Optimizing Transitions

Collaboration, Communication and Requirements for Successful Discharges in Long Term Care

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Prior to Admission

- Resident Assessment
  - Overall health
    - Medical
    - Mental/psychosocial/behavioral
    - Physical Abilities
  - Lifestyle choices
  - Financial ability
- Facility Assessment
  - Capacity
  - Capability

2

CMS Definition

- Discharge
  - Refers to the movement of a Resident from a bed in one certified facility to a bed in another certified facility or other location in the community
    - Return to facility is NOT expected
- Transfer
  - Refers to movement of a Resident from a bed in one certified facility to a bed in another certified facility
    - Return IS anticipated to original facility

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Against Medical Advice (AMA)

- According to SOMs— "a Resident who leaves the facility prior to his or her planned discharge, but WITH facility knowledge of the departure and despite facility efforts to explain the risks of leaving, would be leaving against medical advice (AMA)
  - Documentation needs to include the facility attempted to provide other options to the Resident and informed the Resident of potential risks of leaving AMA
  - Documentation also needs to include the time the facility became aware of the Resident leaving the facility
- AMA discharge VS. Unsafe Discharge

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F-Tags

- F622—Transfer and Discharge Requirements
- F623—Notice Requirements before transfer/discharge
- F624—Preparation for safe/orderly transfer/discharge
- F626—Permitting Residents to Return to Facility
- F660—Discharge Planning Process

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Updated Regulations--pending

- F622
  - Will be split into F627 & F628
  - Removed "facility" and "Resident" initiated transfers/discharges
- F623
  - Relocated to F628
- F625
  - Relocated to F628
- F660
  - Included into F627
- F661
  - Discharge summary is included in the requirements for both F627 & F628

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Discharge Planning Process

- The facility is required to develop and implement an effective discharge planning process
- Discharge Planning Process MUST Include:
  - IDT involvement in planning (and alert of final plan)
    - Resident, Family/Representative (with Resident's permission), and facility representative
  - Identification of the discharge needs, goals and preferences of the Resident
  - Documentation to support the Resident has been asked about their interest in receiving information regarding returning into the community
    - If yes, facility must document
      - Referrals to local contact agencies or other appropriate entities
      - Update care plan related to the response from referrals
      - If return to the community is not feasible—there must be documentation who made the determination and why
  - Caregiver
    - Availability
    - Capacity
    - Capability
  - If transferring to another SNF or another institutional setting assist Resident and Representative in selecting using quality based data
  - Regular re-evaluations to identify changes that require modification of the discharge plan
    - Discharge plan of care MUST be updated, as needed, to reflect changes

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Discharge Assessment

- Resident's true capacity for self-care (basic ADLs)
- Resident's prognosis
- Availability of appropriate care and services
  - Primary care provider
- Transportation
- Medication and disease management
- Living Arrangement
  - Availability, ability and willingness of family to provide care
  - Environmental accommodations and assistive devices
- Risk factors that may influence the Resident's compliance with the discharge plan
  - Motivation—diet, physical activity (daily routine how can impact care demands), medication management

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Action Items

- Review throughout the stay and make alterations as needed
- Discharge plan review needs to also consider and discuss level of prognosis and anticipated level of independence in basic ADLs (bathing, dressing, transfers, toileting and feeding)
  - Treatment and Care requirements
  - Hands on training to demonstrate how to provide
- Post-Discharge Care
  - Home Health, Providers, etc.
- Assistive devices and how to use them
  - Bedside commodes, grab bars, feeding utensils
- Available community resources
- Emotional and Spiritual Needs
  - Self-Care for the Care giver
  - Provide printed information

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Orientation for Discharge/Transfer

- Resident/Representative Understand
  - Where you are going and why
  - Minimizing Anxiety or Depression during the discharge/transfer process
    - This would include transitioning in the facility to long term care
- Culture, language barriers, education level
- Document

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Unsafe Destination

- Resident wishes to discharge to a location that does not appear to meet his/her post-discharge needs, or appears unsafe
  - Document
    - Why the Resident has chosen this location
    - Risks associated with unsafe location
    - Alternative locations that are more suitable
      - Equipped to meet post-discharge needs
    - Despite offering more suitable locations, Resident refused other options, and wishes to discharge to unsafe location
  - Determine if referral to Adult Protection Services (APS) or other state entities are warranted

