The National Long-Term Care Ombudsman Resource Center

ADVOCACY TOOLS AND SUCCESSFUL PRACTICES TO PROTECT RESIDENTS FROM NURSING FACILITY-INITIATED DISCHARGES

Ombudsman Learning Collaborative to Protect Residents Against Nursing Facility-Initiated Discharges

September 25, 2019

Training Objectives

- Enhanced understanding of revised federal nursing facility regulations and guidance.
- Learn new ways to apply the revised regulations and guidance to three common reasons for discharge.
- Hear about how Ombudsman programs and legal services working together at the state and local level.
- Highlight project state successes, challenges, and outcomes.

Project Overview

- **Complaints about discharges** have been the **most common** nursing home complaint received by Ombudsman programs for **the last 7 years**. In 2017, 10,610 of the 144,003 nursing home complaints were about discharges.

- Supplemental grant from the Administration on Community Living (ACL) for the project.

- **7 project states (representing 6 of the 10 ACL regions)**
  - DC, Mississippi, Pennsylvania (ACL Regions III/IV)
  - Ohio (ACL Region V/VII)
  - Oklahoma, Louisiana (ACL Region VI)
  - Nevada (ACL Region IX)

PRE-TEST POLL

ADVOCACY TOOLS AND STRATEGIES FOR COMMON DISCHARGE REASONS

Robyn Grant, Director, Public Policy and Advocacy, Consumer Voice

Regulatory Tools

- **Regulations:** Requirements that facilities must follow in order to participate in the Medicare and /or Medicaid programs (Requirements of Participation)

- **Guidance:** Also called Interpretive Guidelines or Interpretive Guidance, these interpret, explain and clarify the Requirements of Participation. Surveyors use the guidance to determine if a facility complies with federal requirements. The guidance is found in the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17).

Regulatory Tools

- **Critical element pathways:** The pathways help direct the surveyor's inspection and identify points to observe, questions to ask, and records to review. There are critical element pathways for many, but not all the requirements.

- **Investigative Protocols, Procedures, Probes:** There are several areas that do not have a pathway. If an area does not have a pathway, surveyors are instructed to use the guidelines, investigative protocols, procedures, and/or probes in Appendix PP, which also include observation, interview and record review probes.

- **Key Elements of Noncompliance:** These are the main points for surveyors to focus on to determine if there is a deficiency.

State Operations Manual

Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Table of Contents

(Rev. 11-22-17)

Transmittals for Appendix PP

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https://theconsumervoice.org/uploads/files/issues/Revised_Interpretive_Guidelines_with_Clickable_TOC.pdf

F624

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.15(c)(7) Orientation for transfer or discharge.
A facility must provide and document 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.

DEFINITIONS

"Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. 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, when return to the original facility is not expected.

GUIDANCE

The guidance at this tag generally addresses the immediate orientation and preparation necessary for a transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate discharge where a complete discharge planning process is not practicable.

For concerns related to how the facility planned for a discharge that meets a resident's health and safety needs, as well as their preferences and goals in circumstances which permit a complete discharge planning process, please refer to F660, Discharge Planning.

Sufficient preparation and orientation means the facility informs the resident where he or she is going, and takes steps under its control to minimize anxiety.
Examples of preparation and orientation may include explaining to a resident why they are going to the emergency room or other location or leaving the facility; working with family or resident's representative to assure that the resident's possessions (as needed or requested by the resident) are not left behind or lost; and ensuring that staff handle transfers and discharges in a

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility requirements to permit residents to return following hospitalization or therapeutic leave.

Summary of Investigative Procedure

If concerns arise regarding facility failure to permit a resident to return, review the medical record for evidence of whether a notice of transfer and discharge and notice of bed-hold were provided. Determine the basis for discharge and how the facility evaluated the resident. The surveyor may have to obtain hospital records for further investigation. Review any other documentation necessary to ascertain the extent to which the facility made efforts to enable the resident to return.

In cases where a facility did not allow a resident to return due to lack of an available bed, the surveyor should review facility admissions beginning with when the resident was ready to return to determine if residents with similar care needs have been admitted. Additionally, if the facility does not readmit the resident due to risk to the health or safety of individuals in the facility, the surveyor should review documentation for how the facility made this determination.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F626, the surveyor's investigation will generally show that the facility failed to:

- Establish and/or implement a policy that is in accordance with the State Medicaid plan, and addresses returning to the facility following hospitalization or therapeutic leave; or
- Ensure that residents whose hospitalization or therapeutic leave exceeds the State's bed-hold period are returned to their previous room and/or the first available bed in a semi-private room; or
- Ensure (for a resident not permitted to return) the medical record and notification contain a valid basis for discharge; or
- Permit a resident to return to the same composite distinct part in which they previously resided.

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

Examples of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ☐ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How does staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

https://ltcombudsman.org/uploads/files/support/CMS-20067_Behavioral-Emotional.pdf

Links

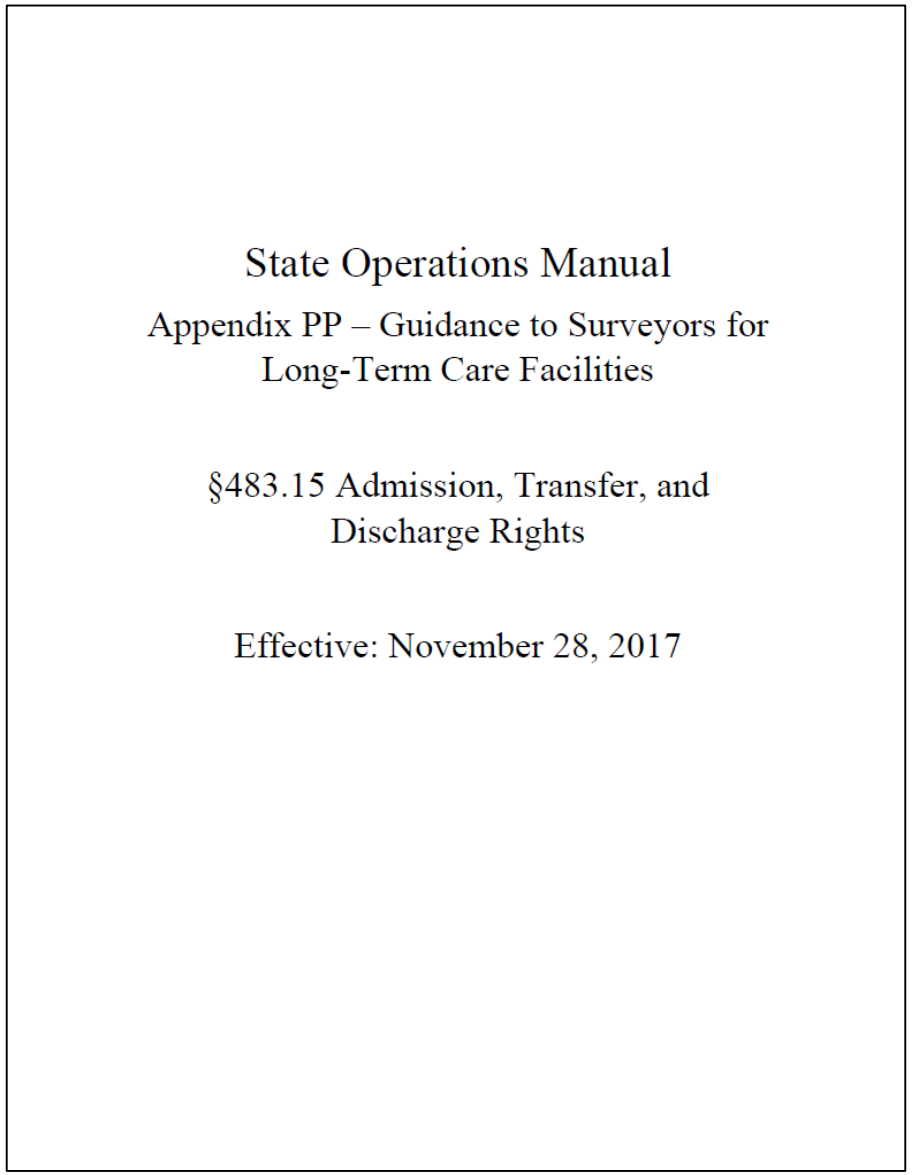
Appendix PP

- file:///C:/Users/Admin/Desktop/Revised_Interpretive_Guidelines_with_Clickable_TOC.pdf

