REASON 2

The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

- *A complaint investigation and resolution strategy are contingent upon consulting with and receiving permission from the resident and in accordance with the program's policies and procedures.*
- *This is not an exhaustive list for every case and the resolution strategies and action steps are not in chronological order.*
- *The specific circumstances surrounding the discharge, including state regulations that may be applicable, will also factor into the complaint resolution strategies.*
- *Review the* Basic Discharge Complaint Investigation Process Checklist *before using the charts to address specific discharge reasons.*
- *The word "resident" is inclusive of resident representative.*
- *"Ombudsman" is used as a generic term that may mean the State Ombudsman, a representative of the Office, or the Ombudsman program.*

Initial Information Gathering

Upon receipt of a discharge or transfer complaint, the Ombudsman will meet with the resident and gather information to determine a resolution strategy. These questions intend to guide you through the investigation process to help you build the argument to rescind the notice and prevent the eviction. Not all questions will be applicable, but it is helpful to review them all as you prepare for interviews to ensure that you review all aspects of the complaint.

During your initial visit or contact with the resident, consider asking:

1. Does the resident want to leave or stay in the facility?
2. Does the resident have necessary services set up at the location to where he or she will be discharged?
3. Does the resident have family or other support at the setting to where he or she will be discharged?
4. Has the resident's payor source stopped or threatened to stop payments?
5. If the facility has notified the resident that Medicare skilled coverage is ending, does the resident believe/want services to continue? Does the resident wish to appeal the termination of Medicare services?
6. Has the resident spoken to their doctor about their wishes/concerns?
7. Is the resident concerned about their safety at home? If yes, what are the concerns?
8. If applicable, does the resident want you to make a referral to a community social service agency for at home services or to a local contact agency for assistance with transitioning from the nursing home back to the community?

During your initial contact with the administrator or designated facility staff, consider asking:

1. Does the resident have necessary services set up at the location to where he or she will be discharged?
2. If applicable, has the facility made a referral to the local contact agency for assistance with transitioning back to the community [4823.21(c)(1)(A)]?
3. Does the resident have family or other support at the location to where he or she will be discharged?
4. Has the resident's payor source stopped or threatened to stop payments?
5. Has the resident's doctor documented in the medical record that the resident no longer needs the services provided at the facility?
6. Is the administrator or designated staff member aware of any safety concerns at home? If yes, what are the concerns and how are they being addressed?
7. Is the facility following the discharge plan in the resident's records?

The interviews with pertinent parties will help you in gathering appropriate documents. As a reminder, these strategies are not in sequential order and some will have more relevance depending on the circumstances of the resident and the complaint. This document intends to link resolution strategies with action steps and with the legal basis to support your advocacy to rescind the discharge notice thereby allowing the resident to remain in the facility.

Resolution Strategies	Action Steps *(attempt one or all)*	Legal Basis
Review the Discharge Notice. Check the location listed on the discharge notice. The hospital is an appropriate **transfer** location, but it is **not** an appropriate **discharge** location. Other locations that may not be appropriate or safe include hotels, homeless shelters, family who cannot care for the resident, etc.	❑ **Attempt to Resolve with the Facility.** If the facility did not provide a location or it is not safe and/or appropriate, ask the facility staff to rescind the notice because it does not meet the required elements. If the facility reissues the notice with the required information this will restart the 30-day period. ❑ **Contact the State Survey Agency.** Consult with a surveyor or submit a complaint if the resident wishes. Follow your state policies and procedures for referring a complaint. When submitting the complaint describe the problem in detail and the impact on the resident. ❑ **Appeal the Discharge.** Request a hearing (fair hearing or administrative hearing) which will allow the resident to stay in the facility until a decision is made after the fair hearing. Review Section 4: Appeal Hearings of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.	**Regulation §483.15(c)(5):** The discharge notice must include the location to which the resident is to be transferred or discharged. **Interpretive Guidelines:** For significant changes, such as a change in the destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date, to provide 30-day advance notification. **Regulation §483.15(c)(1)(ii):** The facility cannot transfer/discharge a resident while the appeal is pending (except in certain situations).[1] **Interpretive Guidelines:** 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. *Pertinent Definitions:* **Discharge** – 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. **Transfer** – 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.

[1]The exceptions include if a resident's condition changes and needs emergent care or becomes a danger to self or others and needs hospitalization.