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Documentation

- Return anticipated
- Return NOT anticipated

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Documentation Required: Transfer—return anticipated

- Contact information for practitioner who is responsible for the Resident's care
- Resident representative information/contact
- Advanced Directive information
- Special instruction/precautions for ongoing care
  - Treatments and devices (oxygen, implants, Ivs, tubes/catheters)
  - Transmission-based precautions (contact, droplet or airborne)
  - Special Risks (falls, elopement, bleeding, pressure injury and/or aspiration precautions)
- Comprehensive care plan goals
  - Information MUST be conveyed as close a possible to actual time of transfer
- All other information necessary to meet Resident's needs
  - Resident status
    - Baseline and current mental, behavioral and functional status
    - Reason for transfer
    - Recent vital signs
    - Diagnosis & Allergies
    - Medications (including last received)
    - Most recent relevant labs and other diagnostic testing
    - Immunizations

Additional information, if any, outlined in transfer agreement with acute care provider (483.70(i))

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Documentation Required: Discharge—return NOT anticipated

- All information listed in previous slide
- Discharge Summary
  - F661

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Discharge Summary

- Must include
  - Recap of Resident's stay
    - Diagnosis
    - Course of Illness/Treatment
    - Therapy services (if applicable)
    - Pertinent labs, radiology and consultation reports
  - Summary of Residents status at the time of discharge
    - Items from 483.20(b)(1)(i)—(xviii) Comprehensive Assessment
    - Available for release to authorized persons/agencies, with the consent of Resident/Representative
  - Reconciliation or all pre-discharged medications with Resident's post-discharged medications
    - Both prescribed and over-the-counter
  - Post-Discharge plan of care

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Communicating Required Information

- Communicating the required information is a way of reducing the risk of complications and adverse events during transition to new setting
- Facility determination of method
  - Universal transfer form
  - Electronic health record summary
- Timing
  - "should occur as close as possible to the time of transfer/discharge"
    - 7-days to provide the information to the provider that will be resuming cares

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Discharge Best Practices

- Prepare the Resident well in advance
  - Actively work the discharge process throughout the entire length of stay, involve daily opportunities for training
  - Involve therapy services
- Document and Address the barriers
- Post Discharge Complications & 30-day window
  - Follow up phone calls day 7, 15 and then day 28
    - Most common post discharge complication is medication errors and falls resulting in serious injury
- Obtain several community resources
- Care giver resources for reference

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Discharge Criteria

42 C.F.R. § 483.15(c)(1)(i)(A)-(F); § 19 C.S.R. 30-82.050(2)

- The resident's welfare and the resident's needs cannot be met in the facility (inability to meet needs)
- The resident's health has improved sufficiently so the resident no longer needs the services by the facility
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident (unsafe environment)
- The health of individuals in the facility would otherwise be endangered
- 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
- The facility ceases to operate

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Notification Requirements

- Notification must be completed PRIOR to transfer/discharge to Resident and the Resident's representative(s)
  - Timely
    - At least 30-days prior to date of discharge
      - Exceptions addressed in next slide
  - In writing
    - Language and manner they understand
- A copy of the notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman

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Less than 30-day notice

See 42 C.F.R. § 483.15(c)(4); § 19 C.S.R. 30-82.050(5)

- The safety of individuals in the facility is endangered
- The health of individuals in the facility is endangered
- The resident's health improves sufficiently to allow a more immediate transfer or discharge
- An immediate transfer or discharge is required by the resident's urgent medical needs
- The Resident has not resided in the facility for 30 days

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Notification Content

- Reason for transfer/discharge
- Proposed/Effective discharge date
- Specific location
- Resident's right to appeal
  - Name, address (mailing and e-mail) and telephone number of entity which receives the requests
  - Information on how to obtain an appeal form
    - Assistance completing
    - Assistance submitting the request of appeal hearing
- Contact information for State Agency and Ombudsman
  - Name, address (mailing and e-mail) and telephone number
- Intellectual and Developmental Disabilities—IF APPLICABLE
  - Contact information for Agency responsible for the protection and advocacy of individuals with developmental disabilities
    - Name, address (mailing and e-mail) and telephone number
- Mental Disorders or related disabilities
  - Contact information for Agency responsible for the protection and advocacy of individuals with a mental disorder
    - Name, address (mailing and e-mail) and telephone number

