

Guide to Facility Closures
for Long-Term Care Ombudsman Coordinators
in California



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Introduction and Acknowledgements

This Guide is designed to assist representatives of the State of California's Office of the State Long-Term Care Ombudsman (OSLTCO) in preparing for and responding to partial or complete closure of a long-term care (LTC) facility resulting in the relocation of multiple residents. It describes the general process and offers recommendations for actions to take before, during and after a closure of a facility.¹ The Guide draws from the Ombudsman's Program Manual and provides additional references to inform Ombudsman of the specific statutory requirements for a LTC facility's submission and implementation of a relocation plan. It is strongly recommended that Local Ombudsman Programs familiarize themselves with the relevant state and federal regulations related to resident relocation.

The Office of the State Long Term Care Ombudsman appreciates the contributions of the many stakeholders who have provided valuable input into this draft, including staff from the Department of Aging, the California Department of Public Health, the California Department of Social Services, and the California Department of Health Care Services. We also thank resident advocates and key partners, including California Advocates for Nursing Home Reform, Disability Rights California and the California Association of Health Facilities for their important insights and recommendations. A special recognition to the many Ombudsman Coordinators who offered critical input into drafts of this document and who protect the rights of California's LTC residents every day.

¹ This guide focuses on voluntary and involuntary regulatory closures of facilities. Emergency closures and temporary evacuations of residents due to natural or human-provoked emergencies will be addressed in a separate guide.

Acronyms

ADRC - Aging and Disability Resource Connections

ARF- Adult Residential Facility. Licensed to provide board and care services 24-hours a day, non-medical care, and supervision for clients ages 18-59 or any person 60 years of age or older under specified requirements. These clients may have a mental, physical, or developmental disability. ARFs are licensed by the State Department of Social Services, Community Care Licensing Division (CCLD).

CCDL- California State Department of Social Services, Community Care Licensing Division

ICF - Intermediate Care Facilities. A health facility, or a distinct part of a hospital or skilled nursing facility, which provides the following basic services: Inpatient care to patients who have need for skilled nursing supervision and need supportive care, but who do not require continuous nursing care.

ILC - Independent Living Centers

LCA – Local Contact Agencies

L&C- California Department of Public Health, Center for Health Care Quality, Licensing and Certification Program

LTC - Long-Term Care. Includes a wide variety of settings and services which are available to meet people's special needs.

LLTCOP- Local Long-Term Care Ombudsman Program

MCP – Medi-Cal Managed Care Health Plans

OSLTCO – California Department of Aging, Office of the State Long-Term Care Ombudsman

POC- Plan of Correction

PSA- Program Service Area

RCFE - Residential Care Facility for the Elderly. Housing arrangements for persons, 60 years of age and over, where 24-hour non-medical care and supervision is provided. RCFE's include "retirement homes", assisted living facilities as well as board and care homes. RCFEs are licensed by the State Department of Social Services (DSS), Community Care Licensing Division (CCLD)

SNF - Skilled Nursing Facility. A health facility or a distinct part of a hospital which provides skilled nursing care and supportive care to patients whose primary need is for nursing care on an extended basis. It provides 24-hour inpatient care that includes at a minimum, medical, nursing, dietary, pharmaceutical services, and an activity program. SNFs are licensed by the California Department of Public Health (CDPH), Licensing and Certification.

Where to Begin?

Monica had been working as an Ombudsman Coordinator in a largely rural Program Service Area (PSA) for the last eight months. Since completing the Ombudsman training course, she had become familiar with most of the facilities in her PSA and was feeling more comfortable with her responsibilities. However, yesterday she learned that a 120 bed SNF had been notified by CDPH that the facility had received an “immediate jeopardy” finding during a recent survey, placing their provider status in jeopardy. While she knew the facility had received citations in the past, they had always been able to make the necessary improvements to continue operations. But a critical deadline was fast approaching, and she was worried about what could happen to the more than 100 current residents, many with complex needs and most of them dependent on state Medi-Cal payments for their care. She knew there were not enough available beds nearby able and willing to accept these residents. What could she do? Where to begin?

Closures of Long-Term Care Facilities in California

As of May 2022, there were just over 12,000 licensed Long Term Care (LTC) facilities in the State of California, including some 1,200 Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF), and more than 11,000 Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE). Every year some of these facilities close their doors, requiring residents and their families to transfer to other facilities or seek community-based alternatives. In other instances, facilities may relocate residents to combine wings or units in an effort to better manage patient census levels or staffing ratios.

There are a multitude of reasons for a facility or a certain type or level of service to be closed. These may include: the sale of the entity or organization, bankruptcy, going out of business, financial receivership, decline in market or community demand, age of the physical plant, shift in location, regulatory compliance problems, loss of provider agreements, and other reasons.

The large majority of facility closures are voluntary, initiated by a business decision taken by a private board or owner. Since these are the result of internal deliberations often unrelated to performance, they can be difficult to anticipate from a vantage point outside of the organization. As a result, the issuance of a formal notice of a facility’s intention to voluntarily close can come as an unwelcome surprise to Ombudsman, residents, and their families.

Less frequently, facilities may have their licenses suspended or revoked for failure to meet care or safety standards or contractual obligations mandated by the state or federal regulatory agencies. In the case of these involuntary (or regulatory) closures, there are often early warning signs, such as citations issued by Centers for Medicare and Medicaid Services (CMS) or state licensing agencies for failure to establish compliance with standards of care. Citations are fairly common, and most facilities that receive citations will not close. All the same, facilities that receive

Recent Trends:

The total number of skilled nursing facilities (SNFs) in California has decreased over the last five years, while bed capacity per facility has risen, on average.

The majority of facility closures occur among the more than 7,500 RCFEs across the state.¹ These facilities range from privately-owned, small, 6-bed homes to large residential complexes with contiguous ICF and SNFs.

multiple citations over time, that are cited for more serious violations, or that fail to resolve issues in a timely manner, merit special attention. Providers that are frequently cited and threatened with closure multiple times, only to have these threats ultimately rescinded, may not believe they will ever be decertified or lose their licenses. Consequently, these facilities may be unprepared when they are actually forced to close, leaving remaining staff, residents, and families to scramble to prepare and coordinate the transfer of residents.

