§483.12 Admission, Transfer, and Discharge Rights

§483.12(a) Transfer, and Discharge

(1) Definition
Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

Guidelines §483.12
This requirement applies to transfers or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility’s decision, these requirements apply whenever a facility initiates the transfer or discharge. “Transfer” is moving the resident from the facility to another legally responsible institutional setting, while “discharge” is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident’s care.

If a resident is living in an institution participating in both Medicare and Medicaid (SNF/NF) under separate provider agreements, a move from either the SNF or NF would constitute a transfer.

Transfer and discharge provisions significantly restrict a facility’s ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility may not transfer or discharge the resident unless:

1. The transfer or discharge is necessary to meet the resident’s welfare and the resident’s welfare cannot be met in the facility;

2. 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;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or

6. The facility ceases to operate.

To demonstrate that any of the events specified in 1 - 5 have occurred, the law requires documentation in the resident’s clinical record. To demonstrate situations 1 and 2, the resident’s physician must provide the documentation. In situation 4, the documentation must be provided by any physician. (See §483.12(a)(2).)
Moreover, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility’s notice must include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a developmentally disabled individual, the notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled, and in the case of a mentally ill individual, the name, address and phone number of the agency responsible for advocating for mentally ill individuals. (See §483.12(a)(3) and (5).)

Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

• Endangerment to the health or safety of others in the facility;
• When a resident’s health has improved to allow a more immediate transfer or discharge;
• When a resident’s urgent medical needs require more immediate transfer; and
• When a resident has not resided in the facility for 30 days.

In these cases, the notice must be provided as soon as practicable before the discharge. (See §483.12(a)(4).)

Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. (See §483.12(a)(6).)

Under Medicaid, a participating facility is also required to provide notice to its residents of the facility’s bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).)

A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

§483.10(o), Tag F177, addresses the right of residents to refuse certain transfers within an institution on the basis of payment status.
§483.12(a)(2) Transfer and Discharge Requirements
The facility must 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;

(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. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.
SEE GUIDANCE UNDER TAG 202

§483.12(a)(3) Documentation
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident’s clinical record must be documented. The documentation must be made by--

(i) The resident’s physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

Interpretive Guidelines §483.12(a)(2) and (3)
If transfer is due to a significant change in the resident’s condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident’s needs. (See §483.20(b)(4)(iv), F274, for information concerning assessment upon significant change.)
Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others.

Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy.

**Procedures §483.12(a)(2) and (3)**

During closed record review, determine the reasons for transfer/discharge.

• Do records document accurate assessments and attempts through care planning to address resident’s needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident’s customary routines?

• Did the resident’s physician document the record if:

  o The resident was transferred/discharged for the sake of the resident’s welfare and the resident’s needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization)? or

  o The resident’s health improved to the extent that the transferred/discharged resident no longer needed the services of the facility.

• Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered?

• Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? Did the survey team observe residents with similar safety concerns in the facility? If so, determine differences between these residents and those who were transferred or discharged.

• Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a)(2).

• Ask the ombudsman if there were any complaints regarding transfer and/or discharge. If there were, what was the result of the ombudsman’s investigation?

• If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident’s physician justify why the facility could not meet the needs of this resident.
§483.12(a)(4) Notice Before Transfer
Before a facility transfers or discharges a resident, the facility must--

(i) 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.

(ii) Record the reasons in the resident’s clinical record; and
(iii) Include in the notice the items described in paragraph (a)(6) of this section.

§483.12(a)(5) Timing of the notice.

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) The safety of the individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section;

(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident’s urgent medical needs, under paragraph (a)(2)(i) of this section; or

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

§483.12(a)(6) Contents of the notice
The written notice specified in paragraph (a)(4) of this section must 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;
(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Procedures §483.12(a)(4)-(6)
If the team determines that there are concerns about the facility’s transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including:

• Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge);

• Reason for transfer/discharge;

• The effective date of the transfer or discharge;

• The location to which the resident was transferred or discharged;

• Right of appeal;

• How to notify the ombudsman (name, address, and telephone number); and

• How to notify the appropriate protection and advocacy agency for residents with mental illness or mental retardation (mailing address and telephone numbers).

• Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.

§483.12(a)(7) Orientation for Transfer or Discharge
A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Interpretive Guidelines §483.12(a)(7)
“Sufficient preparation” means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident’s family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are
not left behind or lost; orienting staff in the receiving facility to resident’s daily patterns; and reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.

**Procedures §483.12(a)(7)**
During Resident Review, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.

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**F205**

**§483.12(b) Notice of Bed-Hold Policy and Readmission**

**§483.12(b)(1) Notice before transfer.** Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility’s policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

**§483.12(b)(2) Bed-hold notice upon transfer.** At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

**Interpretive Guidelines §483.12(b)(1) and (2)**

The nursing facility’s bed-hold policies apply to all residents.

These sections require two notices related to the facility’s bed-hold policies to be issued. The first notice of bed-hold policies could be given well in advance of any transfer. However, reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility’s policy were to change. The second notice, which specifies the duration of the bed-hold policy, must be issued at the time of transfer.

In cases of emergency transfer, notice “at the time of transfer” means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident’s copy of the notice is sent with other papers accompanying the resident to the hospital.
Bed-hold for days of absence in excess of the State’s bed-hold limit are considered non-covered services which means that the resident could use his/her own income to pay for the bed-hold.

However, if such a resident does not elect to pay to hold the bed, readmission rights to the next available bed are specified at §483.12(b)(3). Non-Medicaid residents may be requested to pay for all days of bed-hold.

If residents (or their representatives in the case of residents who are unable to understand their rights) are unsure or unclear about their bed-hold rights, review facility bed-hold policies.

• Do policies specify the duration of the bed-hold?

• Is this time period consistent with that specified in the State plan?

• During closed record review, look at records of residents transferred to a hospital or on therapeutic leave to determine if bed-hold requirements were followed. Was notice given before and at the time of transfer?

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F206
(Rev. 70, 01-07-11, Effective: 10-01-10 Implementation: 10-01-10)

§483.12(b)(3) Permitting Resident to Return to Facility

A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident--

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

Interpretive Guidelines §483.12(b)(3)

“First available bed in a semi-private room” means a bed in a room shared with another resident of the same sex. (see §483.10(m) for the right of spouses to share a room.)

Medicaid-eligible residents who are on therapeutic leave or are hospitalized beyond the State’s bed-hold policy must be readmitted to the first available bed even if the residents have outstanding Medicaid balances. Once readmitted, however, these residents may be transferred if the facility can demonstrate that non-payment of charges exists and documentation and notice requirements are followed. The right to readmission is applicable to individuals seeking to return
from a transfer or discharge as long as all of the specific qualifications set out in §483.12(b)(3) are met.

**Procedures §483.12(b)(3)**

For Medicaid recipients whose hospitalization or therapeutic leave exceeds the bed-hold period, do facility policies specify readmission rights?

Refer to the *current MDS* for discharge information.

Review the facility’s written bed-hold policy to determine if it specifies legal readmission rights.

Ask the local ombudsman if there are any problems with residents being readmitted to the facility following hospitalization. In closed record review, determine why the resident did not return to the facility.

Ask the social worker or other appropriate staff what he/she tells Medicaid-eligible residents about the facility’s bed-hold policies and the right to return and how Medicaid-eligible residents are assisted in returning to the facility.

If potential problems are identified, talk to discharge planners at the hospital to which residents are transferred to determine their experience with residents returning to the facility.

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**F207**

**§483.12(c) Equal Access to Quality Care**

**§483.12(c)(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;**

**§483.12(c)(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and**

**§483.12(c)(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.**

**Interpretive Guidelines §483.12(c)**

Facilities must treat all residents alike when making transfer and discharge decisions. “Identical policies and practices” concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law. All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities that are mandated by the law must be
provided to residents according to residents’ individual needs, as determined by assessments and care plans.