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Appeal

- A Resident cannot be discharged while appeal is pending
  - UNLESS delay will endanger the health and safety of a Resident or others in the facility---Documentation in medical record
    - "Unable to meet need(s)" at time Resident is ready to return

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Significant Change in Resident Condition

- Emergent Need for Acute Care Setting
  - 911 required
- Non-Emergent need (no 911 required)
  - If the Resident's condition does not require emergent/immediate transfer, then prior to any action an assessment must be completed to determine if changes to care plan would allow the facility to meet the Resident's need(s)
    - F637 (assessment of significant change)

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Returning to the Facility

- Emergency, Non-Emergent, routine treatment, planned procedure
  - This is a transfer and NOT a discharge
    - Return is anticipated (usually)
  - MUST be permitted to return
    - 483.15(e)(1), F626)
    - Right to return pending an appeal of any discharge initiated after transfer
      - Unless the return would endanger the health or safety of the Resident OR OTHER individuals in the facility
        - The facility MUST document what the danger is and would pose
- Discharge initiation while Resident is inpatient in hospital setting
  - Facility must show that the Residents status at the time the Resident is ready to COME BACK (not when sent out) meets the criteria for discharge/notice requirements
- Therapeutic Leave
  - A Resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, returns to the facility to their previous room (if available) or immediately upon the FIRST availability of a bed in a semi-private room if the Resident
    - Requires services provided by the facility AND
    - Is eligible for Medicare skilled nursing facility services OR Medicaid Nursing Facility Services

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Bed Holds

- Notice prior (1st notice) to AND upon transfer (2nd notice) to the hospital or Resident goes on therapeutic leave
  - Place in Admission Packet (BEST PRACTICE)
    - "well in advance to any transfer"
  - All Residents (regardless of payor source)
  - Would only need to re-address first notice if State or Facility policy changes
- Written information to Resident OR Resident Representative
  - Duration of the state bed-hold policy (if any) during which the Resident is permitted to return and resume residence in the nursing facility
  - Reserve bed payment policy in the state plan (447.40), if any
  - Nursing facility's policy regarding bed-hold periods
    - Consistent with (e)(1) of section 483.15, permitting Resident to return
  - Information specified in (e)(1) of this section
- In cases of emergency
  - At time of transfer OR within 24-hours
  - Document multiple attempts to reach the Resident's representative in cases where the facility was unable to notify the representative
- Medicare will NOT pay to hold the bed
  - Facility policy may allow Resident to pay privately to hold bed

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IDAHO—Medicaid Payments for LOA

- Limitations
  - Facility Occupancy Limits
    - Less than 100 LICENSED beds and have 5 or more unoccupied beds (NO PAYMENT)
    - Equal to or more than 100 LICENSED beds and have an occupancy of 94% or below (NO PAYMENT)
  - Time Limits
    - 3 days at a time
      - If longer than 3 days, written authorization must be obtained in advance from the Bureau of Long-Term Care and a copy attached to the UB-04 claim form.
    - Not to exceed 15 days
  - Limits on Amount of Payments
    - 75% of audited allowable costs of the facility OR
    - Rate charged to private paying Residents for reserve bed days

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Common Reasons for a Notice to Discharge

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Cannot meet the Resident's Needs

- **Resident's** provider (Physician)
- Documentation from Physician must include:
  - What has changed: This needs to be a significant change that was not present prior to or at the time of admission
    - If was previously identified—what efforts has the facility made
      - This should be reflected in the care plan through revisions
      - Care Conferences
  - What is the SPECIFIC need the facility cannot meet
  - How will the receiving facility be able to meet the needs of the Resident since the current facility cannot
- This is not related to behavioral concerns unless impacting Resident's level of medical complexity

