WAC 388-97-0080 Discharge planning. (1) A resident has the right to attain or maintain the highest practicable physical, mental, and psychosocial well-being, and to reside in the most independent setting. Therefore, the nursing home must:

(a) Utilize a formal resident discharge planning system with identical policies and practices for all residents regardless of source of payment;

(b) Inform the resident or resident's representative in writing of the nursing home's discharge planning system when the resident is admitted or as soon as practical after the resident's admission, including:

(i) Specific resources available to assist the resident in locating a lesser care setting;

(ii) The name of the nursing home's discharge coordinator(s);

(iii) In the case of a medicaid certified nursing facility, the address and telephone number for the department's local home and community services office; and

(iv) In the case of a resident identified through pre-admission screening and resident review (PASRR) as having a developmental disability or mental illness, the address and telephone number for the division of developmental disabilities or the mental health PASRR contractor.

(2) The nursing home must prepare a detailed, written transfer or discharge plan for each resident determined to have potential for transfer or discharge within the next three months. The nursing home must:

(a) Develop and implement the plan with the active participation of the resident and, where appropriate, the resident's representative;

(b) In the case of a medicaid resident, coordinate the plan with the department's home and community services staff;

(c) In the case of a resident identified through PASRR as having a developmental disability or mental illness, coordinate the plan with the division of developmental disabilities or the mental health PASRR contractor;

(d) Ensure the plan is an integral part of the resident's comprehensive plan of care and, as such, includes measurable objectives and timetables for completion;

(e) Incorporate in the plan relevant factors to include, but not be limited to the:

(i) Resident's preferences;

(ii) Support system;

(iii) Assessments and plan of care; and

(iv) Availability of appropriate resources to match the resident's preferences and needs.

(f) Identify in the plan specific options for more independent placement; and

(g) Provide in the plan for the resident's continuity of care, and to reduce potential transfer trauma, including, but not limited to, pretransfer visit to the new location whenever possible.

(3) For a resident whose transfer or discharge is not anticipated in the next three months, the nursing home must:

(a) Document the specific reasons transfer or discharge is not anticipated in that time frame; and

(b) Review the resident's potential for transfer or discharge at the time of the quarterly comprehensive plan of care review. If the reasons documented under subsection (3)(a) of this section are un-

changed, no additional documentation of reasons is necessary at the time of plan of care review.

(4) The nursing home must initiate discharge planning on residents described in subsection (3) of this section:

(a) At the request of the resident or the resident's representative; and

(b) When there is a change in the resident's situation or status which indicates a potential for transfer or discharge within the next three months.

(5) Each resident has the right to request transfer or discharge and to choose a new location. If the resident chooses to leave, the nursing home must assist with and coordinate the resident's transfer or discharge. The medicaid resident, resident's representative, or nursing facility may request assistance from the department's home and community services or, where applicable, the division of developmental disabilities or mental health in the transfer or discharge planning and implementation process.

(6) The nursing home must coordinate all resident transfers and discharges with the resident, the resident's representative and any other involved individual or entity.

(7) When a nursing home anticipates discharge, a resident must have a discharge summary that includes:

(a) A recapitulation of the resident's stay;

(b) A final summary of the resident's status to include items in WAC 388-97-1000(1), at the time of discharge that is available for release to authorized individuals and agencies, with the consent of the resident or and surrogate decision maker; and

(c) A postdischarge plan of care that is 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.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-0080, filed 9/24/08, effective 11/1/08.]