Regardless for the reason for the closure, these events often entail the transfer of residents from their current home to another location. Research has demonstrated that these moves can be highly disruptive to the lives of residents and can have a negative impact on their quality of life and quality of care, particularly when resident choice is not adequately taken into consideration. Medical support can be delayed, routines and activities interrupted, and important personal relationships can be strained. Many residents experience transfer trauma or relocation stress, the “physiologic and/or psychosocial disturbances as a result of transfer from one environment to the another.”² The response to the stress caused by this unexpected life event may include depression, manifesting as agitation; increase in withdrawn behavior; self-care deficits; falls; and weight loss.³

Fortunately, the worst effects of resident relocations on the health and well-being of residents can be mitigated through adequate preparation and following established protocols that protect the well-being of residents and staff at the facility before, during and after the transition event. This is supported by active engagement with - and proper monitoring by - state and federal regulatory agencies. The local Ombudsman program plays a critical role ensuring residents and their families are aware of existing legal protections for residents during a planned transfer and discharge. Often, this also means playing a coordinating role between the various actors involved in the closure and subsequent transfer.

Who is Involved in a Facility Closure and What Are Their Responsibilities?

Facility closures and associated resident transfers will be handled in slightly different ways depending on the type and size of the facility and circumstances prompting the closure. However, federal and state policies are aligned in the shared objective of managing resident transfers in a way that **minimizes their potential negative effect on the health and welfare of displaced residents**. Achieving this goal requires the active involvement of several key agencies and actors, and a coordinated approach to the facility closure process. These include:

State Licensing Agencies: There are two **state licensing agencies** primarily responsible for oversight and regulation of LTC facilities in the state of California. The **California Department of Social Services, Community Care Licensing Division (CCLD)** issues licenses and monitors RCFEs and ARFs. The **California Department of Public Health, Center for Health Care Quality, Licensing and Certification Program (L&C)** licenses and oversees SNFs and ICFs.

These agencies are charged with determining facility compliance with state statutes and regulations through regular on-site surveying and monitoring. They are responsible for enforcing standards, investigating complaints, pursuing administrative actions, including the issuance of citations and civil penalties for non-compliance, license revocations and exclusions of individuals from licensed facilities. In the event of an involuntary (or regulatory) closure they are responsible for notifying the facility and

² As defined by NANDA International (formerly North American Nursing Diagnostic Association), 1992

³ Murtiashaw, S. The Role of Long-Term Care Ombudsmen in Nursing Home Closures and Natural Disasters, National Long Term Care Ombudsman Resource Center, National Citizens’ Coalition for Nursing Home Reform, January 2000.

applying statutes related to the closure process, including those governing resident transfers in the facilities falling under their purview.

L&C also has the responsibility for certifying a skilled nursing facility's or nursing facility's compliance or noncompliance with federal requirements.⁴ However, the State's certification for a skilled nursing facility is subject to CMS' approval. "Certification of compliance" means that a facility's compliance with Federal participation requirements for being a Medicaid (Medi-Cal) nursing home provider has been ascertained. In addition to certifying a facility's compliance or noncompliance, the State recommends appropriate enforcement actions to the State Medicaid agency for Medicaid and to the regional office for Medicare.

The CMS regional office (Region IX) determines a facility's eligibility to participate in the Medicare program based on the State's certification of compliance and a facility's compliance with civil rights requirements.

Facility Licensees: Facility Licensees are legally and financially accountable for maintaining the safety and security of residents throughout the entire closure and relocation process. They are responsible for adhering to internal policies as well as state and federal laws established to protect the well-being of residents. Facility staff are expected to comply with all requirements and for maintaining consistent medical and personal support services while cooperating with the cognizant agencies in the closure process.

Office of the State Long-Term Care Ombudsman (OSLTCO): The Ombudsman serves as the resident's advocate and an informed observer working with licensing, certification, and other enforcement agencies to ensure the rights and preferences of residents are upheld during the closure process and included in decisions about relocation. Ombudsman at the state and local level make regular visits to the facility, communicate directly with residents and their families, agency representatives and facility staff. Ombudsman can also perform an important coordinating role during a closure, helping to mobilize the resources of other actors as part of a facility closure "Strike Team" in support of the resident.

Residents, their families, guardians and legal representatives: Residents have the right to advance notice of transfer, discharge, disenrollment, termination or changes in services. Their needs and preferences must be taken into account in decisions about transfer and placement.

Preparing for a Facility Closure

Increase Situational Awareness

Ombudsman Program Coordinators should become familiar with each facility in their Program Service Area through scheduled, quarterly facility monitoring activities.⁵ Through these visits, Ombudsman have the opportunity to get to know the residents and members of Resident Councils and to develop positive professional working relationships with facility staff and Administration. Through these visits, the Ombudsman will become aware of:

- **Locations of facilities** — Relative distances and travel times relative to the Ombudsman's offices, emergency services and key evacuation routes

⁴ Except in the case of State-operated facilities. 42 CFR Part 483, Subpart B

⁵ Following standards for completing the State Long-Term Care Program Reporting System (NORS). However, this depends on the number of facilities, number of certified Ombudsman representatives, and available resources.

- **Resident profiles**– Number of residents, level of care required, payer source
- **Facility profile and average census**– Facility size, services, programs and activities
- **Staff count, names, titles and contact information**– Including the facility Administrator, Nursing Director, Discharge Planners/Nurse and other key staff; Note level of staff engagement with management and rates of staff turnover; Labor issues
- **Facility climate**– Observations of residents’ well-being, the environment, resident-staff interactions, residents’ status, activities, staff members’ demeanor and responsiveness to residents
- **History of the facility**– Ownership, relationships with other facilities, important service contracts. Previous regulatory actions.

Through frequent visits and monitoring, Ombudsman may be able to observe emerging issues or challenges that a facility might be facing that could eventually result in a voluntary or regulatory closure. Frequent staff complaints about compensation levels and lack of resources, high rates of staff turnover, and other issues that could directly affect resident quality of care are indications that a facility may be struggling. Other indications may be signs that vendors are not being paid, such as an accumulation of refuse and shortages of disposable supplies. A consistent trend towards lower occupancy at a facility, with decreasing bed capacity through attrition, and with little or no efforts taken to fill vacant beds could be another indication that a closure is imminent.

More obvious signs are citations and/or penalties issued by the cognizant regulatory agency, either the state’s CDSS’s CCLD or CDPH’s L&C Program, or the federal CMS agency, warning the facility to take corrective actions. Depending on the frequency and severity of the issues that resulted in the citations, these may merit discussion and further investigation by members of the Strike Team. It is important to note that, because these citations are issued by the regulatory agency directly to the facility, the Ombudsman may not be initially aware that the facility has been cited. This underscores the importance of developing close working relationships with both CCLD and L&C field staff to improve informal communication about issues with the potential to affect resident care and safety before they rise to the level of a closure. CCLD and L&C colleagues should be considered as vital members of the facility closure “Strike Team” described below.