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Declination of Treatment

- Does not constitute ground for discharge
  - UNLESS the facility is unable to meet the needs of the Resident OR protect the health and safety of others.
- Documentation
  - The facility must provide information/education to Resident and/or Representative regarding the risks of refusal of treatment
    - F552 and F578
  - Staff must conduct appropriate assessment to determine if care plan revisions would allow the facility to meet the Resident need OR protect the health and safety of others
    - 483.20 Resident Assessment
    - 483.35 Nursing Services

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Threat to the Safety

- Prior to determining need for discharge
  - Assess
  - Treatment
  - Care Conference
  - Plan of care updates with appropriate interventions
- Documentation Requirements
  - Care plan revision—to reflect changes and interventions the facility implemented to address the Resident's need
  - Progress Notes—detail about the Resident's behavior and/or change in condition and the attempts to address them (basis for reason for discharge)
  - Provider documentation—detailed and supportive for the reason for discharge
    - Reason for transfer or discharge must be provided by a physician but unlike the medical inability to meet their need(s) it does not necessarily have to be their primary care physician
    - Attempts to find Alternative placement
  - Reflection of the best interest for the Resident and/or others

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Problematic or Risky Behavior

- Problematic or Risky Behaviors
  - Physical aggression
  - Verbal Threats
  - Sexually inappropriate
  - Wondering into unsafe environments
  - Hoarding dangerous objects
  - Disruptive behaviors
  - Spreading infectious
- Document and intervene PRIOR to the need to arrange discharge
  - Care plan revision—to reflect changes and interventions to address the Residents need
  - Progress Notes—detail about the Resident's behavior and/or change in condition and the attempts to address them (basis for reason for discharge)
  - Provider documentation—detailed and supportive for the reason for discharge
  - Provider order
- Communication with Resident and family about facility abilities, concerns and interventions
- Alternative placement attempts
- Documentation needs to reflect the best interest for the Resident and other facility Residents

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Best Practices for Behaviors

- Preventative attempts
  - Resident assessment to identify possible triggers
  - Sensory baseline and continual consideration of contributing factor
  - Cognitive Impairments
- De-escalation techniques
  - Reduced stimulation spaces
  - Staff training
- Structured Environments to promote safety
- Choices
- Crisis Management
- Behavioral Contracts

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Non-Payment

- Reasonable Attempts & Appropriate Notice
  - Resident has not submitted the necessary paperwork for 3rd party billing (including Medicare/Medicaid) payment
  - After 3rd party payor (including Medicare/Medicaid) denied the claim and Resident refused to pay for his/her stay

If paperwork has been submitted and just awaiting decision this does not meet requirement for non-payment

- Medicare Coverage Ending
  - Offer option to stay in the facility private pay
  - Offer Medicaid-eligible Resident with assistance to apply for Medicaid
- 3rd Party Billing Obtainment
  - Assistance
    - The facility must offer assistance in obtainment and submission of the application
    - The facility must ensure the Resident has necessary assistance to submit any 3rd party required paperwork
  - Eligibility after admission
    - Can only charge allowable under Medicaid
    - Conversation from a private pay rate to payment at the Medicaid rate does NOT constitute non-payment

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Working Tools for Success

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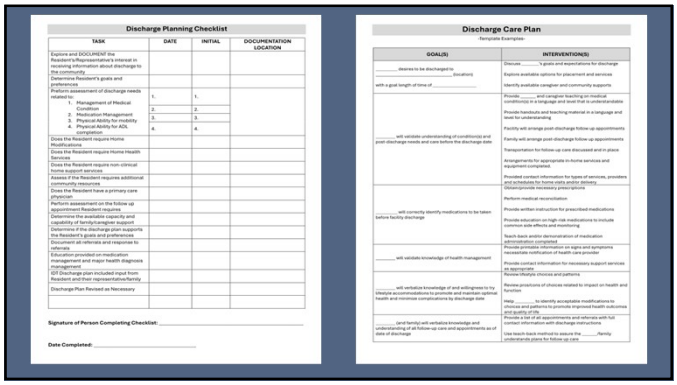

