December 9, 2024

Based on survey findings, discussion of accurate and timely completion of a Discharge Summary when a resident leaves the facility. Beginning February 24. 2025, F661 will be relocated to F628 and F627.

Currently, common deficiencies focus on 2 areas:

1. Failure to complete the Discharge Summary at all: Recommend review of the policy on who and when the Discharge Summary is to be completed
2. Failure to include a Medication Reconciliation that meets the regulations/requirements: Will discuss appropriate medication reconciliation next week.

Most facilities have electronic medical records that provide tools for completing the Discharge Summary. Each facility should have a process/procedure to audit appropriate, complete and accurate Discharge Summary in a timely manner.

For right now, F661 says:

§483.21(c)(2) Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

i. **A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.**

ii. **A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.**

iii. **Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).**

iv. **A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, 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, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.**

F627 is the Transfer and Discharge Regulation

F628 is Transfer and Discharge Documentation Regulation

§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. when—

(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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- **(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.**

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

Surveyor Guidance includes:

§483.21(c)(2) Discharge Summary

The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge. A discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care.

In the case of discharge to a non-institutional setting such as the resident's home, provision of a discharge summary, with the resident's consent, to the resident's community-based physicians/practitioners allows the resident to receive continuous and coordinated, person-centered care.

For residents who are being discharged from the facility to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care. The medical record must identify the receiving facilities or physicians/practitioners to whom the discharge summary is provided.

Content of the Discharge Summary

§483.21(c)(2)(i) **Recapitulation of Resident's Stay**

Recapitulation of the resident's stay describes the resident's course of treatment while residing in the facility. The recapitulation includes, but is not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results.

§483.21(c)(2)(ii) **Final Summary of Resident Status**

In addition to the recapitulation of the resident's stay, the discharge summary must include a final summary of the resident's status which includes the items from the resident's most recent comprehensive assessment identified at §483.20(b)(1)(i) – (xviii) Comprehensive Assessment. This is necessary to accurately describe the current clinical status of the resident. Items required to be in the final summary of the resident's status are:

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication
- Vision;
- Mood and Behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnoses and health conditions;
- Dental and nutritional status
- Skin condition;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge planning (as evidenced by most recent discharge care plan);,
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and
- Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.

Timing of the Discharge Summary

The discharge summary contains necessary medical information that the facility must furnish **at the time the resident leaves the facility**, to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary may be furnished in either hard copy or electronic format, if the provider assuming responsibility for the resident's care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident. The medical record must contain the discharge summary information and identify the recipient of the summary.
NOTE: In situations where there is no continuing care provider (e.g., resident has no

primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider.

§483.21(c)(2)(iii) **Reconciliation of Medications Prior to Discharge**

A resident's discharge medications may differ from what the resident was receiving while residing in the facility. Facility staff must compare the medications listed in the discharge summary to medications the resident was taking while residing in the nursing home. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes. For example, a resident who was receiving rehabilitative services may have required antibiotic therapy postoperatively but does not need to continue the antibiotic at home. The discontinuation of the medication should be documented in the discharge summary.

Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative must accurately reflect the reconciled medication list in the discharge summary.