Form a Local Facility Closure “Strike Team”

Ombudsmen are strongly encouraged to recruit and develop a local facility closure “Strike Team” before a closure event becomes imminent. This team should be prepared to meet regularly (at least quarterly) to 1.) articulate their role and their scope of responsibility 2.) Discuss any problems related to current or recent closures; 3.) Assess potential future closure threats; and 4.) commit to be on-site during a closure.

When a closure is anticipated or imminent, Strike Team members will be expected to participate more frequently in communications, typically through conference calls or interagency meetings held locally. When a closure has been confirmed, the Strike Team will begin to meet with the Facility Administration and Staff on a weekly basis, or more frequently, as needed. For this reason, it is important to select individuals who will be available and committed to active participation as part of your “Strike Team”.

The composition of the local facility closure Strike Team Core may differ across different Program Service Areas, according to the presence or absence of a particular resource or the unique needs of the community. Participants in a facility closure Strike Team may include representation from:

- **Office of the State Long-Term Care Ombudsman, OSLTCO Program** – Ombudsman Coordinators serve as the convening entity of the facility closure Strike Team. OSLTCO State Officials, particularly Program Analysts that support the work of local Ombudsmen programs, can provide technical assistance and serve as a conduit for information sharing between the local program, OSLTCO, CCLD, L&C and other relevant entities.
- **Office of the Long-Term Care Patient Representative** – Provides representation and makes care decisions on behalf of residents who are unable to represent themselves and who have no other legal guardians.
- **CA Department of Public Health, Center for Health Care Quality, Licensing and Certification Division (L&C)** – CHCQ District Offices are committed under the terms of an inter-agency MOU to working with the Ombudsman Program to facilitate resolution of complaints made by or on behalf of long-term care residents of nursing facilities.
- **CA Department of Social Services, Community Care Licensing Division (CCLD)** – CCLD Regional Offices are committed under the terms of an inter-agency MOU to work with the Ombudsman Program to facilitate resolution of complaints made by or on behalf of residents of RCFE and ARF facilities.
- **CA Department of Health Care Services** – Issues payments for care services rendered to residents of LTC facilities. Medi-Cal Navigators program can help provide connections to health care system benefits.
- **Medi-Cal Managed Care Health Plans (MCP)** – DHCS contracts with Medi-Cal Managed Care Health Plans, which consist of network providers and subcontractors to coordinate the delivery of health care services for enrollees in the state’s Medi-Cal program. Care managers can also assist with identifying alternative facilities.
- **County Health Department** – Representatives can support needs related to home and community-based supportive services and assess Assisted Living Medicare Waiver availability in the region. These offices may be able to provide support for the preadmission screening process to determine and clear resident eligibility requirements.
- **Local Contact Agencies (LCA)** – The Department of Health Care Services has designated one or more LCA in each county to provide information/education to individuals who have indicated interest in learning about home and community-based options. LCAs may be one of several agency types: Aging and Disability Resource Connection (ADRC) programs, California Community Transitions Lead Organizations, Independent Living Centers (ILCs), or Area Agencies on Aging.
- **Regional Centers** – Case workers at the 21 community-based, non-profit agencies that serve as regional centers provide assessments, determine eligibility for services, and offer case management services for individuals with cognitive and/or developmental disabilities. Regional centers also develop, purchase, and coordinate services.
- **Other Potential Allies:** In addition to the Strike Team members, other partners and allies may be enlisted to support residents at different stages of the facility closure and relocation process, including:
 - **Neighboring Ombudsman Programs** – Fellow Ombudsman can be valuable resources for identifying alternative housing options for relocating residents in neighboring PSAs and for following up with residents who have been transferred to facilities located there.
 - **Office of the District Attorney** – The local DA’s office provides protections against possible discriminatory practices or other violations of residents’ legal rights. The state licensing agency may also seek injunctive relief and damages from Licensees that do not provide the required relocation services.
 - **CA Department of Rehabilitation** – Provides support for the continuity of services for residents with developmental disabilities.

- **CA Department of Veterans Affairs, County Veteran’s Services Offices**
- **Legal aid organizations** – Legal advocacy organizations such as California Advocates for Nursing Home Reform (CANHR) or Disability Rights CA may provide additional guidance to residents about their rights during a facility transition or involuntary move.
- **Local Media** – Local media may be leveraged to mobilize community donations in favor of residents during a transition or in the case of emergency.
- **Faith-based, Civic and Philanthropic Organizations** – Community congregations and organizations such as Rotary or Kiwanis Clubs may be able to support efforts to inventory and transport personal effects of residents being transferred from one facility to another.
- **Local businesses** – Commercial entities may be able to provide donations of supplies helpful to the transition of residents and their property.

Anticipate a Closure

Learning about a closure as far in advance of the official “public” notice can provide additional time for planning and preparing residents for a possible relocation. Ombudsman and the assembled facility closure “Strike Team” may become aware of this possibility through both informal and formal channels.

Informal discovery relies upon the strength of the Ombudsman’s professional networks and the ability to develop positive, trusting working relationships with the facility and key stakeholders. This is particularly the case with voluntary closures, where facility owners may prefer to keep this news confidential until the last practicable moment.

Regulatory, or involuntary closures, may be more easily anticipated as they are the unfortunate end result of successive failures to take corrective actions to address deficiencies in standards of care or facility conditions. Multiple poor surveys or administrative actions, while not official announcements of a facility’s intention to close, are another indication that a facility may be struggling with serious issues that could ultimately lead to closure. There are several ways that LLTCOPs can learn of these.

For SNFs and ICFs, per the current agreement between CDPH and OSLTCO, local CHCQ District Offices (L&C) are expected to provide copies of Statements of Deficiencies and Plans of Correction regarding all complaints referred by LLTCOPs, (as well as all surveys where the misuse of antipsychotic medications is substantiated), and any related citations and civil penalties levied by L&C against the facility.⁶ While there is no requirement for L&C to proactively share reports and Plans of Correction issued to facilities that do not originate with the LLTCOP, these can be shared at the discretion of the CHCQ District Office during regular quarterly meetings with the Ombudsman. In addition, the CHCQ’s [State Enforcement Actions Dashboard](#) provides information on all citations issued by the L&C Program to nursing home facilities in the state. The Dashboard can be searched using a variety of filters, including facility type, name, license number and issue date.