Discharge Planning Checklist

TASK	DATE	INITIAL	DOCUMENTATION LOCATION
Explore and DOCUMENT the Resident's/Representative's interest in receiving information about discharge to the community			
Determine Resident's goals and preferences			
Perform assessment of discharge needs related to: 1. Management of Medical Condition 2. Medication Management 3. Physical Ability for mobility 4. Physical Ability for ADL completion	1. 2. 3. 4.	1. 2. 3. 4.	
Does the Resident require Home Modifications			
Does the Resident require Home Health Services			
Does the Resident require non-clinical home support services			
Assess if the Resident requires additional community resources			
Does the Resident have a primary care physician			
Perform assessment on the follow up appointment Resident requires			
Determine the available capacity and capability of family/caregiver support			
Determine if the discharge plan supports the Resident's goals and preferences			
Document all referrals and response to referrals			
Education provided on medication management and major health diagnosis management			
IDT Discharge plan included input from Resident and their representative/family			
Discharge Plan Revised as Necessary			

Signature of Person Completing Checklist: _____

Date Completed: _____

Discharge Care Plan

-Template Examples-

GOAL(S)	INTERVENTION(S)
_____ deserves to be discharged to _____ (location) with a goal length of time of _____	Discuss _____'s goals and expectations for discharge Explore available options for placement and services Identify available caregiver and community supports
_____ will validate understanding of condition(s) and post-discharge needs and care before the discharge date	Provide _____ and caregiver teaching on medical condition(s) in a language and level that is understandable Provide handouts and teaching material in a language and level for understanding Facility will arrange post-discharge follow up appointments Family will arrange post-discharge follow up appointments Transportation for follow-up care discussed and in place Arrangements for appropriate in-home services and equipment completed Provided contact information for types of services, providers and schedules for home visits and/or delivery
_____ will correctly identify medications to be taken before facility discharge	Obtain/provide necessary prescriptions Perform medical reconciliation Provide written instruction for prescribed medications Provide education on high-risk medications to include common side effects and monitoring Teach-back and/or demonstration of medication administration completed
_____ will validate knowledge of health management	Provide printable information on signs and symptoms necessitate notification of health care provider Provide contact information for necessary support services as appropriate
_____ will verbalize knowledge of and willingness to try lifestyle accommodations to promote and maintain optimal health and minimize complications by discharge date	Review lifestyle choices and patterns Review provisions of choices related to impact on health and function Help _____ to identify acceptable modifications to lifestyle and patterns to promote improved health outcomes and quality of life
_____ (and family) will verbalize knowledge and understanding of all follow-up care and appointments as of date of discharge	Provide a list of all appointments and referrals with full contact information with discharge instructions Use teach-back method to assure the _____/family understands plans for follow up care

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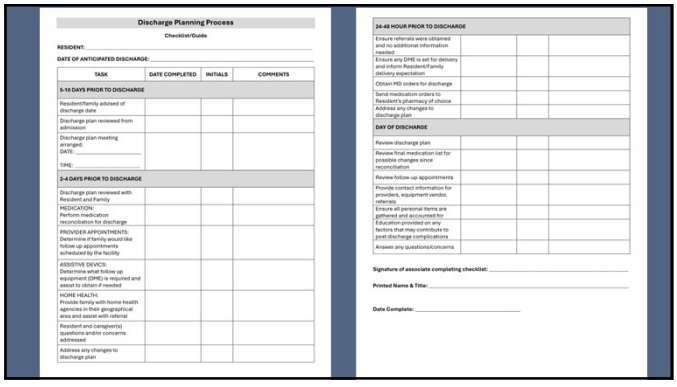

Discharge Planning Process

Checklist/Guide

RESIDENT: _____

DATE OF ANTICIPATED DISCHARGE: _____

TASK	DATE COMPLETED	INITIALS	COMMENTS
5-10 DAYS PRIOR TO DISCHARGE			
Resident/family advised of discharge date			
Discharge plan reviewed from admission			
Discharge plan meeting arranged: DATE: _____ TIME: _____			
2-4 DAYS PRIOR TO DISCHARGE			
Discharge plan reviewed with Resident and Family			
MEDICATION: Perform medication reconciliation for discharge			
PROVIDER APPOINTMENTS: Determine if family would like follow-up appointments scheduled by the facility			
ASSISTIVE DEVICES: Determine what follow up equipment (DME) is required and assist to obtain if needed			
HOME HEALTH: Provide family with home health agencies in their geographical area and assist with referral			
Resident and caregiver(s) questions and/or concerns addressed			
Address any changes to discharge plan			