Critical Element Pathways

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

Handout



State Operations Manual

Appendix PP – Guidance to Surveyors for Long-Term Care Facilities

§483.15 Admission, Transfer, and Discharge Rights

Effective: November 28, 2017

https://ltcombudsman.org/uploads/files/support/Appendix_PP_-_Transfer-Discharge.pdf

Reason: Resident's Welfare and Needs Cannot be Met in the Facility

Scenario:

Mr. W has a traumatic brain injury and has difficulty thinking, understanding and concentrating. He is impulsive, restless, and verbally aggressive. Facility issued a 30-day notice stating they cannot meet his needs. Mr. W does not want to leave the nursing home and requests Ombudsman assistance.

Prevent eviction:
Encourage resident to file an appeal

- Regulation: Facility cannot transfer/discharge a resident while the appeal is pending (except in certain situations)
  - F622 483.15(c)(1)(ii) Handout: p. 156

- Guidance: When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending.
  - F622 Handout p. 159

Disclosure of Limitations

- Regulation: The facility must disclose notice of special characteristics or service limitations prior to admission
  - F620 483.15(a)(6) Handout: p. 148

- Guidance: To enable potential residents and resident representatives to make informed decisions in choosing a facility for admission, facilities must inform residents and resident representatives and potential residents or representatives of any special characteristics or service limitations the facility may have prior to admission. For example … **if a facility has limitations in the type of medical care it can provide, this information must be communicated prior to admission.** For example, if the need for a specific type of care or service becomes necessary, knowledge of service limitations may make the need for transfer or discharge more predictable and understandable for the resident and/or his or her representative
  - F620 Handout: p.151

Admission of only residents whose needs can be met

- Guidance: Transfer/discharge regulations only permit transfer or discharge under certain limited conditions. This means that once admitted, for most residents (other than short-stay rehabilitation residents) the facility becomes the resident's home**. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment**. (See F838, Facility Assessment).
  - F622

Handout: p. 158

Documentation

- Regulation: The resident's attending physician must document that the resident's needs cannot be met
  - F622 483.15(c)(2)(ii)(A) Handout: p. 156

- Regulation: Documentation in the medical record must include:
  - Specific resident need(s) that cannot be met
  - Facility attempts to meet the resident needs
  - Service available at the receiving facility to meet the need(s)
  - F622 483.15 (c)(2)(i)(B) Handout: 156

Ask: Did the facility do everything required to meet a resident's needs?

- *Review regulations, guidance, investigative protocols, procedures, probes, critical element pathways*
  - *If the answer is no:*
    - *It is premature for the facility to say it can't meet the resident's needs*
      - *Which means the discharge is invalid*

Care Planning

Components of Person-Centered Care Planning

1. Is the resident's care plan person-centered?

- Regulation: The facility must develop and implement a comprehensive **person-centered care plan** … **to meet a resident's** medical, nursing, and mental and psychosocial **needs** that are identified in the comprehensive assessment.
- F656 483.21(b) Appendix PP: p. 206

Person-centered care - means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Care Planning

Includes reflecting resident preference and choices?

- Regulation: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences
- F558 483.10(e)(3) Appendix PP: p. 20

- Regulation: Self-determination.

(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

- F561 483.10(f)(1)-(3) Appendix PP: p. 23

Care Planning

2. Does the care plan have specific and appropriate interventions?

- Guidance: The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.
- F656 Appendix PP: p. 208

3. Is the care plan carried out?

- Regulation: The facility must develop and i**mplement** a comprehensive person-centered care plan for each resident
  - F656 483.21(b)(1) Appendix PP: p. 206
- Regulation: Residents have the right to receive the services and/or items included in the plan of care
  - F553 483.10(c)(2)(iv) Appendix PP: p. 14

Care Planning

4. Is the care plan carried out consistently?

- Investigative Summary and Probes: Is there evidence that the care plan interventions were implemented consistently across all shifts?
  - F656 Appendix PP: p. 210

5. Is the care plan evaluated and modified if it's not working?

- Regulation: The care plan must be reviewed and revised after each assessment, including both the comprehensive and quarterly review assessments.
  - F657 483. 21(b)(2)(iii) Appendix PP: p.212
- Guidance: The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, **and revised based on changing goals, preferences and needs of the resident and in response to current interventions.**
  - F657 Appendix PP: p. 214

Behavioral Health Services

- Regulation: The facility must provide behavioral health services so each resident can reach his or her highest possible level of functioning and well-being
  - F740 483.40 Appendix PP: p. 423

- Regulation: The facility must provide a resident who displays or is diagnosed with mental disorder …with appropriate treatment and services to correct the assessed problem or to reach highest possible level of functioning and well-being
  - F742 483.40(b)(1) Appendix PP: p.434

Behavioral Health Services

- Investigative Protocol: Record Review

- Review the resident's care plan for interventions to address the assessed problem.
  - How are mental and psychosocial adjustment difficulties, a history of trauma, and/or PTSD addressed in the care plan?
  - Does it describe the programs and activities that have been implemented to assist the resident in reaching and maintaining the highest level of mental and psychosocial functioning?
  - Is the care plan written in measurable language that allows assessment of its effectiveness?
- Are the data to be collected to evaluate the effectiveness of the care plan identified?
- Are the data collection done according to the care plan?
- Does record review indicate that the care and services outlined in the care plan are effective in decreasing the resident's expressions or indications of distress?
- If the data collected indicate that expressions or indications of distress are unchanged in frequency or severity over two or more assessment periods, is the plan reassessed and intervention approaches revised to support the resident in attaining the highest practicable mental and psychosocial well-being?
  - F742

Appendix PP: p. 438

Behavioral Health Services

Key Elements of Noncompliance: To cite deficient practice at F740, the surveyor's investigation will generally show that the facility failed to:

- Identify, address, and/or obtain necessary services for the behavioral health care needs of residents;
- Develop and implement person-centered care plans that include and support the behavioral health care needs, identified in the comprehensive assessment;
- Develop individualized interventions related to the resident's diagnosed conditions;
- Review and revise behavioral health care plans that have not been effective and/or when the resident has a change in condition;
- Learn the resident's history and prior level of functioning in order to identify appropriate goals and interventions;
- Identify individual resident responses to stressors and utilize person-centered interventions developed by the IDT to support each resident; or • Achieve expected improvements or maintain the expected stable rate of decline based on the progression of the resident's diagnosed condition.
  - F740 Appendix PP: p. 425

Behavioral Health Services

Staff

- Regulation:
  - There must be sufficient staff
  - Staff must have appropriate competencies and skills sets
  - Competencies and skills sets must include knowledge of and appropriate training and supervision to care for residents with mental and psychosocial disorders
    - F741 483.40(a) & (a)(1) Appendix PP: p. 428

Reason: The Safety of Individuals in the Facility is Endangered Due to the Clinical or Behavioral Status of the Resident

Scenario:

Mrs. J has a diagnosis of Lewy Body Dementia and has hallucinations that cause her to become scared and combative. Recently Mrs. J became frightened in the dining room on several occasions. She then struck another resident in the dining room and was immediately transferred to the hospital. Mrs. J received treatment and was in the hospital for a few days. When she was ready to go back to the nursing home, the facility issued a notice of discharge. Mrs. J has asked for Ombudsman assistance.

