The National Long-Term Care Ombudsman Resource Center

# *ENHANCING YOUR ADVOCACY TOOL BOX: PROTECTING RESIDENTS FROM NURSING FACILITY-INITIATED DISCHARGES*

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

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# Project Overview

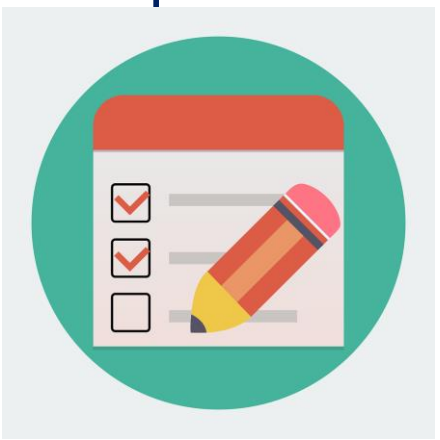
- **Complaints about discharges** have been the **most common** nursing home complaint received by Ombudsman programs for **the last 7 years**. In 2017, 10,610 of the 144,003 nursing home complaints were about discharges.

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

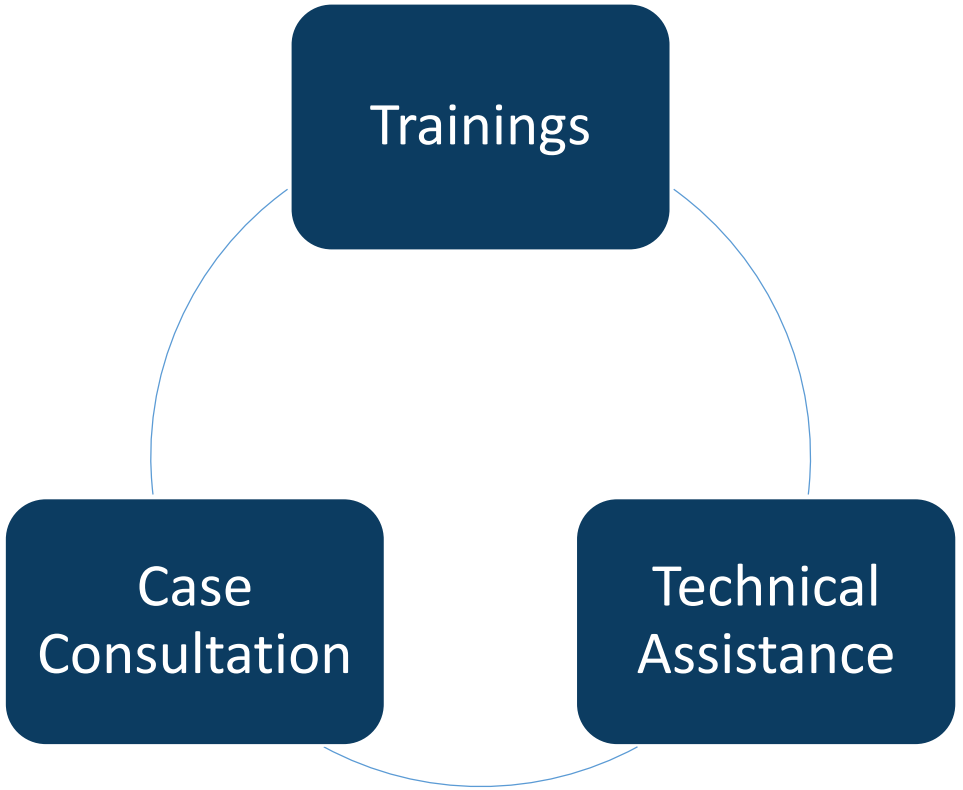
- **7 project states (representing 6 of the 10 ACL regions)**
  - DC, Mississippi, Pennsylvania (ACL Regions III/IV)
  - Ohio (ACL Region V/VII)
  - Oklahoma, Louisiana (ACL Region VI)
  - Nevada (ACL Region IX)

# Training Objectives

- Enhanced understanding of revised federal nursing facility regulations and guidance.
- Learn new ways to apply the revised regulations and guidance to advocacy regarding nursing facility-initiated discharges.
- Share project state successes in collaborating with legal assistance providers and individual case advocacy.