24-48 HOUR PRIOR TO DISCHARGE			
Ensure referrals were obtained and no additional information needed			
Ensure any DME is set for delivery and inform Resident/Family delivery expectation			
Obtain MD orders for discharge			
Send medication orders to Resident's pharmacy of choice			
Address any changes to discharge plan			
DAY OF DISCHARGE			
Review discharge plan			
Review final medication list for possible changes since reconciliation			
Review follow-up appointments			
Provide contact information for providers, equipment vendor, referrals			
Ensure all personal items are gathered and accounted for			
Education provided on any factors that may contribute to post-discharge complications			
Answer any questions/concerns			

Signature of associate completing checklist: _____

Printed Name & Title: _____

Date Complete: _____

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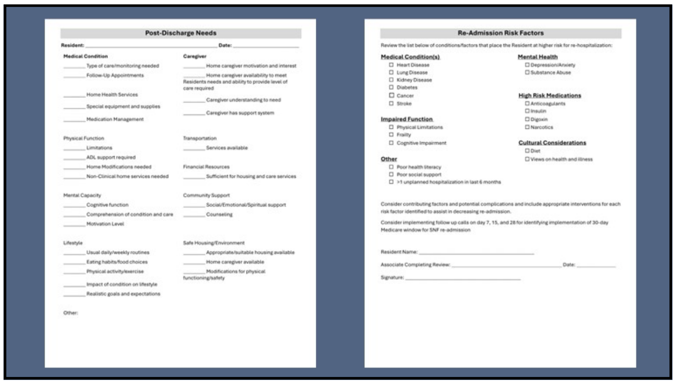

Post-Discharge Needs

Resident: ______________________ Date: ______________

Medical Condition
- _______ Type of care/monitoring needed
- _______ Follow-Up Appointments
- _______ Home Health Services
- _______ Special equipment and supplies
- _______ Medication Management

Caregiver
- _______ Home caregiver motivation and interest
- _______ Home caregiver availability to meet Residents needs and ability to provide level of care required
- _______ Caregiver understanding to need
- _______ Caregiver has support system

Physical Function
- _______ Limitations
- _______ ADL support required
- _______ Home Modifications needed
- _______ Non-Clinical home services needed

Transportation
- _______ Services available

Financial Resources
- _______ Sufficient for housing and care services

Mental Capacity
- _______ Cognitive function
- _______ Comprehension of condition and care
- _______ Motivation Level

Community Support
- _______ Social/Emotional/Spiritual support
- _______ Counseling

Lifestyle
- _______ Usual daily/weekly routines
- _______ Eating habits/food choices
- _______ Physical activity/exercise
- _______ Impact of condition on lifestyle
- _______ Realistic goals and expectations

Safe Housing/Environment
- _______ Appropriate/suitable housing available
- _______ Home caregiver available
- _______ Modifications for physical functioning/safety

Other:

Re-Admission Risk Factors

Review the list below of conditions/factors that place the Resident at higher risk for re-hospitalization:

Medical Condition(s)
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke

Mental Health
- ☐ Depression/Anxiety
- ☐ Substance Abuse

High Risk Medications
- ☐ Anticoagulants
- ☐ Insulin
- ☐ Digoxin
- ☐ Narcotics

Impaired Function
- ☐ Physical Limitations
- ☐ Frailty
- ☐ Cognitive Impairment

Cultural Considerations
- ☐ Diet
- ☐ Views on health and illness

Other
- ☐ Poor health literacy
- ☐ Poor social support
- ☐ >1 unplanned hospitalization in last 6 months

Consider contributing factors and potential complications and include appropriate interventions for each risk factor identified to assist in decreasing re-admission.

