TRANSFERS, DISCHARGES, & REFUSALS TO READMIT FROM HOSPITAL

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TRANSFER VS. DISCHARGE

- "Transfer"
  - Any temporary move of the resident outside the facility, including sending resident to hospital
- "Discharge"
  - Moving the resident from the facility to another setting, including home, when return is not expected.
    - Residents sent to the hospital on a temporary basis should not be considered discharges.

TRANSFER NOTICES (EMERGENCY)

- To/with Resident:
  - W-10
  - Notice of Emergency Transfer (appeal rights)
  - Bed Hold Notice
- To Others:
  - **List of all residents sent to hospital must be sent to Ombudsman on monthly basis via the discharge portal**
  - https://portal.ct.gov/LTCOP/LTCOP-Discharge-Portal
  - Transfer and Bed Hold Notices must also be sent to Resident Representative

HOSPITALIZATION AND READMISSIONS

- There is increased pressure to discharge individuals from the hospital.
- SNFs must take determine the extent of physical and psychiatric condition of resident before making readmission determinations.
- NOTE: F622 interpretive guidance
  - “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.”

REFUSAL TO READMIT

- C.G.S. 19a-537(g): A SNF can refuse to readmit only if:
  - The resident's needs cannot be met in the facility;
  - The resident no longer needs nursing home level of care due to improved health; or
  - The health or safety of others would be in danger.
- SNF cannot refuse a readmission from the hospital due to nonpayment.
  - SNF must readmit them and proceed with 30-day notice.
- Skilled nursing facility must also follow the federal rules related to involuntary transfer and discharges with respect to required notice.

REFUSING TO READMIT (CONT'D)

- If a SNF has concerns about readmitting a resident
  - SNF must request a consultative process with hospital (within 24 hours of notice from hospital that the resident is ready for discharge).
- The SNF should not state they are refusing to readmit or don't want to take them back, unless they have/are issuing proper notice.
- Hospital can request a copy of the involuntary transfer/discharge notice to give to the resident/resident representative.
- If the resident wants the Ombudsperson's involved
  - call 1-866-388-1888 to make a referral
  - The Resident has the right to file an appeal

REFUSING TO READMIT (CONT'D)

- Consultation Process is in place address concerns the SNF might have and reach an agreement so that the residents needs are met.
  - The process must be completed within 3 business days from date requested by the SNF
  - Hospital must participate, as well as grant access to the resident and the resident's hospital records
  - The resident's wishes must be considered
  - The SNF must reserve the bed in the facility pending the outcome

REFUSING TO READMIT (CONT'D)

- Int. Guidance F626:
  - https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf
  - Facility must not refuse readmission based upon condition when originally transferred to hospital.
  - Facility is expected to:
    - Ascertain current condition of the resident
    - Determine what treatments, medications and services hospital provided to improve the resident's condition and whether this care/treatment can be duplicated at the facility.
    - The SNF should work with hospital to ensure the resident's condition is within the SNF's scope of care before return to facility.

REFUSING TO READMIT (CONT'D)

- Int. Guidance F626 (cont'd)
  - If facility is unable to provide same treatments, medications and services, the facility may not be able to meet needs and may consider discharge.
  - In order to ensure they can meet the resident's needs; the facility may ask hospital to attempt changes to the plan of care and monitor in order to determine if the SNF will be able to appropriately care for and replicated the plan of care in the SNF setting.

REFUSING TO READMIT (CONT'D)

- If after consultative process, the SNF still does not believe can take resident back, they must give Notice of Decision Not to Readmit/Discharge.
- The SNF must submit a copy to the Ombudsperson at the same time as given to the resident, the submission must be sent through the Ombudsperson web-based portal:
  - Involuntary Discharges (ct.gov)
  - **Nursing Home Notice of Transfer / Discharge Requirements Outlined by Public Act 22-57**
  - Requirements of Skilled Nursing Facilities to Use LTCOP Electronic Portal **(Public Act 22-57)**

DISCHARGE PENDING APPEAL §483.15(E)(1), F626

- 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.
    - If the resident, or if applicable, their representative, appeals his or her discharge while in a hospital, 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.