Similarly, DSS (CCLD) has also committed through interagency agreement for their Regional Offices to meet with local Ombudsman Programs on a quarterly basis, or more frequently as mutually agreed upon. The objective of the meeting is to share information regarding problem facilities, forfeitures, final decisions and orders, and status of legal cases, including revocations of licenses. CCLD Program Offices are expected to notify the OSLTCO when an administrative process has been initiated and, subsequently, when an accusation has been served against a Licensee.⁷ CCLD does not yet provide

⁶ See Agreement MOU 18-10114

⁷ See Agreement 16-MOU-00706

inspection reports and complaint information on Residential Care Facilities for the Elderly in an electronic format readily available to consumers and consumer advocates. A limited amount of information regarding the licensing status and regulatory history of licensed facilities can be found on the [Division's Care Facility Search page](#). However, each [local district licensing office](#) has a complete file on each facility and can provide this upon request.

In addition, CMS maintains the [Health Deficiencies Database](#), a searchable public database that provides detailed information on all nursing home citations over the last three years, including the associated inspection date, description, scope and severity, the current status of the citation and the correction date. Often, the first serious indication of a potential closure comes through a formal Denial of Payment for New Admissions (DOPNA) letter issued by CMS (Region IX office). This letter is a formal notice indicating that a nursing facility has been temporarily disqualified as a provider of Medicaid-funded services as a result of their failure to meet critical requirements or standards. The DOPNA letter advises the facility that they will not be reimbursed for services provided to new residents as of a specified date. This letter is typically sent from the CMS Region IX offices to both CDPH and to the State OSLTCO office and subsequently shared with the LLTCOP.

Verify the Closure

Once the Ombudsman and/or member of the Strike Team learns of a likely closure or resident draw-down scenario, it is important to convene a meeting as soon as possible to discuss and verify this information. If critical details are unknown, a member of the Strike Team can be assigned to verify the information by communicating directly with the facility. It is recommended that this be done in a manner that fosters a spirit of collaboration with the Facility Administration and staff to promote transparency and partnership throughout the continuing process. Ombudsman should notify OSLTCO as soon as possible in all cases with the potential to require the relocation of multiple facility residents.

At this time, a determination may be made whether there is an adequate plan of action or if no further action is needed. Alternatively, there may be a determination there is an inadequate plan of action, and that additional action is required. If confirmed that additional action is required, it is important to establish a timeline for specific actions as early as possible.

The Closure Process

The Facility Closure Plan

When a Licensee makes a decision to close down part of or an entire facility that will result in the relocation of seven or more residents, Facility Administration is required to develop and submit a facility Closure Plan to the Department of Public Health or Department of Social Services (depending on the type of facility) for agency for review and approval.

While reviewing and approving the Closure Plan is the responsibility of the CCLD or L&C, the Ombudsman may be included in the review of the draft document to provide important guidance and feedback to ensure it includes robust considerations for the rights of displaced residents. Consultations with the local CCLD Regional Offices or L&C District Offices should be ongoing, providing the opportunity to compare notes on resident needs and preferences and strategize about how best to achieve outcomes that are in the best interests of residents.

The final Closure Plan should include sufficient detail to clearly identify the steps the facility will take, and the individual(s) responsible for ensuring the steps are successfully carried out. Specifically, the Closure Plan should include:

- The process and procedures for providing timely written notification (a Notice Letter) of the facility's impending closure, including its Closure Plan, to the appropriate state licensing agency, OSLTCO, Residents and/or their legal representatives. This should include how the facility will address potential language barriers.
- The process for providing notification of the facility's impending closure, including its closure plan to all facility staff, vendors, contractors and unions as appropriate.
- A process that provides assurance for how the closing facility will identify available facilities or other settings in terms of quality, services, and location, taking into consideration the need, choice, and best interests of each resident. This should entail a relocation evaluation for each resident.
- Provisions for sufficient preparation and orientation to residents to ensure a safe and orderly move from the facility.
- The roles and responsibilities of the facility's owners, administrator, or their replacement(s) or temporary managers/monitors during the closure process.
- The primary contact(s) responsible for the daily operation and management of the facility during the facility's closure process.
- The primary contact(s) responsible for the oversight of those managing the facility operations during the closure process.
- Assurance that no new residents will be admitted to the facility on or after the date that the written notice of impending closure was provided to the state regulatory agency.
- Identification of any and all available sources of supplemental funding to assist in maintaining the facility's daily operations until all residents are safely relocated and/or transferred.
- The provisions for ongoing operations and management of the facility and its residents and staff during the closure process that include:
 - Payment of salaries and expenses to staff, vendors, contractors, etc.,
 - Continuation of appropriate staffing to meet the needs of all residents.
 - Ongoing assessment of each residents' care needs and the provision of necessary services and care, including the medications, services, supplies and treatments as ordered by the resident's physician/practitioner.
- The ongoing accounting, maintenance and reporting of resident personal funds.
- The provision of appropriate resident care information to the receiving facility to ensure continuity of care.
- The labeling, safekeeping and appropriate transfer of residents' personal belongings, such as clothing, medications, furnishings, etc. at the time of transfer or relocation, including contact information for missing items after the facility has closed.

Upon receipt of the Closure Plan, the licensing agency has 15 working days to approve or disapprove the plan. If approved, the Plan becomes effective on the date that the agency grants its written approval. If disapproved, the Licensee may resubmit an amended Plan. The agency must, within 10 working days of receipt of an amended Plan, approve or disapprove the amended Closure Plan in writing. If a facility's original or amended Closure Plan is disapproved, the agency must inform the Licensee in writing of the

reasons for the disapproval.⁸ Until the Closure Plan has been approved, the facility should not require any resident to transfer. Upon approval of the Closure Plan by the licensing agency, the facility should send a copy of the closure plan to the LLTCOP.⁹

It is highly recommended that the facility does not make any verbal or written announcements of the facility's closing to residents, families, staff, the public or media before the Closure Plan has been approved. This will help to avoid unnecessary confusion and anxiety among residents currently living in the facility and facilitate a collaborative, well-planned approach to their successful relocation.

Written Notification

Once the Closure Plan is approved, the Licensee is required to provide a formal Notice Letter announcing the impending closure to the relevant state Agency overseeing the facility, the Office of the State Long-Term Care Ombudsman, residents of the facility, and their resident representatives or other responsible parties.¹⁰ This Notice Letter must be submitted at least 60 days prior to the date of the closure. (In the case of a facility being terminated from participation in Medicare and/or Medi-Cal, the date must be no later than the date the CMS determines to be appropriate.)¹¹ If the facility or service unit is a Medi-Cal Managed Care Provider and network members are in residence, the MCP is also required to send a letter to network members notifying them of the pending decertification and/or closure.