This is a Facility-Initiated Discharge

- Regulation: If the facility decides the resident can't return, it must follow transfer/discharge requirements (e.g. notice)
- F626 483.15(e)(1)(ii) Handout: p. 170

- Guidance: In situations where the facility intends to discharge the resident, the facility must comply with Transfer and Discharge Requirements at 483.15(c)….
  - F626 Handout: p.170

Permitting resident to return

Evaluation (can't meet needs/health or safety)

- Guidance: A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on their condition when originally transferred to the hospital. The medical record should show evidence that the facility made efforts to:
  - Determine if the resident still required services and is eligible for Medicare or Medicaid
  - Obtain an accurate status of the resident's condition
  - Find out what treatments, medications, and services were provided by the hospital, and determine whether the facility can provide them
  - Work with the hospital to ensure the resident's needs and condition are within the nursing home's scope of care
- F626

Handout: p.173

Permitting resident to return

Appeals

If the resident appeals discharge while in a hospital:

- Guidance: Facilities must allow the resident to return pending their appeal, unless there is evidence that the facility cannot meet the resident's needs, or the resident's return would pose a danger to the health or safety of the resident or others in the facility.
  - A facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending **must not be based on the resident's condition when originally transferred to the hospital.**
    - F622

Handout: p. 159

- Additional guidance: Handout p. 170, 173

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive MDS/CAAs for Sections B – Hearing, Speech, and Vision, C – Cognitive Patterns, E – Behavior, G – Functional Status, I – Active Diagnoses, J – Health Conditions-Pain, Falls, N – Medications, and O – Special Treatments, Procedures, and Programs.
- ☐ Physician's orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).
- ☐ Pertinent diagnoses.
- ☐ Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident's hospitalization.
- ☐ Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident's needs, goals, preferences, and assessment).

Observations:

- ☐ Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
  - Physical distress;
  - Mental status changes;
  - A change in condition; and/or
  - Pain?
- ☐ If symptoms are exhibited, what does staff do?
- ☐ Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

- ☐ Why were you sent to the hospital? Has your condition improved? If not, do you know why it's not getting better?
- ☐ When did you start to feel different, sick, or have a change in condition?
- ☐ Do you feel staff responded as quickly as they could have when you had a change in condition?
- ☐ Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?
- ☐ Do you have pain? If so, what does staff do for your pain?
- ☐ Has your health declined since you were in the hospital? If so, what has staff done?
- ☐ What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html

Behavioral Health Services

Dementia care

- Regulation: The facility must ensure that—

  A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

  - F744 483.40(b)(3) Appendix PP: p. 445

Dementia Care Critical Element Pathway

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measureable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html

Behavioral Health Services

Training

- Regulation: Facilities must provide training to all staff on dementia management
  - F943 483.95 (c)(3) Appendix PP: p.695

Reason: Resident has Failed to Pay After Reasonable and Appropriate Notice

Scenario

Mrs. S had been paying privately for her nursing home stay, but she has exhausted her financial resources. Her family helped her complete and submit a Medicaid application, but Mrs. S has not yet heard if her application has been approved. The facility has not been paid for 2 months and has issued a discharge notice. Mrs. S has asked the Ombudsman for help.

Nonpayment has not occurred

- Regulation: … Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.
- F622 483.15(c)(1)(i)(E) Appendix PP: p.157

- **Guidance:** ***NOTE****: A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending (See F622, Transfer and Discharge Requirements).*
  - F620 §483.15(a)(4)(i) and (ii) Appendix PP: p.152

Nonpayment has not occurred

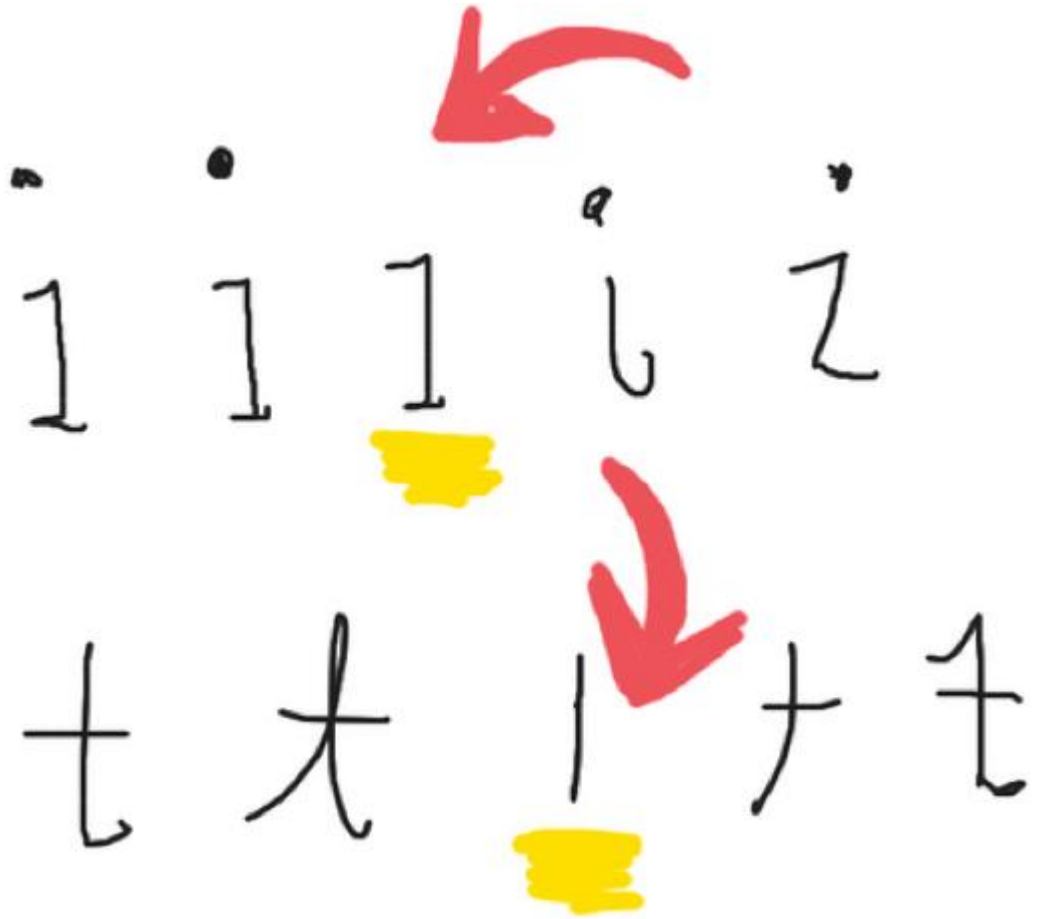
- Guidance: Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment.
- F622 Appendix PP: p. 159

Facility responsibility

- Guidance: It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third party paperwork.
- F622 Appendix PP: p. 159

Procedural arguments

- Is the nursing home following the required process?
- Are there any:
  - T’s that aren’t crossed?
  - I’s that aren’t dotted?



Notice

Contents of the notice 483.15(c)(5)

- Does it include the reason for discharge and is that reason an allowable reason for discharge pursuant to state & federal law?
- Is there an effective date for discharge?
- Does the notice list a specific place to which the resident will be discharged?
- Does it tell residents they have the right to appeal?
- Does the appeal information contain all the required information:
  - The name, address (mailing and email), and telephone number of the entity which receives such requests;
  - Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
- Does it include contact info for SLTCO and Protection & Advocacy?

- **AND**: **Is all the information accurate/correct?**

Notice

Who is notified 483.15(c)(3)

- The resident
- The resident's representative
- The LTCOP

Timing of the notice 483.15(c)(4)

- Was the notice given at least 30 days before the proposed discharge?