**Procedures §483.12(c)**
Determine if residents are grouped in separate wings or floors for reasons other than care needs.

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**F208**

**§483.12(d) Admissions Policy**

(1) The facility must--

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

**Interpretive Guidelines §483.12(d)(1)**

This provision prohibits both direct and indirect request for waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, requires residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver includes requiring the resident to pay private rates for a specified period of time, such as two years (“private pay duration of stay contract”) before Medicaid will be accepted as a payment source for the resident. Facilities must not seek or receive any kind of assurances that residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

**Procedures §483.12(d)(1)**

If concerns regarding admissions procedures arise during interviews, review admissions packages and contracts to determine if they contain prohibited requirements (e.g., “side agreements” for the resident to be private pay or to supplement the Medicaid rate).

Ask staff what factors lead to decisions to place residents in different wings or floors. Note if factors other than medical and nursing needs affect these decisions. Do staff know the source of payment for the residents they take care of?

Ask the ombudsman if the facility treats residents differently in transfer, discharge and covered services based on source of payment.

With respect to transfer and discharge, if the facility appears to be sending residents to hospitals at the time (or shortly before) their payment source changes from private-pay or Medicare to Medicaid, call the hospitals and ask their discharge planners if they have detected any pattern of dumping. Also, ask discharge planners if the facility readmits Medicaid recipients who are ready to return to the facility. During the tour, observe possible differences in services
• Observe if there are separate dining rooms. If so, are different foods served in these dining rooms? For what reasons? Are residents excluded from some dining rooms because of source of payment?

• Observe the placement of residents in rooms in the facility. If residents are segregated on floors or wings by source of payment, determine if the facility is providing different services based on source of payment. Be particularly alert to differences in treatment and services. For example, determine whether less experienced aides and nursing staff are assigned to Medicaid portions of the facility. Notice the condition of the rooms (e.g., carpeted in private-pay wings, tile in Medicaid wings, proximity to the nurses’ station, quality of food served as evening snacks).

As part of closed record review, determine if residents have been treated differently in transfers or discharges because of payment status. For example, determine if the facility is sending residents to acute care hospitals shortly before they become eligible for Medicaid as a way of getting rid of Medicaid recipients.

Ask social services staff to describe the facility’s policy and practice on providing services, such as rehabilitative services. Determine if services are provided based on source of payment, rather than on need for services to attain or maintain functioning.

§483.12(d)(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident’s income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident’s income or resources.

Interpretive Guidelines §483.12(d)(2)
The facility may not require a third person to accept personal responsibility for paying the facility bill out of his or her own funds. However, he or she may use the resident’s money to pay for care. A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.

§483.12(d)(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

**Interpretive Guidelines §483.12(d)(3)**
This requirement applies only to Medicaid certified nursing facilities. Facilities may not charge for any service that is included in the definition of “nursing facility services” and, therefore, required to be provided as part of the daily rate. Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes deposits from Medicaid-eligible residents or their families, or any promise to pay private rates for a specified period of time. A nursing facility may charge a Medicaid beneficiary for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a “nursing facility” service;
- The facility informs the resident and the resident’s representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident’s admission or continued stay is not conditioned on the resident's requesting and receiving that service.

**Procedures §483.12(d)(3)**
Review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services.

Determine if the facility requires deposits from residents. If you identify potential problems with discrimination, review the files of one or more residents selected for a focused or comprehensive review to determine if the facility requires residents to submit deposits as a precondition of admission besides what may be paid under the State plan.

If interviews with residents suggest that the facility may have required deposits from Medicaid recipients at admission, except those admitted when Medicaid eligibility is pending, corroborate by, for example, reviewing the facility's admissions documents or interviewing family members.

**§483.12(d)(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.**