MDS Alert

Reader Question: Include Care Plan When Transferring Resident

Question: I work for a skilled nursing facility and we have a resident transferring to another SNF. Do we need to prepare and send care plan the resident upon discharge from our facility?

Indiana Subscriber

Answer: Yes, otherwise you may face a citation from surveyors, specifically F622.

The **Center for Medicare and Medicaid Services** (CMS) State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities says:

§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. (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 eet 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.

Note requirements C through E, which, when provided to the new facility, help paint a comprehensive picture of the resident's goals, hopes, and realities for care.

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

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