(except under certain circumstances)

Changes in the notice 483.15(c)(6) & Guidance p. 166

- Has anything significant changed since the original notice was issued. e.g. location of discharge
- If so, the facility must issue a new notice and restart the 30-day clock

Documentation

- Regulation: The resident's record must include:
  - Basis for transfer/discharge
  - When discharge allegedly for resident's welfare, the specific resident needs that cannot be met, how facility attempted to meet needs, and how receiving facility will meet needs.
  - Documentation by resident's physician/a physician
- F622 483.15(c)(2)(i)&(ii) Handout: p. 156

Documentation

- Regulation: Discharge planning
  - Documentation about returning to the community
    - F660 483.21(c)(1)(vii) Appendix PP: p. 219
  - A discharge plan, discharge summary
    - F660, F661 483.21(c)(1)(i) & (c)(2) Appendix PP: p. 219, p. 224
  - Post discharge plan
    - F661 483.21((c)(2)(iv) Appendix PP: p. 225

Bottom Line

If *anything* in the notice is missing or inconsistent with federal requirements:

- **Advocate for the facility to reissue the notice and restart 30-day clock or throw out the notice on procedural grounds.**
- **At appeal: argue to have the proposed discharge dismissed on procedural grounds**

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

The National Consumer Voice for Quality Long-Term Care

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LEGAL SERVICES AND OMBUDSMAN PROGRAMS – WORKING TOGETHER

Eric Carlson, Directing Attorney, Justice in Aging

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Legal Services and Ombudsman, Working Together

Eric Carlson

September 25, 2019

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Difficulty for Legal Services in Reaching Potential Clients

- Physical limitations.
- Dementia.
- Unfamiliarity with laws.
- Deference to/intimidation by facility.
- Plus all other reasons potential clients don’t get to legal services offices.

Possible Strategies

- Contact Ombudsman Program.
  - Ombudsman meets residents face-to-face.
    - Willingness to work with legal services will vary, depending on the program.
- Publicize relevant law.
  - Presentations.
  - Guides.
- Publicize legal services program and its interest in these issues.

Unfamiliar Law

- Resources include (apologies for self-promotion)
  - 25 Nursing Home Problems, and How to Resolve Them (Justice in Aging)
  - Long-Term Care Advocacy (LEXIS Publishing)
  - Resources from National Consumer Voice for Quality Long-Term Care
  - Resources (particularly re: Medicare coverage) from Center for Medicare Advocacy

Sometimes Legal Services and Ombudsman Join Forces

- Statewide programs
  - Michigan Elder Justice Initiative
  - Vermont Legal Aid, Inc.

Local Cooperation Between Ombudsman & Legal Services

- E.g., Western New York.
  - People Inc. (ombudsman program) and Center for Elder Law & Justice.
    - Thanks to Lindsay Heckler of CELJ for info.
  - Role of "legal liaison"
    - Trainings.
    - In-house legal support.
    - Training for facilities and community.
    - Legislative and administrative advocacy.

Common Legal Services Issues

- Transfer/discharge; eviction.
- Return from hospital.
- Medicare coverage denials.
- Medicaid eligibility issues and coverage denials.
- Defending collection actions.
- Decision-making issues.

Litigation to Prevent Residents from Being Dumped in Hospitals

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

Only Six Reasons to Evict Nursing Facility Resident

1. Nonpayment.
2. Endangering others' safety.
3. Endangering others' health.
4. Needing higher level of care.
5. Not needing nursing facility care.
6. Nursing facility closing.

Resident has right to an administrative hearing.

Returning to Nursing Facility After Hospitalization

- Bed hold under state law.
  - Paid out-of-pocket or through Medicaid.
- Beyond bed hold, right to return under federal law to next available bed if returning under Medicaid or Medicare payment.

Falsehood: "You Can't Return Because We Can't Meet Your Needs."

- Under federal regs and guidance, facility must allow resident to return pending eviction hearing.
- But some facilities nonetheless refuse to let residents return.
- Resident may have difficulty getting prompt action from survey and certification agency.

Litigation Can Seek Prompt Return

- Potential causes of action:
  - Consumer law violations
  - Breach of admission agreement
  - Breach of Medicaid provider agreement, with resident as third-party beneficiary
  - Tort claims, e.g., infliction of emotional distress
- Request for immediate relief; i.e., temporary restraining order.
- Judge likely will recognize unfairness of being "locked out" without due process.

Thank You

- Eric Carlson
  - ecarlson@justiceinaging.org
- To receive Justice in Aging alerts, text 51555 with the message “4justice”

PROJECT HIGHLIGHTS

Jamie Freschi, NORC Consultant

The Learning Collaborative

Project Challenges

Project Challenges

- Tracking transfer and discharge information
  - Managing the notices
  - What information to track
  - Who is responsible for tracking
  - What is to be gained from tracking
  - Current documentation systems
  - Lack of understanding on the part of the facilities about the specific requirements related to notifying the Ombudsman

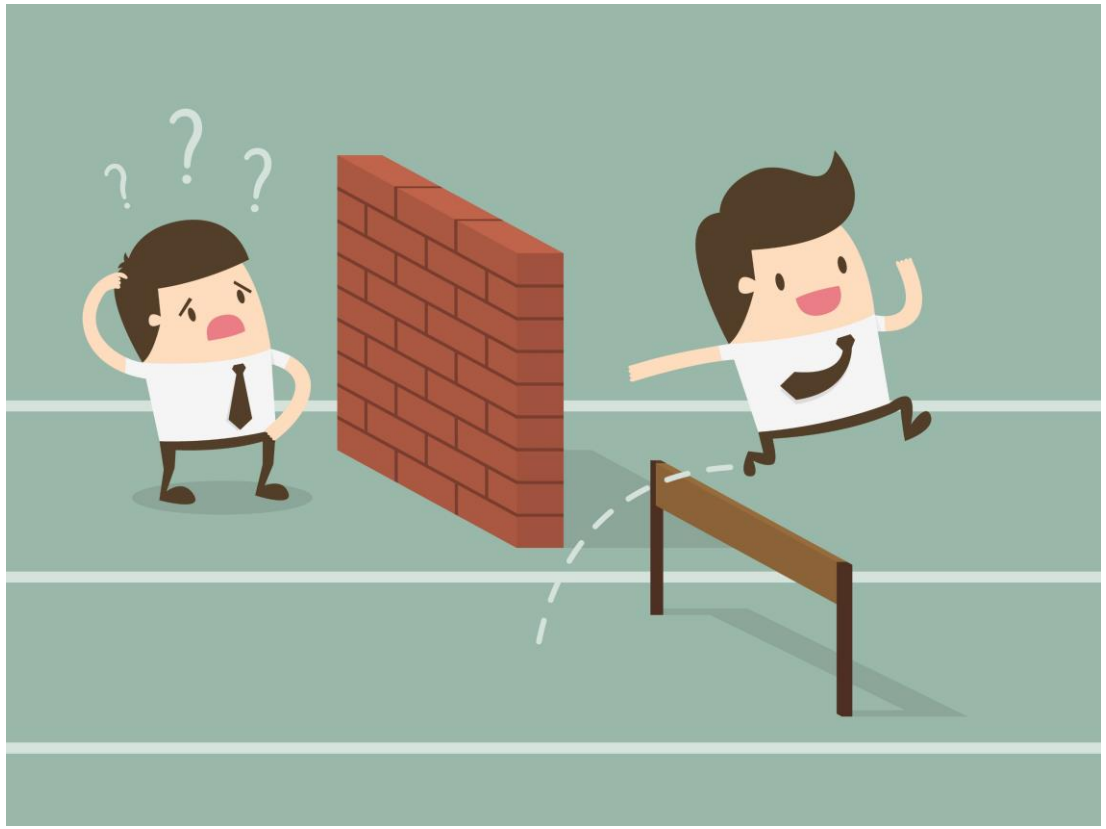
Project Challenges

- Individual Advocacy
  - Residents that cannot communicate consent and/or provide direction
  - Residents not receiving proper notice
  - Residents not allowed to return to the facility after a hospitalization
  - “Behaviors” as a reason for discharge

