Training: Discharge Plans

Resident Assessment
• Facilities are to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment (42 C.F.R. §483.20(b)).

• Facilities are to assess the resident's discharge potential, an assessment of the facility's expectation of discharging the resident from the facility within the next 3 months (42 C.F.R. §483.20(b)((xvi)).
Discharge planning

• A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility (42 C.F.R. §483.12(a)(7)).
• Resident records should contain a final resident discharge summary which addresses the resident's post-discharge needs (42 C.F.R. §483.20(l)).

• Facilities are to develop a post-discharge plan of care, developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This applies to discharges to a private residence, to another nursing facility, or to another type of residential facility such as board and care or nursing facilities (42 C.F.R. §483.20(l)).

• Post-discharge plan of care means the discharge planning process, which includes assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community (42 C.F.R. §483.20(l)).

Section 2: Discharge Planning

Supports Needed for Community Placement:
Reasons Why Alternative Placement is not Feasible or Appropriate:
Plan for Discharge:

Supports Needed for Community Placement:
This section must explain what Supports an individual requires that meet Nursing Level of Care.

Examples:
(24 hour supervision, ADL/IADLs, Therapy, Specific Medical Treatments, Wound Care...)

Reasons Why Alternative Placement is not Feasible or Appropriate:
This Section must explain why there are no alternative placement options other than a Long Term Care Nursing Facility.

Examples:
(No availability for ALF/ALH placement, Lack of Community supports, Intensive/Skilled needs exceed available resources required to care for the person…)

Plan for Discharge:
The discharge planning process includes assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. (42 C.F.R. §483.20(l)).

This section should explain what conditions must be met to discharge the patient. If the patient's current facility was no longer available, what kind of care environment is required to meet their needs?

Examples:
(Patient will return home with natural supports once she has met her PT/OT Goals. Or Patient can only be discharged to another facility with 24 hour skilled observation due to complex medical needs outlined in the form. Patient is receiving end of life care and requires a Long Term Care Facility because of the skilled needs listed above.)