**Purpose & Intent 483.15(c)(2):** To improve care coordination by providing information to the receiving health care organization and provider that can help them provide quality care to the resident.

The new Requirements of Participation (RoP) outline specific information that must accompany a resident whenever they are discharged or transferred. The actual RoP language is contained on the last page of this tool, including the language from the cross-referenced sections in the RoP.

To assure that the Center has provided all the required information, AHCA staff recommend that you create a checklist to make sure all the required information is sent with the resident and that you create a template discharge summary with all the required information outlined to avoid inadvertently omitting necessary information. This tool does not outline the required discharge criteria [see AHCA Tool: Admission, Transfer, and Discharge Rights - 483.15(c)(1)] nor the overall discharge planning process [see AHCA Tool: Discharge Planning Process – 483.21(c)(1)].

The checklist below captures the information a Center will need to provide to accompany each resident when they are discharged or transferred. However, please note that CMS has not yet issued its interpretative guidance for this new requirement. When they do, some of the items on this checklist may need to be updated.

**Tips to comply:**

- Complete the checklist for the information that must accompany each resident at the time they are being discharged or transferred.

- Make sure some of this information is easily accessible to staff, such as the night or weekend staff, when residents are discharged or transferred outside of normal business hours. This will help with new or per diem staff who may not initially be as familiar with where to find all of this information.
Information Accompanying Residents at Discharge or Transfer (Checklist)

Is the following Information copied and available to go with the resident?

- Contact information of the practitioner responsible for the care of the resident upon transfer/discharge
- Resident representative information including contact information
- Advance Directive information
- All special instructions or precautions for ongoing care
- Most recent Comprehensive care plan goals
- Resident’s discharge summary (see below), as applicable
- Any other documents or information to ensure a safe and effective transition of care (Specify additional documents or information)
- Resident’s consent to share information

Discharge Summary Template

- Recapitulation of Stay:
  - Diagnoses
  - Course of illness/treatments/therapy during nursing center stay
  - Pertinent laboratory tests and results
  - Pertinent radiology or other tests and results
  - Pertinent consultations along with findings and recommendations
- Final Summary of Resident’s Status:
  - Specified items from Resident Assessment Instrument comprehensive assessment including
    - Resident’s needs, strengths, goals, life history, and preferences using the RAI
- Medication Reconciliation:
  - Reconciliation of all pre-discharge medications and post-discharge medications (including over-the-counter)
- Post-Discharge Plan of Care including:
  - Where the individual plans to reside
  - Any arrangements for follow up care
  - Any post-discharge medical and non-medical services
  - Consent of the resident or resident’s representative to share discharge summary

Centers may want to add additional information to this list, such as date of completion, but this information must be in the Discharge Summary to be compliant with the NEW RoP.
Information Accompanying Residents at Discharge or Transfer

(Phase II)

The RoP language for 483.15(c)(2) is as follows: When a resident is discharged or transferred for any reason specified in section 483.15(c)(1) [see AHCA Tool: Admission, Transfer, and Discharge Rights - 483.15(c)(1)] the facility must ensure that appropriate information is communicated to the receiving health care institution or provider. Information provided to the receiving provider must include at a minimum the following:

- 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
- All other necessary information, including a copy of the resident’s discharge summary (see below), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care
- Resident’s consent to share information

Discharge Summary Required Content (Phase I)

The RoP language for 483.15(c)(2) is as follows: When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

- A recapitulation of the resident’s stay that includes, but is not limited to,
  - diagnoses,
  - course of illness/treatment or therapy,
  - pertinent lab, radiology, and consultation results.
- A final summary of the resident’s status to include items specified 483.20(b)1 [AKA - resident assessment instrument - RAI (see below)], at the time of the discharge that is available for release to the authorized persons and agencies, with the consent of the resident or resident’s representative.
- Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).
- A post discharge plan of care that is
  - developed with the participation of the resident and, the resident representative(s),
  - which will assist the resident to adjust to his or her new living environment.
  - The post-discharge plan of care must indicate:
    - where the individual plans to reside,
Resident Assessment Instrument Content (Phase I)

**483.20(b)(1)** “(b) Comprehensive assessments—(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information.
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment.