

REASON 3

The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.

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- *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.*
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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 stay in or return to the facility?
2. What are the resident's concerns?
3. Did the resident receive a notice of the facility's bed-hold policy [§483.15(d)]?
4. Did the resident receive a notice of discharge?
5. What is the resident's understanding of what led to the facility's claim that the resident is endangering the safety of others? What happened according to the resident?
6. Did the resident attend the last care plan meeting? If not, why?
7. Is the concern addressed in the care plan?
8. Is the resident in agreement with the care plan? If not, why?
9. Is the resident interested in having a new care plan to address the concerns? If yes, does the resident wish to have an Ombudsman present at the care plan meeting?
10. Does the facility follow the care plan?

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

1. What harm does the resident pose?
2. Is the behavioral status related to the resident's diagnosis?

3. What are the resident's diagnoses?
4. Did the resident have these diagnoses upon admission?
5. What has the facility done to support the resident?
6. What is the facility currently doing to ensure all residents' safety?

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

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.

At times, a nursing facility may transfer a resident to the hospital and not allow them to return to the facility when the resident is ready to leave the hospital.

Action Steps *(attempt one or all)*

- ❑ **Attempt to Resolve with the Facility.** If the facility decided to issue a discharge notice after the transfer, you may receive a complaint or copy of the discharge notice while the resident is still in the hospital. Remind the facility of the federal requirements that state they must comply with discharge requirements.
- ❑ **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 (e.g., the facility transferred the resident to a hospital and will not allow them to return to the nursing facility the resident has called home for several years).
- ❑ **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 or return to the facility from the hospital pending the appeal.¹ For additional advocacy considerations when an appeal is pending, and/or when a resident is hospitalized, or how to prepare for an appeal hearing review [Section 2: Federal Requirements and Advocacy Considerations](#) and [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges*.

Legal Basis

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(e)(1)(ii): If a facility determines that a resident who was transferred to the hospital cannot return, the facility must comply with the requirements for discharge under 483.15 (c).

Regulation §483.15(c)(1)(ii): The facility may not transfer or discharge a resident while the appeal is pending unless not doing so endangers the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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.

If the resident appeals the 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. 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.

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.

¹See exceptions identified in the Interpretive Guidelines for §483.15(c)(1)(ii).

Notice of Bed-Hold Policy and Return.

Determine whether the resident received a copy of the facility's bed-hold notice prior to and at the time of transfer.

Review Resident Records. Examine the resident's medical record to determine if the required documentation by a physician is provided.

This does not have to be the resident's physician.

Determine if the facility was aware of the resident's condition or diagnosis prior to admission.

- ❑ **Attempt to Resolve with the Facility.** If the resident did not receive a copy of the facility's bed-hold policy at the time of transfer, or if the facility is refusing to allow the resident to return from the hospital, remind the facility about the applicable federal requirements
- ❑ **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 (e.g., the facility transferred the resident to a hospital and will not allow them to return to the nursing facility the resident has called home for several years).
- ❑ **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 or return to the facility from the hospital pending the appeal. For additional advocacy considerations when an appeal is pending, and/or when a resident is hospitalized, or how to prepare for an appeal hearing review [Section 2: Federal Requirements and Advocacy Considerations](#) and [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges*.

- ❑ **Attempt to Resolve with the Facility.** If there is not adequate documentation, advocate for the facility to rescind the notice, or to reissue the notice after proper documentation has been included in the medical record, which would restart the 30-day time frame.

If the facility knew of the diagnosis and the resident is displaying characteristics based on his or her diagnosis and this is the basis for discharge, you could argue that the facility agreed to meet the resident's needs by admitting the resident.

- ❑ **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 (e.g., the facility transferred the resident to a hospital and will not allow them to return to the nursing facility the resident has called home for several years).
- ❑ **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. You can argue to have the discharge dismissed due to unmet requirements (lack of required documentation). Review [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.

Regulation §483.15(d): Facilities are required to notify residents and their representatives of their bed-hold policy before transfer and at the time of transfer.

Regulation §483.15 (e)(1): Requires facilities to permit residents to return to the facility to their previous room if available, or immediately upon the first availability of a bed in a semi-private room if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.

Regulation §483.15(c)(2): The facility must ensure that a physician has documented the transfer or discharge in the resident's medical record and appropriate information is communicated to the receiving health care provider.

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)(i): The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless...."

Interpretive Guidelines: Section 483.15(c)(1)(i) provides that "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.

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Resolution Strategies

Review Resident Records continued

Review Care Plan. Determine if the resident is familiar with the **care plan** and agrees with the plan or if the resident would like changes to be made to the care plan.

Carefully review the care plan, with the resident if applicable, for evidence that:

- the resident's needs were adequately and appropriately addressed,
- the care plan is person-centered and reflects the resident's preferences and choices,
- there are specific and appropriate interventions,
- there is evidence that the care plan is carried out consistently and, on all shifts,
- the care plan has been revised due to unmet or changing needs, and
- the care plan is written in measurable language that allows assessment of its effectiveness.

What has the facility done to meet the resident's needs and prevent the alleged safety concern? Is this a new concern?

Determine if the facility **comprehensively assessed the physical, mental, and psychosocial needs of the resident** to identify risks and or underlying causes of the behavior and provided the necessary care and services to support those needs.

Action Steps (attempt one or all)

- ❑ **Attempt to Resolve with the Facility.** Consider sharing with the resident their option of requesting a new care plan meeting to address the needs that are not being met and requesting that the facility rescind the notice based on insufficiencies with the current care plan.

If the facility is unwilling to work toward a resolution through a new care plan, you can argue the resident's rights are being violated and resident's needs are not being met due to improper care planning.

- ❑ **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 (e.g., the facility transferred the resident to a hospital and will not allow them to return to the nursing facility the resident has called home for several years).
- ❑ **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. You can argue to have the discharge dismissed due to unmet requirements (lack of required documentation). Review [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.

Legal Basis

Regulation §483.70(e)(1): The facility must conduct and document a facility assessment that, in part, includes the number of residents, the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, and overall acuity. The reason for the assessment is to determine if the facility has the necessary resources to care for its residents competently during both day-to-day operations and emergencies.

Regulation §483.21(b): 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.

Regulation §483.10(e): The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

Regulation §483.10(c)(2)(iv): Residents have the right to receive the services and/or items included in the plan of care.

Regulation §483.21(b)(2)(iii): The care plan must be reviewed and revised after each assessment, including both the comprehensive and quarterly review assessments.

Interpretive Guidelines: 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.

Interpretive Guidelines: 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.

Investigative Summary and Probes (Appendix PP): Is there evidence that the care plan interventions were implemented consistently across all shifts?

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

Regulation §483.40(b)(3): 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.

Resident Reevaluation.

Examine the resident's medical record to determine if the facility has **reevaluated the resident after the resident has received treatment** in the hospital.

- ❑ **Attempt to Resolve with the Facility.** Remind the facility of their responsibility to evaluate the resident after their hospital stay and not base the decision to issue a discharge notice on the resident's condition prior to the transfer to the hospital (e.g., without evaluating the resident after receiving treatment how can the facility determine whether the resident has improved or if the facility can now meet the needs of the resident).

If the resident is in the hospital for treatment and the physician indicates that the resident requires the same level of care as the current facility provides, then you may be able to argue that either the resident is no longer a danger to others, or that the facility needs to revise the care plan to address the issue and take the resident back.

Consider speaking with the hospital social worker or discharge planner to explain residents' rights and facility requirements, including the resident's right to return to the facility. Remind the hospital staff that they can file a complaint with the state survey agency if the facility refuses to take the resident back.

- ❑ **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. Review [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.

Interpretive Guidelines (F626): 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 his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:

- Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.
- Ascertain an accurate status of the resident's condition—this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.
- Find out what treatments, medications, and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.
- Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:
 - Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return.
 - Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

Resolution Strategies

Sufficient Staffing.

Review the **staffing levels** of the facility at crucial times, especially before and during the incident that led to the notice being issued. Determine if there was sufficient staffing by comparing the level of staffing to the needs of the other residents and of the resident being discharged (as specified in the care plan).

Action Steps (attempt one or all)

- ❑ **Attempt to Resolve with the Facility.** Determine if the facility provided adequate and appropriate training to the staff caring for residents with the resident's clinical or behavioral status (e.g., did the facility look to outside resources for guidance, training, and intervention that would meet the resident's specific needs). For example, if the issue relates to behavioral symptoms of a resident with dementia you could refer to the federal requirement that all staff must receive training in prevention and reporting of abuse, neglect, exploitation, and misappropriation of resident property and dementia management [483.95(c)] and in-service training for nurse aides about dementia management [483.95(g)].

If all staff have not received the required training or the training was inadequate remind the facility of their responsibilities per federal requirements and ask them to rescind the notice as the resident's needs were not met due to lack of proper training and individualized care.

- ❑ **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. Review [Section 4: Appeal Hearings](#) of *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges* for additional information.

Legal Basis

Regulations §483.40(a) & (a)(1)

- 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.

Key Elements of Noncompliance (Appendix PP)

Surveyors are looking for the following actions to determine noncompliance:

- 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 Interdisciplinary Team (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.