Resolution Strategies	Action Steps *(attempt one or all)*	Legal Basis
Review Resident Records. Examine the resident's medical record to determine if the resident's physician has documented that the resident no longer needs the services of the facility. Review records to see if there is an appropriate discharge plan.	❑ **Attempt to Resolve with the Facility.** If there is not sufficient or appropriate documentation, ask the facility to rescind the notice because there is not adequate documentation. ❑ **Contact the State Survey Agency.** Consult with a surveyor or if the resident wishes submit a complaint. Follow your state policies and procedures for referring a complaint. When submitting the complaint describe the problem in detail and the impact on the resident. ❑ **Appeal the Discharge.** Request a hearing (fair hearing or administrative hearing) which will allow the resident to stay in the facility until a decision is made after the fair hearing. Review Section 4: Appeal Hearings of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.	**Regulation §483.15(c)(2):** The facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. **Regulation §483.15(c)(2)(ii)(A):** The resident's attending physician must document that the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. **Regulation §483.21(c)(1)(i)(v)(vi):** (i)The facility must ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. **Regulation §483.21(c)(1)(iv):** Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. **Interpretive Guidelines:** Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences.
Review Reasons Related to Medicare. Medicare coverage is not long term and only pays in full for 20 days of nursing facility care (usually for care related to recent hospitalization, such as rehabilitation), then the resident is required to pay a co-payment for up to 100 days of the nursing home stay. If the facility tells the resident they need to move out due to Medicare benefits, determine the specific reason (e.g., Medicare coverage ending, therapy ending due to lack of Medicare days, facility refuses to bill Medicare).	❑ **Attempt to Resolve with the Facility.** The resident can insist the facility submit a bill to Medicare and while Medicare reviews the bill the facility cannot charge the resident for what Medicare may pay. However, if Medicare refuses to pay the resident will be responsible for payment. It is important to ensure residents understand their rights and potential financial liability when deciding how to proceed. ❑ **File an Appeal.** If the discharge is due to Medicare days ending and the resident is not ready to return home, consider appealing to Medicare for additional coverage. A change in payment source is not one of the six reasons for discharge and a resident cannot be discharged while an appeal is pending. For additional advocacy tips if a resident is being discharged because his or her Medicare days are ending, review problems 12, 16 - 20 in Justice in Aging's "25 Common Nursing Home Problems and How to Resolve Them". *Continued on next page*	**Interpretive Guidelines:** Facilities must inform each resident in writing before or at admission, and periodically during their stay, such as when a change in coverage occurs, of the facility's available services and associated costs. **Medicare Resources** *Rights and Protections for Everyone with Medicare* https://www.medicare.gov/claims-appeals/your-medicare-rights/rights-protections-for-everyone-with-medicare **Getting a Fast Appeal** https://www.medicare.gov/claims-appeals/your-right-to-a-fast-appeal/getting-a-fast-appeal-from-non-hospital-settings **Appendix PP Page 58:** For residents who receive(d) Medicare Part A services under the Fee-for-Service (Original) Medicare Program: If a SNF believes upon admission or during a resident's stay that Medicare will not pay for covered skilled services and the SNF believes that an otherwise covered item or service may be denied as not being reasonable and necessary, facility staff must inform the resident or his or her legal representative in writing why these specific services may not be covered and of the resident's/beneficiary's potential liability for payment for the non-covered services. *Continued on next page*

Resolution Strategies	Action Steps *(attempt one or all)*	Legal Basis
Review Reasons Related to Medicare continued	❑ **Contact the State Health Insurance Assistance Program (SHIP).** For more information on Medicare coverage and appealing a Medicare decision, contact your state's health insurance assistance program. https://www.medicare.gov/contacts/#resources/ships	**Facilities must issue the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to residents/beneficiaries prior to providing care that Medicare usually covers, but may not pay for, because the care is:** • not medically reasonable and necessary; or • is considered custodial. The SNFABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the SNF provides the beneficiary with SNFABN, form CMS-10055, the facility has met its obligation to inform the beneficiary of his or her potential liability for payment and related standard claim appeal rights. Issuing the Notice to Medicare Provider Non-coverage (NOMNC), form CMS-10123, to a beneficiary only conveys notice to the beneficiary of his or her right to an expedited review of a service termination and does not fulfill the facility's obligation to advise the beneficiary of potential liability for payment. A facility must still issue the SNFABN to address liability for payment. The NOMNC informs the beneficiary of his or her right to an expedited review of a services termination. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. The SNF may not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the Quality Improvement Organization (QIO) cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for "coverage" reasons. The NOMNC is issued when all covered services end for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. In most cases when all covered services end for coverage reasons, a SNF provider will issue: • NOMNC; or • NOMNC and the SNFABN. In cases where all Medicare covered services are ending, the beneficiary is being discharged and is not requesting an expedited review, only the NOMNC is required. Additionally, there are rare instances where a SNF would issue only a SNFABN. An example of this is when there is a reduction or termination in one Medicare Part A service while other Medicare Part A covered services are continuing. The SNF: • Must file a claim when requested by the beneficiary; and • May not charge the resident for Medicare covered Part A services while an expedited review and final decision is pending. **NOTE: A facility's requirement to notify and explain the SNFABN notices that the individual is no longer receiving Medicare Part A services is separate and unrelated from the admission and discharge requirements under 42 CFR §483.15 which outline the notification and requirements under which an individual may be discharged from the facility.**

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