Consider implementing follow up calls on day 7, 15, and 28 for identifying implementation of 30-day Medicare window for SNF re-admission

Resident Name: ______________________

Associate Completing Review: ______________________ Date: __________

Signature: ______________________

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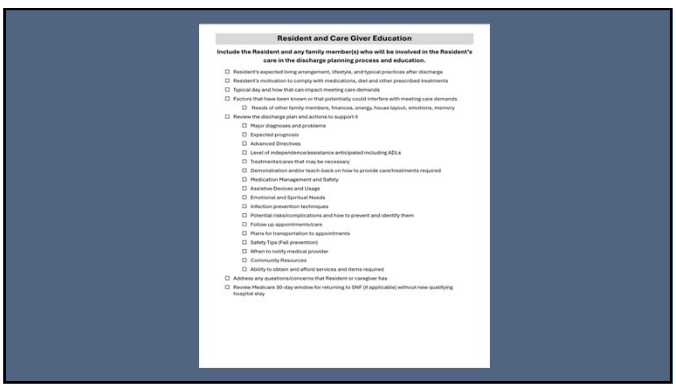

Resident and Care Giver Education

Include the Resident and any family member(s) who will be involved in the Resident's care in the discharge planning process and education.

- ☐ Resident's expected living arrangement, lifestyle, and typical practices after discharge
- ☐ Resident's motivation to comply with medications, diet and other prescribed treatments
- ☐ Typical day and how that can impact meeting care demands
- ☐ Factors that have been known or that potentially could interfere with meeting care demands
  - ☐ Needs of other family members, finances, energy, house layout, emotions, memory
- ☐ Review the discharge plan and actions to support it
  - ☐ Major diagnoses and problems
  - ☐ Expected prognosis
  - ☐ Advanced Directives
  - ☐ Level of independence/assistance anticipated including ADLs
  - ☐ Treatments/cares that may be necessary
  - ☐ Demonstration and/or teach-back on how to provide care/treatments required
  - ☐ Medication Management and Safety
  - ☐ Assistive Devices and Usage
  - ☐ Emotional and Spiritual Needs
  - ☐ Infection prevention techniques
  - ☐ Potential risks/complications and how to prevent and identify them
  - ☐ Follow up appointments/care
  - ☐ Plans for transportation to appointments
  - ☐ Safety Tips (Fall prevention)
  - ☐ When to notify medical provider
  - ☐ Community Resources
  - ☐ Ability to obtain and afford services and items required
- ☐ Address any questions/concerns that Resident or caregiver has
- ☐ Review Medicare 30-day window for returning to SNF (if applicable) without new qualifying hospital stay

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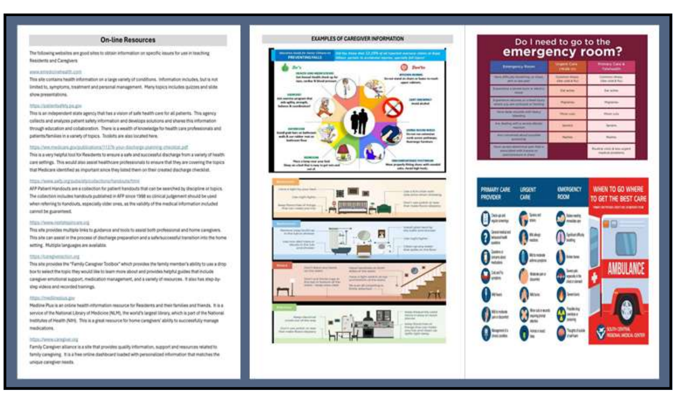

On-line Resources

The following websites are good sites to obtain information on specific issues for use in teaching Residents and Caregivers.

www.emedicinehealth.com
This site contains health information on a large variety of conditions. Information includes, but is not limited to, symptoms, treatment and personal management. Many topics includes quizzes and slide show presentations.

https://patientsafety.pa.gov
This is an independent state agency that has a vision of safe health care for all patients. This agency collects and analyzes patient safety information and develops solutions and shares this information through education and collaboration. There is a wealth of knowledge for health care professionals and patients/families in a variety of topics. Toolkits are also located here.

This is a very helpful tool for Residents to ensure a safe and successful discharge from a variety of health care settings. This would also assist healthcare professionals to ensure that they are covering the topics that Medicare identified as important since they listed them on their created discharge checklist.