Subsequently, the Licensee is required to submit a notice to each individual patient of their proposed transfer or discharge.¹² These notices are based on the individualized needs of each resident after an assessment is completed to minimize the potential of transfer trauma. Each individual patient transfer notice can be sent as soon as the assessment is completed, and a placement is located and available. The contents of the Notice Letter must include the facility's State-approved Closure Plan for the transfer and adequate relocation of the residents; as well as assurances that the residents will be transferred to the most appropriate facility or setting, in terms of quality, services, and location, and considering the needs, choice, and best interests of each resident.¹³ The Notice Letter must be provided to residents and their legal representatives in hard copy and in a language and manner they understand.

The notice is required to have the following information:¹⁴

- The reason for transfer or discharge (i.e., closure).
- The effective date of transfer or discharge.
- The location to which the resident will be transferred.
- Information on the resident's appeal rights, including the name, address (mailing and email) and telephone number of the entity which receives appeal requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.

⁸ If the agency fails to take action within 20 working days of receipt of either the original or the amended closure plan, the plan is automatically deemed approved.

⁹ 483.70(l)(1)(i) - 483.70(l)(1)(ii)

¹⁰ 42 C.F.R. 483.70(l)(1)

¹¹ 483.70(l)(1)(i) - 483.70(l)(1)(ii)

¹² Pursuant to Health & Safety Code Section 1336.2 (a) (3)

¹³ 483.70(l)(3)

¹⁴ 483.15(c)(5)(i-vii)

- Name, address (mailing and email), and telephone numbers of the Office of the State Long-Term Care Ombudsman as well as agencies responsible for the protection and advocacy of individuals with developmental disabilities and mental disorders.
- For nursing residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities.
- For nursing residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder.

Local Ombudsman Coordinators can encourage Facility Administration to share their draft Notice Letter with the Licensing Agency and OSLTCO prior to distribution to ensure it meets regulatory requirements and that it is culturally and linguistically accessible to residents and their families. If the information in the Notice Letter is changed before the effective date of the transfer, then the facility is required to update the recipients of the notice as soon as practicable.

Facility Administration should remain aware that receipt of the Notice Letter will generate many additional questions and concerns from residents and families that they will want addressed immediately. Timely and clear communication with the affected residents and their family or representatives should be initiated early during the process of a facility closure to avoid or mitigate the unintended emotional or psychological impact of learning their housing is under potential threat. It is therefore recommended that the Notice Letter include assurances that additional information will be forthcoming, ideally including dates and times of scheduled in-person resident meetings.

Supporting the Transition Process

Increase On-Site Presence

Once the formal Notice Letter has been issued, Ombudsman and members of the Strike Team should plan to increase their presence at the facility with weekly, or even more frequent, visits. Special attention should be paid to ensuring adequate staffing levels and hygienic standards are maintained as the formal closure date approaches. Resident interviews should be conducted to ensure continuity of services, including program activities, and adequate supplies. Removal of equipment, furniture, or personal aids such as clocks, televisions, remote controls, or call buttons should not occur while residents remain in the facility. Any variations should be noted and discussed with staff and Administration or elevated to the licensing agency, as needed.

Support the Resident Pre-transition

Before and throughout the transition process, the Ombudsman should continue to share information with residents and families regarding:

- Resident's rights throughout the closure process, including the right to have needs and choice taken into consideration; to receive appropriate discharge planning; and to be included in discharge planning.
- What should be included in appropriate discharge planning.
- Where to file a complaint or get help.
- Information on how families can help prevent or minimize transfer trauma in residents.

With resident consent, the Ombudsman, together with other members of the Strike Team, may bring together residents and family members in a group to discuss closure, resident's rights and to answer any questions. Ombudsman can provide information and contacts to legal aid organizations who may provide additional guidance to residents about their rights during a facility transition or involuntary move. Where the facility is a Medi-Cal Managed Care Plan provider with enrolled members present, Managed Care Plan Coordinators could also be considered as resources to provide important information and support.

Attend Ongoing Relocation Meetings

Beginning prior to the transfer of residents, and continuing until all residents have been relocated, the Ombudsman Coordinator and Strike Team members should meet with the Administrator and staff responsible for discharge planning to discuss the process and the items necessary for a smooth transition.¹⁵ Ideally, these meetings will take place at the facility or via video/teleconference and on a weekly basis or more frequently. The outcomes of these meetings may include:

- Review the status of each resident's relocation plan including resident relocation planning meeting.
- Assist in identifying the residents' potential options for living arrangements.
- Establish goal dates for completion of required assessments, resident and legal decision making contacts, confirmation of financial status, guardianship status/updates, screening updates, etc.
- Review resident status with regard to contact with the ADRC, options counseling, enrollment in MCOs, Medi-Care fee for service etc.
- Review status of resident relocation planning, including options counseling and relocation planning occurring under county waiver programs.
- Identify barriers, if any, to achieving the resident's choice of living arrangement and strategize plans for resolution of any barriers to relocations.
- Review the relocation status of currently enrolled members/residents and newly enrolled members/residents.
- Review the status of each resident's discharge planning meeting when the choice of an alternate placement has been made.
- Review possible or actual resident change of condition from their initial status on the Resident Roster.
- Review facility provision of updates on operational status and any potential impact on relocation.
- Discuss potential room/unit consolidation due to relocation.
- Resolve conflicts regarding agency scope of responsibility as it relates to individual residents.
- Assure security of resident protected health information as it pertains to relocation activity.
- Contact information of all parties responsible for the transition.

In the case that a Licensee or Administrator notifies the licensing agency of the existence of financial distress that could limit their ability to continue to provide a safe environment to persons in care during a facility closure, the agency may appoint a Temporary Manager. Temporary Managers can assume the operation of the facility for a period of 60 days, subject to an approved extension. Although assigned for a limited duration, Temporary Managers can be instrumental in providing care and supervision to persons in care when the Licensee is unable to provide a safe environment.

¹⁵ All Medi-Cal certified inpatient facilities are required to have designated staff responsible for discharge planning.

Attend Resident Meetings

The Administration of the facility bears the primary responsibility for communicating with the resident and family or representative, as well as the local Ombudsman's office in the event of a pending Medicaid decertification or facility closure.¹⁶ After sending formal Notification, Facility Administration are highly recommended to convene group meetings where residents, their families and representatives can learn about the process and timelines directly from Administration. In addition to general information about the closure, residents will be assured during these initial meetings that individual relocation meetings will soon be convened to develop their personal relocation plans.

Ombudsman Coordinators should endeavor to attend all of these meetings, resources and time permitting.

Support Individual Resident Relocation Planning

According to federal and state law, the closing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. The closing facility must document this orientation.¹ Ombudsman can help ensure that protocols are followed regarding these preparations, including the facility's obligation to provide a medical assessment, drafting of a discharge summary and relocation plan for each resident.

Before transferring a resident to another facility or to an independent living arrangement, Facility Administration is required to conduct a medical assessment of each resident. This assessment will inform the preparation of a written discharge summary that should include:

- a review of the resident's stay, diagnoses and treatment.
- any laboratory, radiology, and consultation results.
- a summary of status.
- a reconciliation of medications.
- a discharge summary and a post-discharge plan of care.

The facility will use this assessment as a foundation for making initial recommendations on the best alternative housing option for the resident, based on the resident's current service plan. However, notwithstanding the conclusions of the assessment, final decisions about where the resident will ultimately be transferred must be made with the participation of the resident and/or the resident representative.

Within 30 days of sending the Notice Letter, the transferring facility relocation staff should hold an initial planning meeting with each resident and their family, representative, care-manager and/or resource center representatives, as appropriate, and an advocate, as invited. During this meeting, the discharge staff responsible for relocations should share the results of the resident's evaluation and present alternative housing options, including lists and descriptions of facilities that may meet their needs, based on their current service plan, located within a 60-mile radius of their current facility.¹⁷ The relocation plan should describe what steps will be taken to assist the resident in exploring options for alternate living arrangements (including referrals, tours, exchanges of information and assessments), including potential home and community-based options.

¹⁶ See 42 USC §1395i-3(c)(2)(B))

¹⁷ CCLD LIC 625, Appraisal/Needs and Services Plan

While the outgoing facility is responsible for assisting the resident in identifying alternative accommodations, care should be taken to ensure that facilities do not move residents as a group to related facilities owned or operated by the same company, unless individual residents make that choice. Ombudsman and Strike Team partners can play an important role in ensuring options have been presented and the residents are not pressured to move to a facility against their expressed will.

Facilities are required to notify designated Local Contact Agencies (LCAs) when a resident expresses a desire to learn more about options for living in the community.¹⁸ The LCAs should then contact interested individuals by telephone or in person and provide information/education about home and community-based options.

Residents will rely heavily on family members, case workers and other representatives to facilitate their relocation, however, the resident is the primary decision-maker. As such, they need to be in all aspects of the decision. They may want to consider moving to an alternate placement where other residents are relocating and/or wish to have another resident as a roommate in their relocation setting. The more control they exercise in the process, the more accepting they will be of their relocation.

Residents should be encouraged to make a decision about their relocation options based on the anticipated closure timeline. As a resident's advocate, Ombudsman must provide full and complete information to residents about their options while also advising that the longer they wait to select an alternative facility, the fewer options they may have.

Preparation and Orientation

Support the Identification and Securing of Admission to Alternative Housing Options

In some cases, facilities may initially refuse to accept the transfer of a resident who they consider to be difficult or costly to take care of. As a result, a resident may be compelled to accept placement in a facility willing to take them but that may be located far away from family. While it is the mandated responsibility of the facility Administration (and/or appointed Transition Team) to find a bed in an appropriate qualified facility, Ombudsman can play a vital role in supporting the resident secure housing in an appropriate location of their choosing so that negative impacts on residents are minimized. If the resident is enrolled in a Medi-Cal managed care program, the MCPs may assist with this process as well.

If their application to a potential new facility is initially rejected, Ombudsman can encourage residents and transferring facilities to request an interview with the potential receiving facility to assess the resident themselves to accurately determine whether they can meet the resident's needs. Ombudsman should encourage the resident, their family or representative to obtain responses to requests for admission in writing as evidence for potential appeals. This is important because facilities must present a compelling case that they are unable to provide the required service before rejecting an application. Further, it is against California law for a facility to refuse admission based on method of payment. As such, an assertion that "there are no Medi-Cal beds available" could be considered discriminatory and brought to the attention of legal counsel or the local District Attorney for potential injunctive relief.

¹⁸ Specifically, a referral to the LCA is required when a resident answers "yes" to Section Q 0500 questions.

Supporting the Resident During the Transition

During the 60-day transition period, the outgoing facility is expected to continue to maintain consistent levels of support and daily routines for all residents.¹⁹ Facility Administration should be reminded that experienced direct care staff will be needed to provide the necessary quality of care throughout the entire closure process. This is one of the major challenges facing the administration of a closing facility. Strategies for retention must therefore be planned, initiated, and evaluated throughout the closure process. Facilities should be encouraged, if at all possible, to offer financial incentives so that staff will stay and assist in the relocation of residents. Assurances can be made that the facility will be supportive as they seek future employment, for instance, by contacting other facilities to let them know the facility is closing and that staff will be seeking new employment and initiating action to provide job references.

Discharge and Physical Relocation

Physical Relocation

While the outgoing facility's Administration is responsible for ensuring safe and orderly resident discharges, the Ombudsman monitors the process to ensure that all required actions take place. When determined necessary, Ombudsman can solicit assistance from the Department of Public Health or the Department of Social Services and other members of the Strike Team, including consulting with legal counsel.

The physical transition of the resident and their belongings is to be coordinated between the transferring facility and the receiving facility. Residents' personal property should be packed in a careful manner by the transferring facility. The transferring facility is responsible for providing:

- A facility staff person assigned to oversee the packing of the resident's belongings and ensuring that non-boxed items are also labeled
- Boxes and/or bags appropriate for all resident's belongings (plastic bags for toiletries and soiled laundry, and medications)
- Adhesive labels with resident's names and facility they are being transferred are to be made by facility and placed on each box/bag of resident belongings.

Receiving facilities are responsible for arranging the transportation of residents and their belongings. While Ombudsman cannot be involved in the physical transfer of residents or their personal belongings, nor assist with the inventory of belongings prior to and after the move, they can help determine the facility's process for tracking resident's belongings to ensure they are moved to the new location with the resident. They may also provide contacts to the receiving facility to community and civic organizations, (such as the local Rotary or Kiwanis Clubs) to help support these actions.

In preparation for the move, residents, their family or representative should make sure and document all medications, including prescriptions drugs, vitamins and supplements. They should write what each for, how often it is taken and when. Any upcoming appointments or tests should also be listed. This list should be reviewed with transferring facility staff. The name and phone number of a person to consult should be noted in case of questions. Include a list of tips for what family can do to help alleviate transfer trauma.