# National Center on Law & Elder Rights




[Visit the NCLER website: NCLER.ACL.gov](NCLER.ACL.gov)

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# Legal Trainings on Nursing Facility Issues

**Prior NCLER Trainings:**

- Nursing Home Transitions: Success through Collaborative Advocacy
  - View a recording of the webinar
  - Read the slides
- Defending Evictions from Nursing Homes and Assisted Living Facilities
  - View a recording of the webinar
  - Read the Issue Brief

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# Upcoming Trainings of Interest

- **Behavioral Health and Older Adults**: August 21
- **Intersection of Medicare and Social Security:** October 8
- **Self Neglect and Hoarding**: November 12

2019 National Legal Training Curriculum

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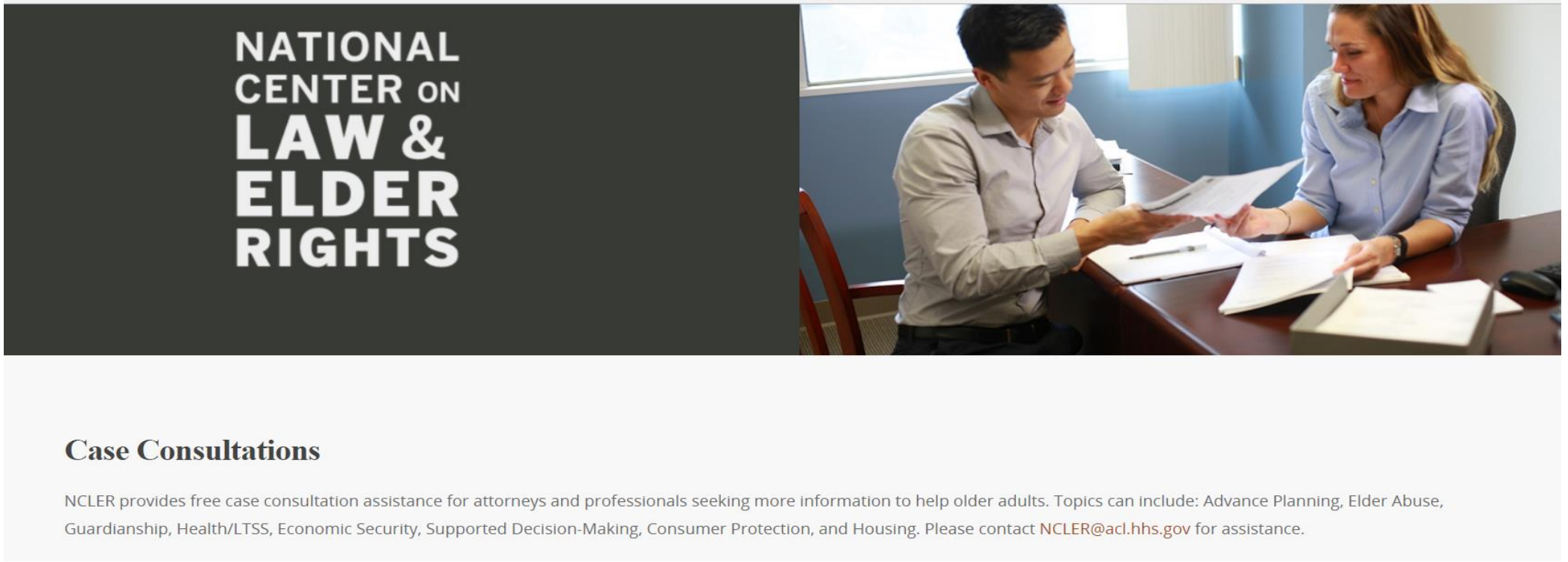
# Case Consultations




Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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# Visit Our Website: NCLER.acl.gov


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# PRE-TEST POLL

# Reasons for Facility-Initiated Transfer/Discharge

1. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.
2. The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.
3. The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.
4. The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.
5. The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.
6. The facility ceases to operate.

*See § 483.15(c)(1) for more details*

# 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).

- **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. You can access them here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

# Regulatory Tools

- **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 in determining if there is a deficiency

## 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.

# Encourage the 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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *Care planning*

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

- **Regulation:** The facility must develop and implement a comprehensive person-centered care plan for each resident
  - 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.*

### 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

# Contesting the Discharge

## *Care Planning*

### 3. Does the care plan reflect 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

# Contesting the Discharge

## *Care Planning*

### 4. 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

### 5. 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

# Contesting the Discharge

## *Care Planning*

### 6. 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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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 Resident's Health Has Improved Sufficiently So the Resident Does Not Need Services Provided by the Facility***

### *Scenario*

Mr. B has improved and no longer needs long-term care, but has no where to go. The facility has indicated the resident will be discharged to a local motel.  Mr. B has requested Ombudsman assistance.

# Contesting the Discharge

***Orientation for safe and orderly transfer/discharge***

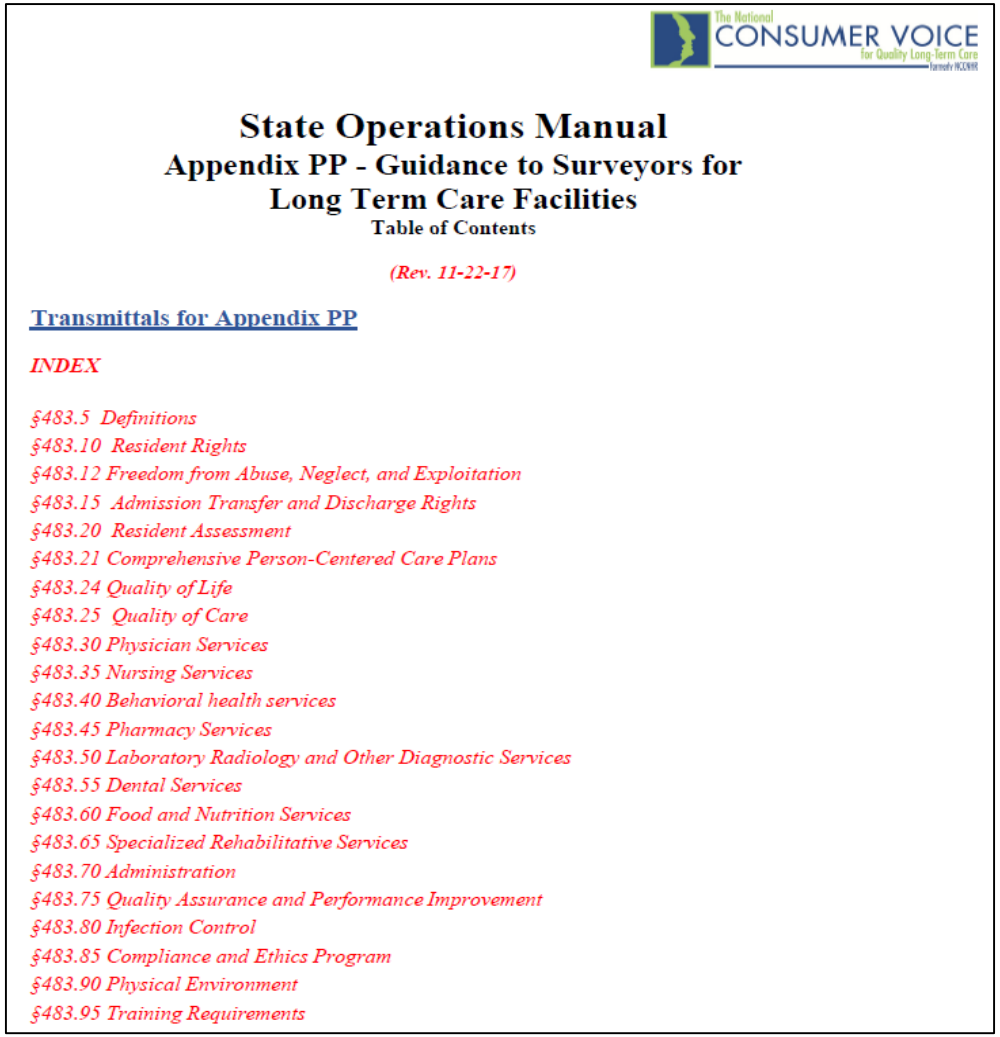
- **Regulation:** Facility must provide - and document - sufficient preparation and orientation to residents to ensure safe and orderly transfer
  - F624 483.15(c )(7) Handout: p.166

*Regulation used successfully on behalf of a resident in discharge appeal hearing in Louisiana*

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

# Contesting the Discharge

## *Discharge Planning Regulations*



The National CONSUMER VOICE for Quality Long-Term Care

**State Operations Manual**

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

**Table of Contents**

*(Rev. 11-22-17)*

Transmittals for Appendix PP

*INDEX*



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

# Contesting the Discharge

## *Discharge Planning Regulations*

- **Regulation:** Discharge planning is part of the comprehensive care plan. Each resident must have a discharge plan.