- Systemic Advocacy
  - Outdated or no standardized forms or confusing letters for transfer and discharge notices, and requests for a hearing
  - Lack of significant penalties for not complying with regulations
  - An overall lack of knowledge of the significant impact discharges have on residents

Project Challenges

- Collaboration
  - State Agencies
    - State Unit on Aging
    - State survey agency



Project Challenges

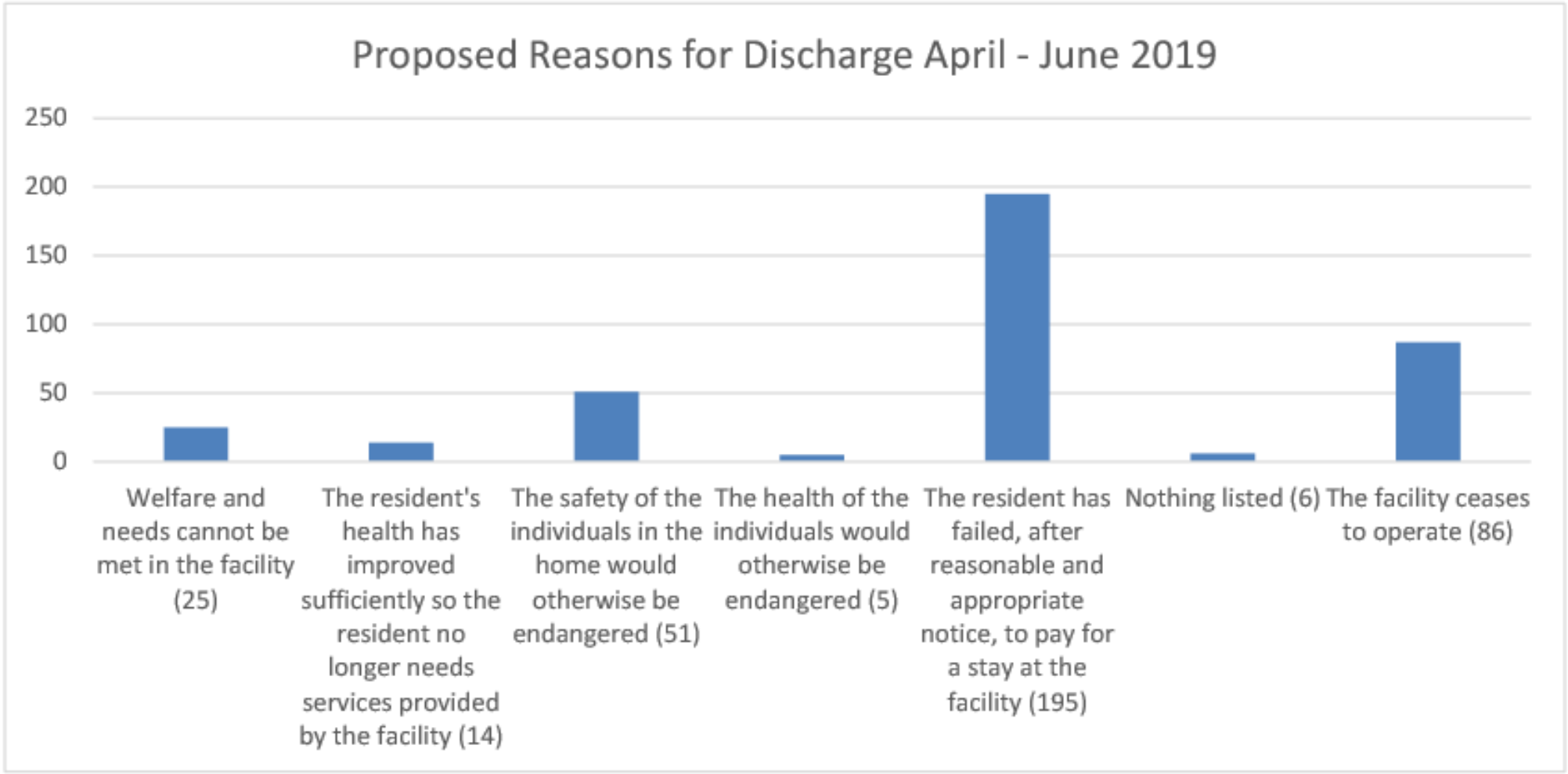
- Legal/Administrative Hearings
  - Hearings held via phone
  - No clear process
  - Lack of training on the Ombudsman program’s role in a hearing
  - Lack of access to legal services
  - Some attorneys and administrative law judges lack a solid understanding of federal requirements and residents’ rights

Project Successes

Project Successes

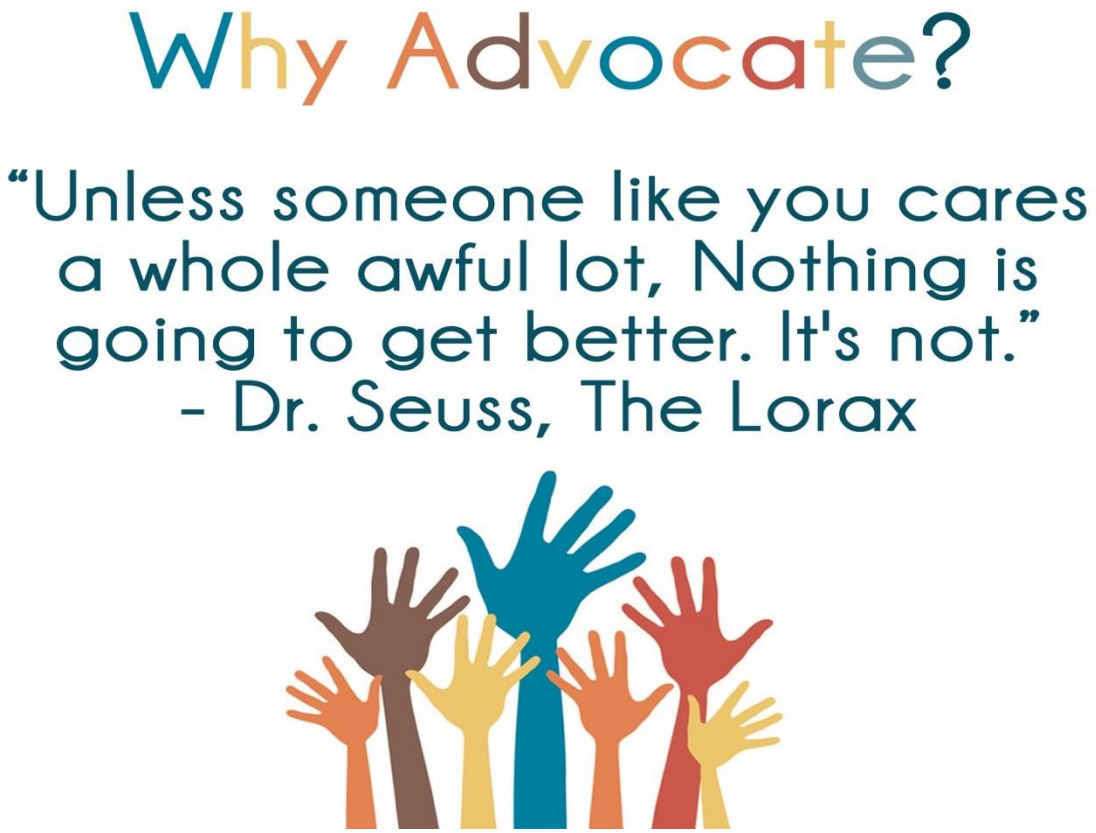
- Tracking transfer and discharge information
  - Examples of information tracked
    - Reason for discharge
    - Location of discharge
    - Facility and/or corporation trends
    - Required information
    - Request ombudsman assistance
  - Analysis of data
    - Shared with state agencies
    - Shared with program staff
  - Improvements made
    - Ombudsman training
    - Facility in-service training