¹⁹ 483.70(m)

Transferring facilities are responsible for ensuring that the residents' new service providers are given access to relevant records, physician orders, advance directives, and family information. Transferring facilities must also ensure that information regarding Personal Needs Allowance accounts, if applicable, are transferred along with the residents.

Document Resident Transfer

The facility is required to ensure that for each resident being transferred or discharged, the reason for the transfer is documented in his/her medical record.²⁰ The closing facility must provide, at minimum, the following information to the receiving facility at the time of the resident's discharge or relocation:²¹

- Contact information of the practitioner responsible for the care of the resident.²²
- Resident representative information, including contact information.²³
- Advance Directive information if the resident has one.²⁴
- Each resident's complete medical record information, including archived files, Minimum Data Set (MDS 3.0) discharge assessment, and all orders, recommendations or guidelines from the resident's attending physician.²⁵
- All special instructions or precautions for ongoing care
- Comprehensive care plan goals.²⁶
- All other necessary information, including a copy of the resident's discharge summary and any other documentation necessary to ensure a safe and effective transition of care.²⁷

Resident records should be kept up to date and reflect the resident's physical and emotional status, including their reaction to the need to relocate. These records will assist the receiving facility in identifying any changes in the resident's condition and accurately assess their current status.

The receiving facility or other service providers, in the case of community-based transfers, should have the closing facility telephone number and name of the person to contact to expedite communication for questions and issues that may arise after relocation.

Support the Resident Post-Transition

Follow-up after relocation is essential to assess the success of the relocation process for residents. The follow-up is a key step in determining if reasonable steps have been taken to mitigate the effects of transfer trauma/relocation stress syndrome on relocating residents. In addition, information gathered during the follow-up process will provide valuable insights into improving future relocation efforts. All of the Strike Team members play a role in following up on the residents after they have been relocated to an appropriate setting of their choice.

Within 10 days of all residents having left the facility, the Licensee/Facility Administration is required to send a list of names and new locations of all residents to the licensing agency and the local Ombudsman program. With the aid of this list, LLCOP representatives can plan follow-up visits to ensure that each

²⁰ 483.15(c)(2) & 483.15(c)(2)(i)(A)

²¹ 483.15(c)(2)(iii)

²² 483.15(c)(2)(iii)(A)

²³ 483.15(c)(2)(iii)(B)

²⁴ 483.15(c)(2)(iii)(C)

²⁵ 483.15(c)(2)(iii)(D)

²⁶ 483.15(c)(2)(iii)(E)

²⁷ 483.15(c)(2)(iii)(F)

resident is settled, have all the services and medical care that they need and that their personal belongings have been delivered. They can confirm their personal needs allowances, Social Security and other issues have been addressed. In the event that residents are transferred outside of the range of the original PSA, LLTCOP representatives can contact the Ombudsman program in the PSA where the resident has been transferred to request follow-up and continued support to the resident. Residents enrolled in MCPs will have care managers who follow them to their new homes or communities when they are relocated there. County waiver programs should continue to engage with residents who choose to live in the community.

The goal for all involved in the resident relocation process is to minimize or mitigate the negative effects of relocation on the residents.

Recent Experience with Facility Closures in California

In recent years, Ombudsmen have been involved in supporting residents during facility closures that have occurred in different parts of the state. These include:

Voluntary Closures

Promenade Care Center, Fresno County, (PSA 14) 2022. This 232-bed facility notified CDPH of its pending closure in mid-July with anticipated closure on October 1st. At the time of the announcement, the facility had 93 residents on site. At the time of this document's printing, Local Ombudsman representatives are currently visiting with all residents to support them in their relocation and will continue to assist residents after their moves.

Atascadero Christian Homes, San Luis Obispo County (PSA 17) 2021. The residential care facility had 29 residents at the time of the announcement. Ombudsman staff provided support to residents and families to identify suitable alternative housing and visited all relocated residents remaining in the county after their moves.

Regulatory Closures

Laguna Honda Hospital, San Francisco (PSA 6). 2022. The facility, the largest specialized nursing and rehabilitation hospital in San Francisco, accountable for more than 30% of all SNF beds in the county, was decertified by CMS in April 2022. As of May 6, 2022, the facility had 686 residents of which 540 were Medi-Cal and 126 were Medicare patients. Of these, 489 lacked capacity to make decisions for themselves. The facility is currently anticipated to close on November 13, 2022. Ombudsman representatives have maintained a constant presence in the facility, advising residents of their rights and ensuring all receive up-to-date assessments, and that skilled nursing care continues uninterrupted during the closure process.

Healdsburg Senior Living, Sonoma County (PSA 27). 2022. The nursing facility had 16 residents at the time of the closure announcement after losing its Medicare/Medicaid funding. Residents were provided with a 17-day notice. A transition team of two was put in place to assist with closure and relocation of residents. The local Ombudsman provided information and support to residents to assist them and identify suitable alternative housing, effectively leveraging the media to generate community support for their relocation.

Kingston Healthcare Center, Bakersfield, Kern County (PSA 33). 2022. This 184-bed SNF had 109 residents at the time CMS suspended funding, effective February 6th. The Ombudsman representative coordinated with community organizations to assist with the inventory and movement of residents' personal effects. The facility's license to operate was ultimately suspended with 4 residents remaining in the facility at the time it transitioned to new ownership.

Sources

The National Consumer Voice for Quality Long-Term Care, *Nursing Home Closures Toolkit for Ombudsmen and Advocates*, May 2017

State of Wisconsin, Department of Health Services, Division of Long Term Care, *Resident Relocation Manual*, November 2010

State of Ohio, *Facility Closure and Resident Relocation Process*

State of Iowa, *Closure Crisis Team Intervention*

Ombudsman and Resident Resources

Centers for Medicare and Medicaid Services' (CMS): Explore, download & investigate provider data on all CMS-registered care facilities in the United States. A searchable database with facility-level information on ownership, bed capacity, certification date and regulatory history, including past and pending enforcement actions.

Visit: <https://data.cms.gov/provider-data/>

CMS also provides information about hospitals throughout the country and their compliance with Medicare and Medicaid regulations and additional information. The site also includes a hospital checklist. Visit:

<http://www.medicare.gov/hospitalcompare/Resources/Choosing-Hospital.aspx>

<http://www.medicare.gov/hospitalcompare/search.html>

Aging and Disability Resource Centers (ADRCs) and Area Agencies on Aging (AAAs): Helps older adults, people with disabilities, and their caregivers find AAA or ADRC in their area.

Call: 1-800-677-1116

Or Visit:

<https://eldercare.acl.gov>

Cal Health Find: Provides public information for finding a health facility, including nursing homes, and for registering complaints.