  Discharge planning process must:

  - Involve the resident and/or resident's representative
  - Involve the interdisciplinary team,
  - Identify resident's needs
  - Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care
  - Address the resident's goals of care and treatment preferences

    - F660-F661 483.21(c ) Appendix PP: p. 218

# Contesting the Discharge

## *Discharge Planning Regulations*

- **Guidance:** … involves the interdisciplinary team … working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a **smooth and safe transition** from the facility to the post-discharge setting
  - F660 Appendix PP: p. 220

- **Guidance:** Discharge planning must identify the discharge destination, and ensure **it meets the resident's health and safety needs**, as well as preferences.
  - F660 Appendix PP: p. 222

# Contesting the Discharge

## *Post-Discharge Plan*

- **Regulation:** The post-discharge plan of care must indicate:
  - Where the individual plans to reside
  - Any arrangements that have been made for the resident's follow-up care
  - Any post-discharge medical and nonmedical services
  - Elements required under the regulation
  - Arrangements made for community care and support services, if needed
    - F661 483.21(c)(2)(iv) Appendix PP: P. 225

# Additional Tools

- **Discharge Critical Element Pathway**

- **Appendix Q** – Core Guidelines for Determining Immediate Jeopardy p. 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

  - X – SUBPART: LONG-TERM CARE (LTC): SITUATIONS WHICH TRIGGER THE NEED FOR FURTHER INVESTIGATION IN SNF/NFs.

    Under category Quality of Care/Quality of Life: Staff/Facility Action

    - *Discharge to destination that is unsafe, or does not meet the resident's immediate health and/or safety needs*

***Call your state licensing agency ASAP!***

# 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

# Contesting the Discharge – Right 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

# Contesting the Discharge – Right 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

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

# Contesting the Discharge

## *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

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

# 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

# Contesting the Discharge

## *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.

# Contesting the Discharge

***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

# Contesting the Discharge

## *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

# Contesting the Discharge

***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

# Contesting the Discharge

## *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 Long-Term Care Ombudsman Program (LTCOP) and Protection & Advocacy?
- **AND**: **Is all the information accurate/correct?**

# Contesting the Discharge

***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

# Contesting the Discharge

## *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

# Contesting the Discharge

## *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.

# QUESTIONS?

# Project States' Successes

*Collaboration with Legal Assistance Providers/Legal Assistance Developers*

- As necessary, all project states refer residents to legal assistance providers to ensure residents have legal representation.
- Oklahoma developed an MOU with the Protection and Advocacy Center and with the Legal Assistance Developer.
- DC has an in-house attorney to assist with administrative hearings.
- Louisiana's State Ombudsman and Legal Assistance Developer submitted a proposal for this project together and have an MOU.
- Mississippi has met with legal assistance providers to begin collaboration efforts.
- Pennsylvania worked with the Legal Assistance Developer who identified existing legal providers for residents by county.

# Project States' Responses to the Questionnaire on Nursing Home Transfer/Discharge: Legal Representation

# Representation During Hearings

- **Who most often represents residents in a hearing?**
  - Ombudsman program (2)
  - Attorneys working in the Ombudsman Program (1)
  - Outside Attorneys (1)
  - Residents (2)
  - Not sure/no hearings held (1)

# No Project State reported a prohibition for an Ombudsman to represent residents during an informal hearing

# Legal Representation During Hearings

- **Project States refer residents to:**
  - Protection and Advocacy
  - Program Legal Counsel
  - Pro Bono Attorneys
  - Legal Services
  - Private Attorneys

# Enforcement of Appeal Decisions

- **Is there an agency in your state that enforces appeal decisions?**
  - No (3)
  - Yes (3)
  - Unsure (1)

# Project States' Success

# Project State Success

*Advocacy to Create a Fair Hearing Process*

- **Mississippi**
  - Collaboration to develop a fair hearing process

# Project State Success

*Resolution Prior to Hearing*

- **District of Columbia**
  - Facility-initiated discharges for not following the facility's new smoking policy.