DISCHARGE PENDING APPEAL (CONT'D) §483.15(C)(1)(II)

- 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.**
- The resident has the right to ask for ombudspersons intervention related to the refusal to readmit
- The Resident can also file a complaint with the Department of Public Health

ADDRESSING READMISSION CONCERNS FROM SNF

- SNF can go onsite to hospital
  - Observe resident/review record, note any behaviors, med administration
  - SNF can involve their medical director and have them speak to MD/Psych at the hospital
    - This is done in an effort to resolve/address concerns
  - SNF may can request that hospital tries additional measures before returning the resident to the SNF
    - Having the person spend time with a roommate, longer period of observation of treatment plan…

ADDRESSING READMISSION CONCERNS FROM SNF (CONT'D)

- If readmission of a resident is denied the SNF must articulate why
  - it should not be for the condition the resident was sent to the hospital
- Can they demonstrate they can not support the resident's current condition?
    - Is the resident a danger to self /others?
    - SNF cannot replicate the current plan being provided at the hospital
- If SNF is stating the resident is a danger to self and/or others
  - Has the hospital witnessed any of the concerns the SNF is reporting
  - Is there a new treatment/medication in place
  - Has there been a consultative process completed
    - Has the SNF submitted an involuntary discharge notice to the State Long-Term Care Ombudsperson's office via the portal

ADDRESSING READMISSION CONCERNS FROM SNF (CONT'D)

- Reason we here is "Unable to meet the residents needs"
  - Facility is required to determine its capacity and capability to care for residents admitted.
    - Discharge on this basis must be supported by some change in level of need that they are not required to support.
    - §483.15(a)(6) A nursing facility **must disclose** and provide to a resident or potential resident **prior to time of admission**, notice of **special characteristics or service limitations of the facility**.

ADDRESSING READMISSION CONCERNS FROM SNF (CONT'D)

- "F621 §483.15(b) Equal access to quality care. All services, including but not limited to nursing services, specialized rehabilitative services, **behavioral health services**, social services, dietary services, and pharmacy services, or activities, that are mandated by the law must be provided to residents according to their individual needs, as determined by assessments and care plans.
  - How can they justify another SNF can accept the resident if they cannot.
  - Almost all SNF are licensed the same
    - What care or service are they not able to provide
    - Was the care or service gap disclosed prior to admission
      - Behavioral Units are not licensed different
      - SNF must provide ALL services, including behavioral health services to residents according to their individual needs

PERMITTED DISCHARGE REASONS
(CGS 19A-535)

- Legal reasons for discharge -NOT Necessarily to the hospital
  - Resident's needs cannot be met in the facility
  - Resident's health has improved, and services are no longer needed
    - Was LOC denial filed? Was it appealed? Is it pending?
  - A transfer to hospital was required due to mental illness or intellectual disabilities specialized services
  - Stay no longer approved under PASARR/Level of Care
  - Health or safety of individuals in facility is endangered
  - A self-pay resident with nonpayment of per diem room rate of 15 days or more
  - Facility ceases to operate

PERMITTED REASONS (CONT.)

- NOTE: a “self-pay” resident is defined as a resident who is not receiving state or municipal assistance to pay for facility care
  - CANNOT discharge Medicaid pending resident for nonpayment so long as they have timely responded to requests from DSS for information
  - Can not discharge for failure to pay applied income
- Resident’s who have not filed a Medicaid application, had application denied (no appeal pending) or failed to provide information to DSS in timely manner can be discharged for nonpayment.

FACILITY INITIATED VS. RESIDENT INITIATED

- “Facility initiated” discharge: Resident objects, resident did not request verbally or in writing, and/or discharge is not in alignment with resident’s stated goals for care and preferences

- “Resident-initiated” discharge: Resident or, if appropriate, the resident representative, has provided verbal or written notice of intent to leave the facility (does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