Tracking Example: Ohio



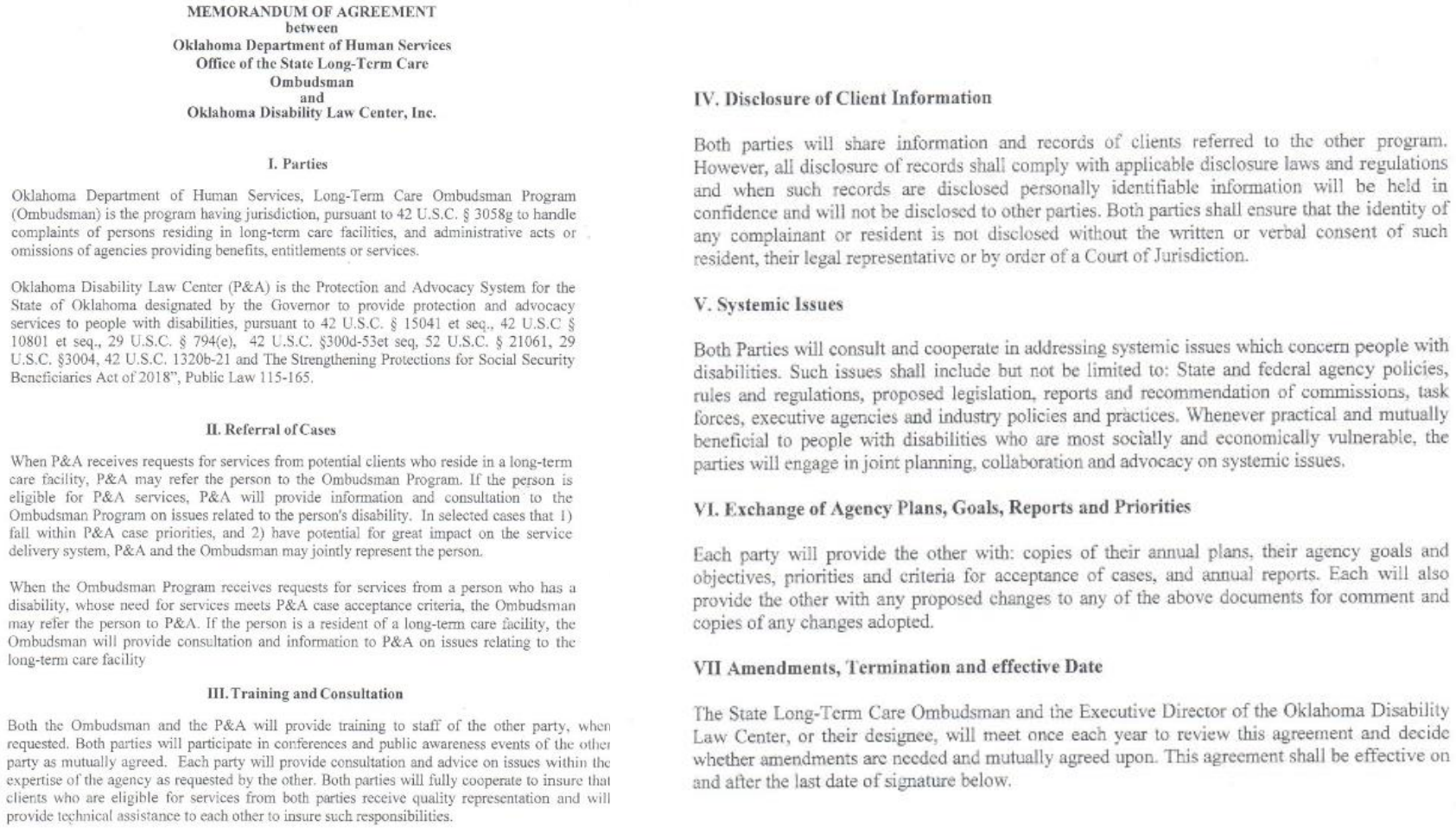
Project Successes

- Advocacy
  - Systemic Advocacy
  - Individual Advocacy



Project Successes

- Collaboration
  - Referrals
  - Training
  - NH associations
  - State agencies
  - MOUs



MEMORANDUM OF AGREEMENT
between
Oklahoma Department of Human Services
Office of the State Long-Term Care
Ombudsman
and
Oklahoma Disability Law Center, Inc.

I. Parties

Oklahoma Department of Human Services, Long-Term Care Ombudsman Program (Ombudsman) is the program having jurisdiction, pursuant to 42 U.S.C. § 3058g to handle complaints of persons residing in long-term care facilities, and administrative acts or omissions of agencies providing benefits, entitlements or services.

Oklahoma Disability Law Center (P&A) is the Protection and Advocacy System for the State of Oklahoma designated by the Governor to provide protection and advocacy services to people with disabilities, pursuant to 42 U.S.C. § 15041 et seq., 42 U.S.C § 10801 et seq., 29 U.S.C. § 794(e), 42 U.S.C. §300d-53et seq, 52 U.S.C. § 21061, 29 U.S.C. §3004, 42 U.S.C. 1320b-21 and The Strengthening Protections for Social Security Beneficiaries Act of 2018", Public Law 115-165.

II. Referral of Cases

When P&A receives requests for services from potential clients who reside in a long-term care facility, P&A may refer the person to the Ombudsman Program. If the person is eligible for P&A services, P&A will provide information and consultation to the Ombudsman Program on issues related to the person's disability. In selected cases that 1) fall within P&A case priorities, and 2) have potential for great impact on the service delivery system, P&A and the Ombudsman may jointly represent the person.

When the Ombudsman Program receives requests for services from a person who has a disability, whose need for services meets P&A case acceptance criteria, the Ombudsman may refer the person to P&A. If the person is a resident of a long-term care facility, the Ombudsman will provide consultation and information to P&A on issues relating to the long-term care facility

III. Training and Consultation

Both the Ombudsman and the P&A will provide training to staff of the other party, when requested. Both parties will participate in conferences and public awareness events of the other party as mutually agreed. Each party will provide consultation and advice on issues within the expertise of the agency as requested by the other. Both parties will fully cooperate to insure that clients who are eligible for services from both parties receive quality representation and will provide technical assistance to each other to insure such responsibilities.

IV. Disclosure of Client Information

Both parties will share information and records of clients referred to the other program. However, all disclosure of records shall comply with applicable disclosure laws and regulations and when such records are disclosed personally identifiable information will be held in confidence and will not be disclosed to other parties. Both parties shall ensure that the identity of any complainant or resident is not disclosed without the written or verbal consent of such resident, their legal representative or by order of a Court of Jurisdiction.

V. Systemic Issues

Both Parties will consult and cooperate in addressing systemic issues which concern people with disabilities. Such issues shall include but not be limited to: State and federal agency policies, rules and regulations, proposed legislation, reports and recommendation of commissions, task forces, executive agencies and industry policies and practices. Whenever practical and mutually beneficial to people with disabilities who are most socially and economically vulnerable, the parties will engage in joint planning, collaboration and advocacy on systemic issues.

VI. Exchange of Agency Plans, Goals, Reports and Priorities

Each party will provide the other with: copies of their annual plans, their agency goals and objectives, priorities and criteria for acceptance of cases, and annual reports. Each will also provide the other with any proposed changes to any of the above documents for comment and copies of any changes adopted.

