11-24-25 Weekly Clinical Update

Based on the increased scrutiny of discharges and transfers, this will be a discussion related to discharge "against medical advice" (AMA). F627 Transfer and Discharge discusses AMA in two places and notes, "As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA). Note: These situations only apply when a resident expresses their wishes to be discharged earlier than outlined in the care plan. These situations do not apply if a facility offers to discharge a resident to a location which does not meet their health and/or safety needs, and the resident agrees (this would constitute noncompliance)."

And "**NOTE:** Situations in which residents sign out of the facility, or leave Against Medical Advice (AMA) should be thoroughly investigated to determine if the resident or resident representative was forced, pressured, or intimidated into leaving AMA. Additionally, the discharge would require further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F628. See additional guidance at Abuse, Neglect and Exploitation at F600."

The first observation is the need for each facility to review the facility's AMA policy to ensure it is compliant with the regulations implemented on April 28, 2025. Residents in nursing facilities may insist on leaving for a variety of reasons: desire to return home, family pressure, financial concerns, dissatisfaction with care, behavioral health crises, or substance-use issues. Properly handling AMA protects both resident rights and the facility's legal and regulatory exposure.

Key regulatory and legal considerations include not only F627 (Transfer and Discharge), but also resident right regulations. The facility must permit residents to remain in the facility and not be discharged except for specific reasons (medical necessity, resident welfare, non-payment, facility closure, etc.). However, residents retain the right to refuse treatment and to leave at any time unless a court has adjudicated them incompetent and appointed a guardian with specific authority to restrict egress.

Resident Rights regulations include: the Right to Refuse Treatment; Right to Self-Determination and Participation in Care Planning; and Freedom From Unnecessary Physical or Chemical Restraints. And of course, the facility cannot discount F600 Freedom from Abuse, Neglect, Exploitation.

Clinical Practice Guidelines from AHCA and AMDA along with Appendix PP provide the following common scenarios for nursing facilities:

Scenario	Typical Trigger	Risk Level
Competent resident wants to go home after short-term rehab	"I'm better, I don't need to be here"	Moderate
Resident with dementia attempts to leave facility unsupervised	Wandering/elopement risk	High
Family demands immediate removal despite active infection or wound care needs	Financial or caregiver burnout	Moderate–High
Resident with active substance use disorder insists on leaving to obtain drugs/alcohol	Addiction-driven decision	High
Guardian wants resident discharged to lower level of care against team recommendation	Cost or placement disagreement	Variable

Here are seven step-by-step protocols related to AMA policies:

1. Immediate safety assessment
    a. Is the resident at imminent risk of harm if they leave now?
    b. If yes, activate emergency protocols such as attending physician (immediately), state Ombudsman, and APS
2. Determine decision-making capacity and document who and when performed the assessment and findings
    a. Can the resident....
        i. Understand relevant information?
        ii. Appreciate the situation and its consequences?
        iii. Reason and weigh options?
        iv. Communicate a consistent choices?
3. Physician/APRN documentation required
    a. Current medical condition and specific risks of leaving
    b. Alternative discussed
    c. Resident's/representative's acknowledgment of risks
    d. That continued stay is recommended
4. Informed Refusal/AMA form
    a. Use facility's approved AMA form that includes:
        i. Detailed description of risks in plain language (i.e., death, fall with injury, infection worsening, readmission, etc.)
        ii. Statement that resident/representative understands and accepts risks
        iii. Witness signatures (preferably two (2))
        iv. Offer reasonable alternatives such as home health, outpatient care, hospice, transportation assistance, behavioral health resources
    b. If the resident/representative refuses to sign, document the refusal and have two (2) witnesses sign that the form was offered and explained

5. Surrogate Decision-Maker
    a. If the resident lacks capacity:
        i. Activated POA for healthcare, court-appointed guardian or state hierarchy must agree
        ii. If surrogate insists on discharge AMA the same documentation and risk discussion apply
6. Care Coordination and Safe Transfer
    a. Even when leaving AMA, the facility still has discharge planning obligations per F627 and F628 including but not limited to:
        i. Provide discharge summary, prescriptions and medication reconciliation and follow-up appointments
        ii. Arrange transportation if possible
        iii. Send copies of records to receiving provider
        iv. Notify the state agency if the resident's discharge status is "unsafe"
7. Special Situations
    a. Behavioral Health/Substance Use
        i. Offer detox/rehab options
        ii. Consider involuntary commitment criteria if the resident is a danger to themselves or others
    b. Suspected Elder Abuse/Neglect
        i. Mandatory reporting to Adult Protective Services (APS) if discharge appears to place resident in harm's way
    c. Medicaid Bed-Hold Issues
        i. Counsel resident/family on potential loss of bed-hold coverage and re-admission challenges

Risk Management Tips:

1. Train all staff, including nights/weekend shifts, on AMA policy
2. Use "teach-back" technique when explaining risks to resident/representatives
3. Document every conversation in real time
4. Involve Medical Director early in the AMA process, especially in difficult situations
5. NEVER use physical force or locked doors unless specific legal authority exists, such as court-ordered guardianship with restricted egress
6. Conduct root-cause analysis after EVERY AMA to improve care planning and communication

AMA discharge does not mean abandonment of responsibility. Facility staff must determine that "fine line" between respect for resident autonomy with thorough assessment, clear communication and evidence-based best practice documentation to protect both the resident and the facility. There are times when a well-executed AMA process turns a potential adverse event into an opportunity to reinforce trust, education the resident/representative and maintain the facility's therapeutic relationship, even if the resident walks out the door.

Resources:

1. CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long-Term Care Facilities
2. CMS QSO letters: QSO 17-31-NH; QSO 16-23-NH

3. AHCA Clinical Practice Guidelines and position statements on discharge planning, capacity assessment, and managing residents with behavioral health/substance-use disorders
4. Wong et al., “Against Medical Advice Discharges from Nursing Facilities” (JAMDA, 2019)
5. El-Solh et al., “Self-discharge from post-acute care” (Journal of Post-Acute and Long-Term Care Medicine, 2021)