirements for the need to be transferred or discharged.

2.      If it determined that the resident has a need for transfer based on the above noted criteria, the determination will be documented on the residents’ medical record. The basis for the transfer will specify the resident’s needs that could not be met and the facility’s attempts to meet those resident needs, and the services available at the receiving facility to meet those needs.

3.      If indicated, the resident will be appropriately hospitalized. Otherwise, the interdisciplinary team will meet to meet to initiate a discharge plan and follow discharge planning procedures.

4. The following information will be provided to the receiving provider will include the following information:

* Contact information of the practitioner responsible for the care of the resident.
* Resident representative information including contact information
* Advance Directive information
* All special instructions or precautions for ongoing care, as appropriate.
* Comprehensive care plan goals
* A copy of the resident’s discharge summary as applicable
* Any other documentation, as applicable, to ensure a safe and effective transition of care.

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**Notice Before Transfer**

POLICY:

Before the facility transfers or discharges a resident, it is the policy of this facility to:

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
2. Send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman
3. Record the reasons in the resident’s clinical record; and
4. Include in the notice the items mandated by the NYS Department of Health.
5. Except when otherwise allowed this notice must be made by the facility at least 30 days before the resident is transferred or discharged.
6. Notice may be made (less than 30 days) as soon as practicable before transfer or discharge when—

(A) The safety of the individuals in the facility would be endangered

(B) The health of individuals in the facility would be endangered,

(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge

(D) An immediate transfer or discharge is required by the resident’s urgent medical needs,

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

PROCEDURE:

The social worker will provide the resident and/or their next of kin a written notice which will 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 that the resident has the right to appeal the action to the State; 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, email and telephone number of the NY State long term care ombudsman;

(vi) For residents with intellectual and developmental disabilities, the mailing address, email and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

(vii) For residents who have a mental disorder or related disease, the mailing address, email and telephone number of the agency responsible for the protection and advocacy of individuals with mental disorders.

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Orientation for Transfer or Discharge

Policy:

It is the policy of this facility to provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Procedure:

1. The social worker will meet with resident and/or family to determine discharge planning options. The facility will actively involve, to the extent possible, the resident and /or family in selecting the new residence.
2. The social worker will maintain ongoing communication with resident and/or family on the status of discharge options.
3. When a discharge location in secured the resident and/or family member will be informed where he or she is going and assure safe transportation.
4. Social worker to document on the medical record all efforts to discharge a resident to another location.
5. The resident will be given a discharge summary which will include a summary of the resident’s care planning needs along with instruction post discharge.
6. Social worker will ensure all post discharge referrals are completed.  This may include but not limited to follow-up appointment with physicians, home care services, durable medical equipment and prescriptions.
7. Prior to discharge, a CCP meeting with the interdisciplinary team and the resident and/family will be initiated to review resident’s care planning needs and discharge needs.