VII Amendments, Termination and effective Date

The State Long-Term Care Ombudsman and the Executive Director of the Oklahoma Disability Law Center, or their designee, will meet once each year to review this agreement and decide whether amendments are needed and mutually agreed upon. This agreement shall be effective on and after the last date of signature below.

Project Successes

- Legal/Administrative Hearings

Conclusions

Goals and Outcomes

Project States' Goals	Outcomes
Manage discharge notices and learn strategies to collaborate with the state licensing agency.	Developed a process and a tracking tool for incoming transfer and discharge notices. Utilized tracked data to explain the significance of transfer and discharge concerns to successfully collaborate with state licensing agency, including a memo going out to facilities stressing the regulatory requirements.
Develop methods to increase effectiveness in program advocacy and complaint resolution.	Utilized a team approach with the ombudsman, the staff attorney, and the licensing agency to address one systemic discharge that violated residents' rights. In the process of developing a "Model Discharge" document.
Collaborate with state agencies to develop a fair hearing appeal process and develop uniformity with ombudsman advocacy throughout the state.	Successfully advocated for a fair hearing process and now residents are afforded due process. Developed a new procedure for ombudsmen to take a more proactive approach to facility-initiated discharges.

Goals and Outcomes

Project States' Goals	Outcomes
Develop and promote education, training and assistance for Ombudsman, cross train with legal services, and track discharge notices.	Brought in a subject matter expert to conduct a state-wide training for ombudsmen and legal services on administrative hearings and is now tracking notices.
Improve communication with the state survey agency and providers on requirements for provisions of notice of discharge. Develop advocacy strategies to challenge complex discharge cases. Develop a data collection system.	Developed a data collection system and provided statistical analysis from data system to the state survey agency and the regional surveying agencies to point out concerns surrounding transfer and discharges. The continued sharing of data and the explanations of the meaning behind the data has improved communication with the state survey agency greatly. Brought in a subject matter expert to a state-wide training to address strategies when working with complex discharge cases.

Goals and Outcomes

Project States' Goals	Outcomes
Avert unnecessary discharges and solidify continuity of care.	Conducted training for ombudsmen about averting discharges and 100 out of 140 of all discharge cases were averted as of the end of July for FY19. Residents were allowed to remain in their facility, solidifying continuity of care.
Ensure approach and advocacy towards discharge is the most effective and identify & approach trends and problems related to discharge.	Achieved an 82.3% resolution rate among discharge complaints within the first three quarters of CY19. Increased frequency of resident contact. In the first 3 quarters of CY19, ombudsman contacted 56% of residents who received notice. Of that 56%, ombudsmen opened cases on 54%. State Office reviews all hearing decision reports to develop guidance for ombudsman representatives for hearing preparation. Identified several common practices by facilities and corporate trends.

QUESTIONS?

POST-TEST POLL

RESOURCES

Project Resources

- Webinars
  - https://ltcombudsman.org/issues/transfer-discharge#norc
- Project States' Resources
  - Transfer and discharge tracking forms
  - Letters to facilities
  - Annual and quarterly reports
- Resource Guide
  - Advocacy considerations
  - Advocacy tools
  - Advocacy tips

Transfer/Discharge Issue Page

https://ltcombudsman.org/issues/transfer-discharge

Transfer/Discharge

Complaints regarding facility-initiated transfers and discharges continue to be one of the top complaints that Ombudsman programs receive nationwide. These complaints can be complex and extremely time consuming and the threat of transfer or discharge from a long-term care facility can be traumatic for residents and their families.

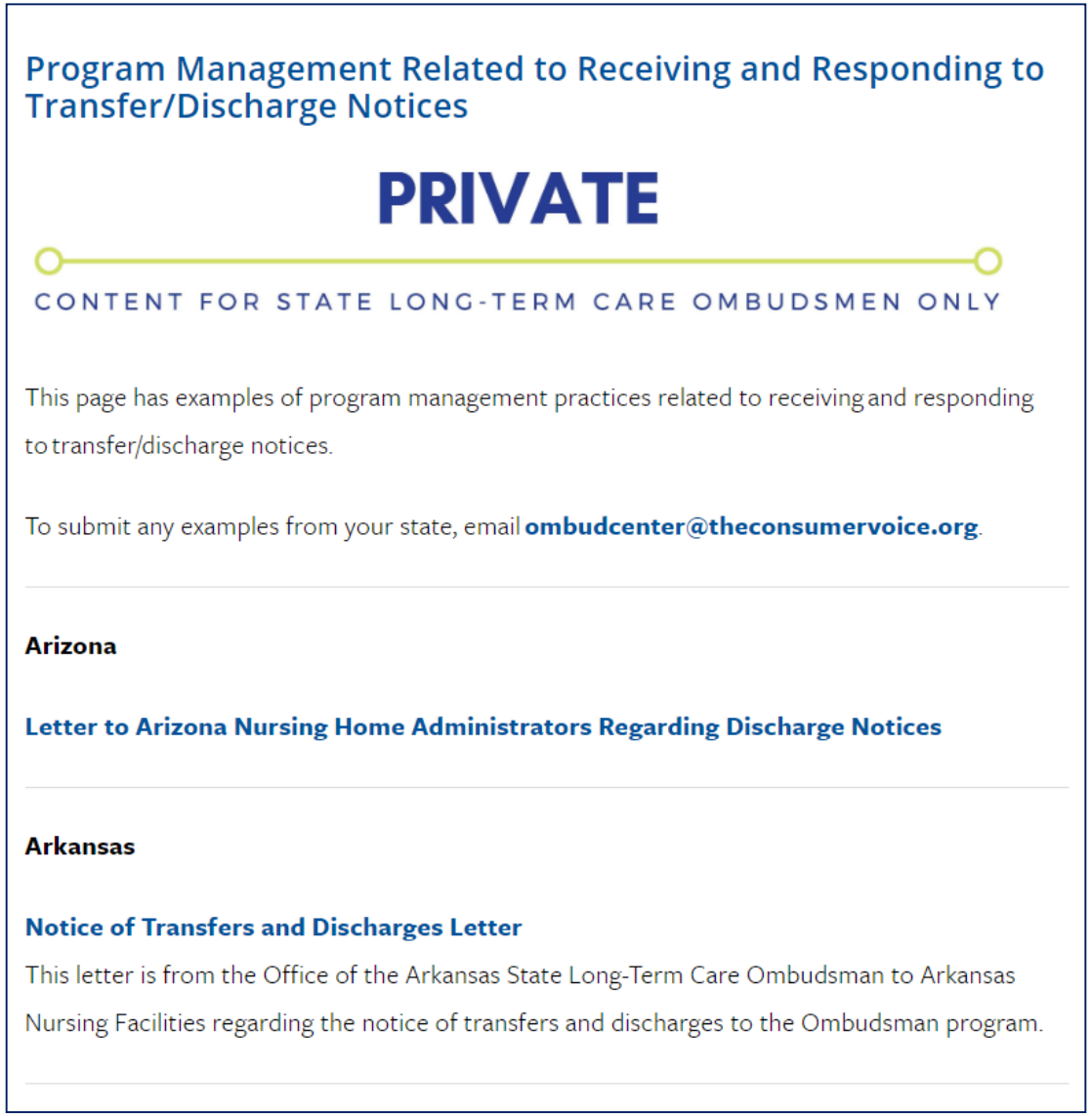
- **NORC Resources**
- **Consumer Voice Resources**
- **Information from CMS**
- **Ombudsman Program Examples**
- **Additional Resources**
- **Information to Share with Consumers**

NORC Resources

Transfers and Discharges - These materials can be used in training by and for Ombudsman program representatives, for members of resident and family councils, and community education.

Program Management Regarding Nursing Facility Transfer/Discharge Notices

https://ltcombudsman.org/state_home/state_support/discharge-notices



Program Management Related to Receiving and Responding to Transfer/Discharge Notices

PRIVATE

CONTENT FOR STATE LONG-TERM CARE OMBUDSMEN ONLY

This page has examples of program management practices related to receiving and responding to transfer/discharge notices.