# Project States' Success

*Case/Hearing Outcomes*

- **Nevada**
  - Discharge to hospital, then to a homeless shelter
- **Pennsylvania**
  - CBD Oil
- **Ohio**
  - Won hearing and facility still refused to accept the resident back from the hospital
- **Oklahoma**
  - Referred to legal team
- **Louisiana**
  - Advocated for resident to return to facility from hospitalization
- **Mississippi**
  - Referred to Legal Assistance Provider

# QUESTIONS?

# POST-TEST POLL

# RESOURCES

# 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**

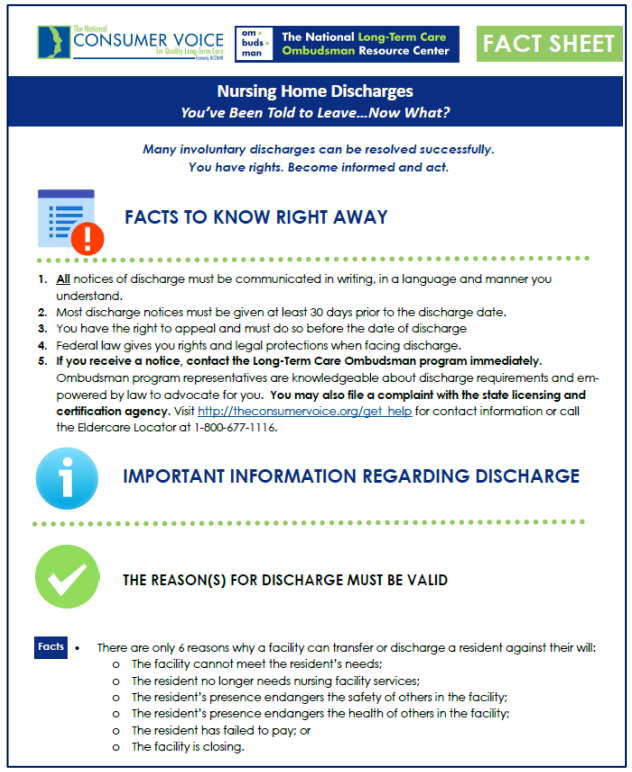
### NORC Resources

**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.

# 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.*

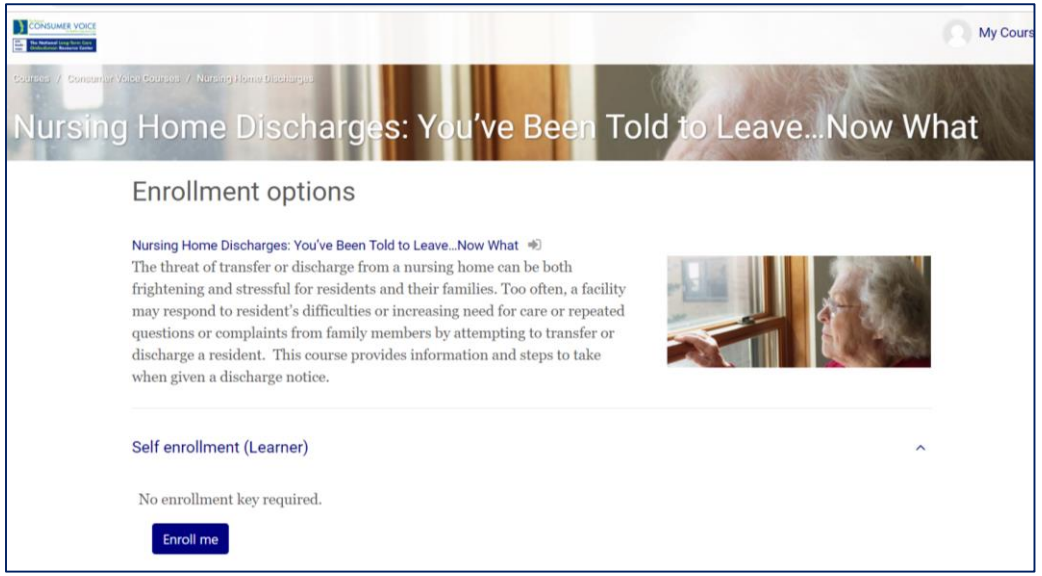
**FACTS TO KNOW RIGHT AWAY**

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/

# The National Long-Term Care Ombudsman Resource Center (NORC)

www.ltcombudsman.org

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**The National LTC Ombudsman Resource Center**

**@LTCombudcenter**

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