AFP Patient Handouts are a collection for patient handouts that can be searched by discipline or topics. The collection includes handouts published in AFP since 1998 so clinical judgement should be used when referring to handouts, especially older ones, as the validity of the medical information included cannot be guaranteed.

This site provides multiple links to guidance and tools to assist both professional and home caregivers. This site can assist in the process of discharge preparation and a safe/successful transition into the home setting. Multiple languages are available.

This site provides the "Family Caregiver Toolbox" which provides the family member's ability to use a drop box to select the topic they would like to learn more about and provides helpful guides that include caregiver emotional support, medication management, and a variety of resources. It also has step-by-step videos and recorded trainings.

https://medlineplus.gov
Medline Plus is an online health information resource for Residents and their families and friends. It is a service of the National Library of Medicine (NLM), the world's largest library, which is part of the National Institutes of Health (NIH). This is a great resource for home caregivers' ability to successfully manage medications.

https://www.caregiver.org
Family Caregiver alliance is a site that provides quality information, support and resources related to family caregiving. It is a free online dashboard loaded with personalized information that matches the unique caregiver needs.

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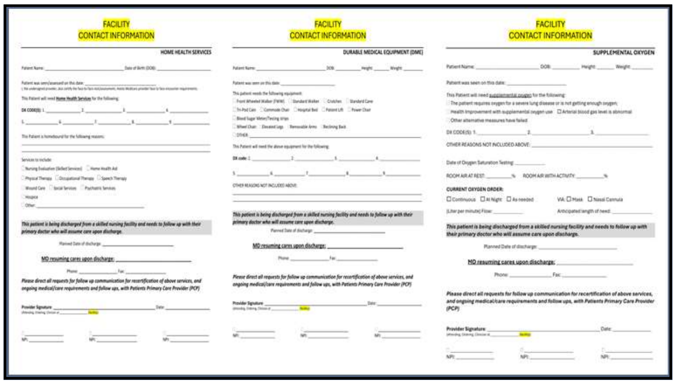

FACILITY
CONTACT INFORMATION

HOME HEALTH SERVICES

FACILITY
CONTACT INFORMATION

DURABLE MEDICAL EQUIPMENT (DME)

FACILITY
CONTACT INFORMATION

SUPPLEMENTAL OXYGEN

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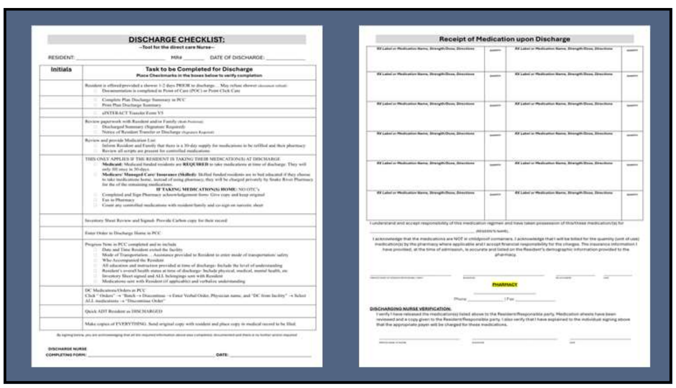

DISCHARGE CHECKLIST:

Task to be Completed for Discharge

Receipt of Medication upon Discharge

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"Nursing Homes are a testament to the dedication and compassion of those who choose to care for the elderly or disabled population, showing us the true meaning of selflessness and love"

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Resources

Understanding Nursing Home Discharges & Evictions
https://www.medicaidplanningassistance.org/nursing-home-evictions/

eCFR :: 42 CFR 483.15 -- Admission, transfer, and discharge rights.
https://ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.15

State Operations Manual. Appendix PP—Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

"Nursing Facility: Payments for Periods of Temporary Absence" IDAPA 16.03.10 "Medicaid Plan Benefits," Sec. 292. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf

IDAPA 16—Idaho Department of Health and Welfare. Division of Medicaid. 16.03.10—Medicaid Enhanced Plan Benefits https://www.idmedicaid.com/Provider%20Guidelines/Long-Term%20Care%20Facility.pdf

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