To submit any examples from your state, email **ombudcenter@theconsumervoice.org**.

Arizona

Letter to Arizona Nursing Home Administrators Regarding Discharge Notices

Arkansas

Notice of Transfers and Discharges Letter

This letter is from the Office of the Arkansas State Long-Term Care Ombudsman to Arkansas Nursing Facilities regarding the notice of transfers and discharges to the Ombudsman program.

Ombudsman Learning Collaborative Landing Page

https://ltcombudsman.org/state_home/state_support/ombudsman-learning-collaborative

Ombudsman Learning Collaborative to Protect Residents Against Nursing Facility-Initiated Discharges

PRIVATE

CONTENT FOR STATE LONG-TERM CARE OMBUDSMEN ONLY

The purpose of the *Ombudsman Learning Collaborative to Protect Residents Against Nursing Facility-Initiated Discharges* project is to enhance the effectiveness of Ombudsman program advocacy and complaint resolution strategies regarding nursing facility-initiated discharges. This page includes information shared by the seven state Ombudsman programs selected for this project, project webinar recordings and materials, and resources produced as a result of this collaborative.

Project State Examples

- **Advocacy Examples and Appeal Hearings**
- **Collaboration**
- **Consumer Education**
- **Data**
- **Ombudsman Program Training**
- **Receiving and Responding to Transfer and Discharge Notices**
- **Systems Advocacy**

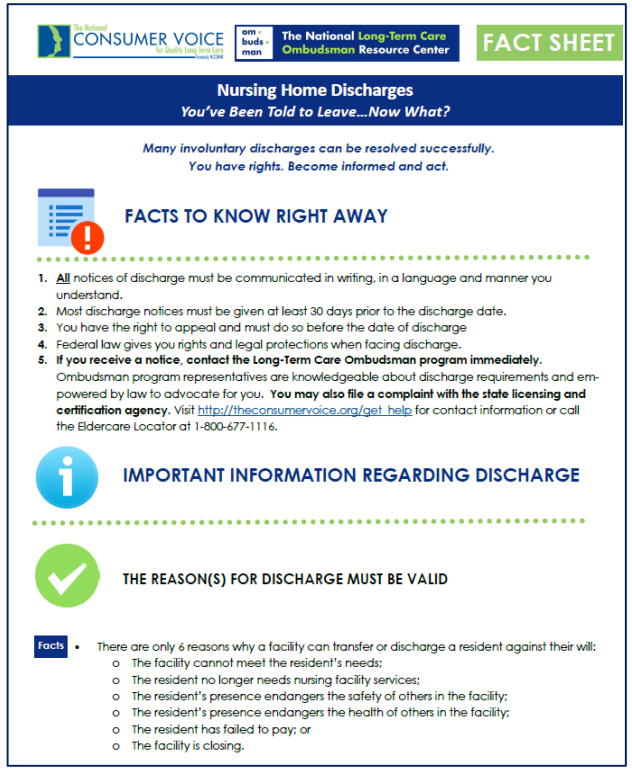
Project Resources and Training

- **Resources**
- **Webinars**

Training and Consumer Education Materials

Transfers and Discharges - These materials can be used in training by and for Ombudsman program representatives, for members of resident and family councils, and community education.

- **Prezi - video, with voiceover**
- **Prezi - clickable, without voiceover**
- **Prezi script**
- **PowerPoint** - This PowerPoint can be used for training purposes.
- **Fact sheet: Nursing Home Discharges You've Been Told to Leave...Now What?** This fact sheet was developed for long-term care consumers to inform them about their rights regarding involuntary discharges. This fact sheet can also be used in training by and for Ombudsman program representatives, for members of resident and family councils, facility-in-service training, and community education.


CONSUMER VOICE | The National Long-Term Care Ombudsman Resource Center | FACT SHEET

Nursing Home Discharges
You've Been Told to Leave...Now What?

Many involuntary discharges can be resolved successfully.
You have rights. Become informed and act.

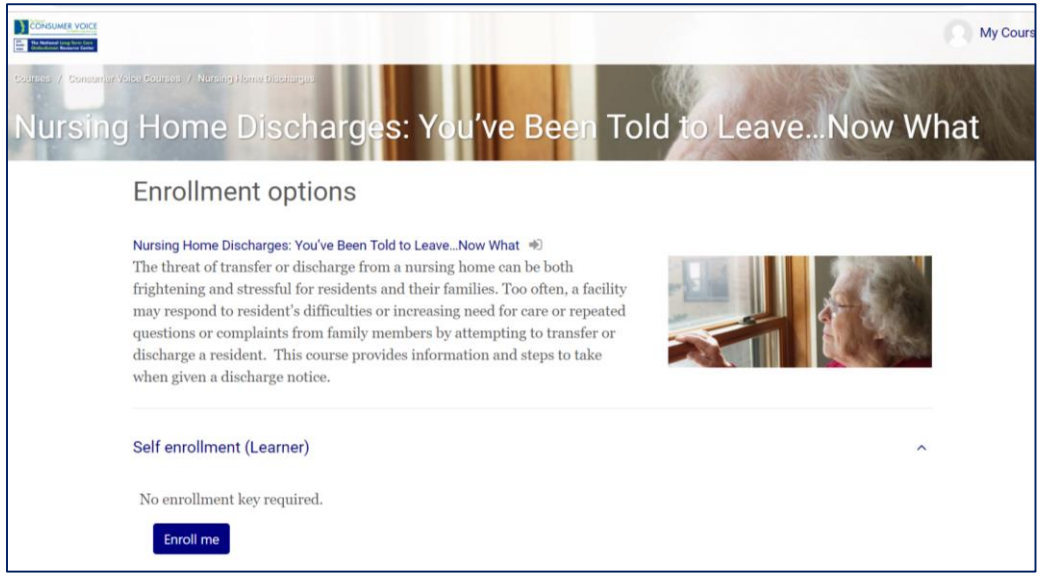
FACTS TO KNOW RIGHT AWAY

1. **All** notices of discharge must be communicated in writing, in a language and manner you understand.
2. Most discharge notices must be given at least 30 days prior to the discharge date.
3. You have the right to appeal and must do so before the date of discharge
4. Federal law gives you rights and legal protections when facing discharge.
5. **If you receive a notice, contact the Long-Term Care Ombudsman program immediately.** Ombudsman program representatives are knowledgeable about discharge requirements and empowered by law to advocate for you. **You may also file a complaint with the state licensing and certification agency.** Visit http://theconsumervoice.org/get_help for contact information or call the Eldercare Locator at 1-800-677-1116.

IMPORTANT INFORMATION REGARDING DISCHARGE

THE REASON(S) FOR DISCHARGE MUST BE VALID

Facts
- There are only 6 reasons why a facility can transfer or discharge a resident against their will:
  - The facility cannot meet the resident's needs;
  - The resident no longer needs nursing facility services;
  - The resident's presence endangers the safety of others in the facility;
  - The resident's presence endangers the health of others in the facility;
  - The resident has failed to pay; or
  - The facility is closing.



https://ltcombudsman.org/issues/transfer-discharge#norc

https://consumervoice.mrooms.net/

Contact Information

- Eric Carlson ecarlson@justiceinaging.org
- Amity Overall-Laib aoveralllaib@theconsumervoice.org
- Robyn Grant rgrant@theconsumervoice.org
- Jamie Freschi jfreschi@fsconsultinghelps.com.

The National Long-Term Care Ombudsman Resource Center

Connect with us:

www.ltcombudsman.org

The National LTC Ombudsman Resource Center

@LTCombudcenter

Get our app! Search for "LTC Ombudsman Resource Center" in the Apple Store or Google Play

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