DISCHARGE NOTICES

- Residents must be given an Involuntary transfer/discharge notice
- Most cases required a 30-day notice
- All notices must be submitted to the Office of the Long-Term Care Ombudsperson through the involuntary discharge portal at the same time they are provided to the resident.
- Per Public Act 22-57, notices will not be accepted unless submitted through the portal
  - SNF as of July 1, 2022, and for RCH's as of January 1, 2023
- Nursing home Notice of Transfer/Discharge requirements outlined by Public Act 22-57
  - https://www.cga.ct.gov/2022/act/pa/pdf/2022PA-00057-R00HB-05313-PA.pdf
- Residential care home notice of transfer discharge requirements outlined by Public Act 22-58
  - https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00058-R00HB-05500-PA.PDF
- Federal Regulation and Notice of Transfer/Discharge to Long-Term Care Ombudsman's Office
  - https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.15#p-483.15(c)(3)

DISCHARGE NOTICES (CONT'D)

- Less than 30 days' notice is only permitted when:
  - There is an emergency
  - Health or safety of individuals in the facility is endangered
  - Resident's health has improved
  - Immediate transfer required due to urgent medical needs; or
  - Resident has resided in the facility for less than 30 days

In these cases:

Notice should be given as many days before discharge as practicable

APPEALS OF DISCHARGES

- Nonemergency Discharges
  - Resident has 60 days to appeal
  - However, must appeal within 20 days in order to stay the discharge.
  - “Good cause” extensions are available for both.
- If an appeal is requested, DSS must now review the Notice and inform the facility within 10 days if the Notice is deficient.
  - If the notice is found to be deficient the facility must reissue the Notice.
- A Discharge hearing is held at facility or hospital with resident present.

APPEALS (CONT'D)

- If decision is issued in favor of the facility, the facility must not discharge resident for 15 days from receipt of the decision by the resident/responsible party.
- If the facility loses on appeal, DSS may require the facility to readmit if discharge already occurred (i.e., emergency or appealed after 20 days).

PERMITTING RESIDENTS TO RETURN TO FACILITY

- F626 (Permitting Residents to Return to Facility):
  - A resident whose hospitalization or therapeutic leave exceeds the bed-hold period returns to same room or first available if requires services and is eligible for nursing home services under Medicare/Medicaid.

RESIDENT-INITIATED DISCHARGE

- Interpretive Guidance:
  - Facilities must not treat leaves when resident returns later than agreed upon, as a resident-initiated discharge.
  - Resident must be permitted to return and be appropriately assessed for any ill-effects and provided missed meds and treatments.

  - Facility must not initiate discharge unless ascertained from resident/Resident representative that resident doesn't want to return.
    - The SNF must have documentation of attempts to contact.

CONDITIONAL AGREEMENTS TO TREATMENT RELATED TO ADMISSION (SUA & MH)

- What is a conditional admission agreement?
  - It is an agreement that says the SNF will only accept the resident if the resident agrees to a type of care, treatment or medication.
  - A SNF cannot require that an individual accept care, treatment or medication as a condition of admission.
  - Residents have the right to refuse treatment & cannot sign away a right.
  - Hospitals cannot make agreements with nursing homes to take the resident back to the hospital if it does not “workout”.
  - Once a SNF accepts a resident they are afforded all the protections related to Involuntary Transfer/Discharge, there’s no exception.

RESIDENTS RIGHTS
§ 483.10 ECFR :: 42 CFR 483.10 -- RESIDENT RIGHTS.

- (a) ***Residents' rights.*** The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.
- (2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

RESIDENTS RIGHTS (CONT'D)
§ 483.10 ECFR :: 42 CFR 483.10 -- RESIDENT RIGHTS.

- (b) Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
- (1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
- (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

COMPETENCY
§ 483.10 ECFR :: 42 CFR 483.10 -- RESIDENT RIGHTS.

- (3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
- (7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law
- (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.

SMOKING

If a resident has been smoking prior to being in the hospital:

- They should be offered SNF with smoking
- Even if the resident representative has said they will not smoke again, because if once they begin feeling better and want to smoke, it will be an issue at the SNF
- If they do go to a NON –smoking SNF the hospital must ensure the resident understands the Policies and procedures of that SNF

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Connecticut LTCOP
Long Term Care Ombudsman Program

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CT State

Long-Term Care Ombudsperson

To Contact the Long-Term Care Ombudsman Program

TOLL FREE

1-866-388-1888

You can e-mail us: ltcop@ct.gov
Visit our website portal.ct.gov/LTCOP
Visit us on Facebook www.facebook.com/CTLTCOP