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx>

Medi-Cal: California's Medicaid health care program pays for a variety of medical services for children and adults with limited income and resources. Individuals apply for Medi-Cal health coverage through the county where they reside. To find county Medi-Cal contacts, visit:

<https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>

California Community Transitions Project: Helps individuals who have resided in state-licensed care facilities for a period of 60 days or longer transition from facilities to community settings of their choice. Includes eligible individuals of all ages with physical and mental disabilities. To find a local CCT Lead Organization contact the DHCS Integrated Systems of Care Division at:

1 (833) 388-4551

Or Visit:

<https://www.dhcs.ca.gov/services/ltc/Documents/CCT-Lead-Org-Contact-Info-Revised-09-2020.docx>

Medicare: Provides information and support to caregivers and people with Medicare.

<https://Medicare.gov>

Senior Medicare Patrol (SMP) Programs: Works with seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error, and abuse. To find a local SMP program, visit <https://smpresource.org>

Centers for Independent Living (CILs): Helps people with disabilities live independently with a state-by-state directory of CILs. For a state-by-state directory of CILs, visit

<https://ilru.org/html/publications/directory/index.html>

State Technology Assistance Project: Has information on medical equipment and other assistive technology in your state.

Call 1-703-524-6686

Or visit:

<https://resna.org>

National Long-Term Care Clearinghouse: Provides information and resources to plan for identifying long-term care needs. Visit <https://longtermcare.gov>

National Council on Aging: Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit <https://benefitscheckup.org>

State Health Insurance Assistance Programs (SHIPs): Offer counseling on health insurance and programs for people with limited income. Also help with claims, billing, and appeals.

Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Or visit

<https://shiptacenter.org>

American Hospital Directory, Inc.: Provides a searchable database for more than 6,000 hospitals. The information includes data from the American Hospital Association and CMS. Visit

<https://www.ahd.com/search.php>

Quality Check: Is a service offered by the Joint Commission, a nonprofit organization that evaluates health care quality and safety. Look up a hospital by name or location. Visit:

<http://www.qualitycheck.org/consumer/searchQCR.aspx>

The Leapfrog Group: Provides reports from hospitals on their progress in safety, quality, and efficiency of care standards established by the Leapfrog Group, a coalition of public and private organizations that purchase health care benefits for their employees. Visit <http://www.leapfroggroup.org/patients-families>

Annex I- Obstacles to a Successful Transition

Experience with both voluntary and involuntary LTC facility closures across the State and country highlight six major obstacles to a successful transition for residents:²⁸

1. Lack of communication, including inaccurate or inadequate information provided by facilities.
2. Poor notice/not enough time to find new placements.
3. Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.
4. Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.
5. Staffing issues such as staff leaving, staff stress and bitterness.
6. Transfer trauma.

LTC facilities, Ombudsman programs and local Strike Teams can reduce the many of the negative effects associated with resident relocations, including the potential for resident relocation stress, by working in coordination to anticipate and address these obstacles.

1. Lack of communication, including inaccurate or inadequate information provided by facilities

Some residents and their families may fail to fully understand the written Notice Letter sent by Facility Administration or receive inadequate or inconsistent information from facility staff. This can be due to lack of clear protocols, language barriers or other reasons.

For this reason, facility staff are expected to discuss this information orally with residents, their families and/or legal representatives. Ombudsman can play an important role by confirming each resident's receipt of this information and discussing it with residents, their families and/or legal representatives in order to help provide a better understanding of the situation and their rights.

2. Poor notice/not enough time to find new placements

Facilities may fail to provide the Notice Letter to the resident or family within the 60 day period required. This may be the result of administrative error, inaccurate contact information or out-of-date records regarding guardianship. By the time a resident or family member finds out about the details of the closure through other means, limited time may remain to find appropriate alternative placements.

Lack of adequate notice about a pending facility closure is one of the most common complaints of residents, family members and Ombudsman. Research has found inadequate advance notice by providers contributes to poor planning, hurried resident transfers and an increase in stress to residents and families.

3. Lack of appropriate and nearby placements, either because there are no vacancies or providers do not want to take a specific resident

Some PSA's, particularly those in rural areas, may have fewer facilities with available beds that could serve as alternatives. Other facilities with available beds may reject a resident because of complex needs that may not be able to meet. Some facilities may attempt to reject residents due to their source of payment, particularly Medi-Cal and SSI residents, who's cost of care may

²⁸ *Successful Transitions: Reducing the Negative Impact of Nursing Home Closures*; The National Consumer Voice, 2016

represent a net financial loss to the facility. Rejecting a potential resident because of their payment source is discrimination and is illegal.

If a facility claims it is unable to care for the resident, the facility should be asked to document specifically which care needs they are unable to meet and why. If the state licensing agency agrees that the reasons for the denial are legitimate, agency staff are expected to be proactive and try to find a solution to the stated problem. Refusing facilities can be urged to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs.

4. Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families

Discharge planners may not have the experience or resources to manage the transfer of residents. This may be even more challenging for larger facilities with more residents or facilities with residents who may be more difficult to place because of more complex needs.

5. Staffing issues such as staff leaving, staff stress and bitterness

If not communicated clearly and addressed properly, staff may respond negatively to the news of a Licensee's intention to close, scale back or change the classification of the facility. If the decision to close is for financial reasons, such as bankruptcy, staff may be concerned about being paid or losing their jobs, potentially resulting in resignations that can impact resident care. Some staff may begin to look for alternative employment or resign with short notice, leaving remaining staff to contend with unmanageable workloads. As a result, quality of care may suffer.

Actions need to be taken which can avoid the possibility of insufficient facility staff due to premature employee resignations. Many facilities provide an incentive to employees agreeing to remain on staff throughout a relocation process to maintain consistent and familiar staffing while decreasing the stress to all involved residents. In addition, depending on the number of employees, a facility must follow the legal notice requirements for employees, including the requirements found in the Worker Adjustment and Retraining Notification Act (WARN Act) at 20 CFR Part 639.

6. Relocation stress and "transfer trauma"

For eliminating or lessening transfer trauma, residents and families should be given a greater sense of control through the provision of additional information, touring alternative facilities, assisting with preparations for moving, assisting residents to acclimate to their new home and helping the new home adapt to the resident. Facility staff from both the transferring home and the receiving home can benefit from additional training in mitigating relocation stress and the concept of transfer trauma.

Annex II- Memorandum of Understanding, CDPH/OSLTCO
(Current MOU 18-10114)

Annex III- Memorandum of Understanding, CDSS/OSLTCO
(Current MOU 16-MOU-00706)