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THE INS & OUTS OF RESIDENT TRANSFER AND DISCHARGE

by Kimberli Poppe-Smart and Joan Redden, RN, BC, CLNC

Nursing home residents have rights that extend to the prohibition against discriminate discharge or transfer. A myriad of rules apply to transfer or discharge of a resident, at least partly in an effort to avoid a constellation of symptoms and outcomes know as relocation stress or transfer trauma.

The stress of transfer may be most significant for the resident with early dementia when they first move from their family home into the nursing facility however, transfers and discharges from the facility must be carefully handled to avoid undue stress. As with all stress responses, the severity and the duration of the stress reaction may range from none to severe and may last a few days or a few weeks. Transfer trauma, when it does occur, manifests in emotional, behavioral and cognitive symptoms.

Despite the desire to protect nursing home residents from this type of stress, there are situations when a transfer or discharge from the facility is necessary. Knowing when such a discharge or transfer is allowable and how to best accomplish it will boost your credibility with families, providers, and state surveyors.

PRE-ADMISSION SCREENING

Proactive measures can be implemented by the nursing home before admission of a resident to minimize the need for transfers and discharges. A full assessment of the potential resident's needs and condition prior to admission, with a thorough evaluation of the ability of the facility to meet the resident's needs and the family's expectations, can minimize the disruption and animosity that can result from an incongruity of needs, abilities, and expectations. Screening the resident by obtaining clinical data about the extent of care needs as well as behaviors of the potential resident will assist in carefully and thoroughly vetting the home's ability to meet the resident's needs.

WHEN CAN YOU DISCHARGE OR TRANSFER A RESIDENT?

"Transfer" and "discharge" of a resident refers to the movement of a resident to a bed outside of the Medicare certified facility, whether that bed is in the same physical plant or not. (See 42 C.F.R. § 483.12(a)(1).) Transfer and discharge in this context does not refer to a bed change within the same certified facility.

The general rule is that a facility is required to allow a resident to remain in the facility. The exceptions, as defined in 42 C.F.R. §483.12(a)(2) include situations when:

- the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- the transfer and discharge is appropriate because the resident's health was improved sufficiently so the resident no longer needs the services provided by the facility;
- the safety of individuals in the facility is endangered;

- the health of individuals in the facility would otherwise be endangered;
- the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
- the facility ceases to operate.

Generally, a "transfer" refers to the movement of a resident from the nursing home to another setting that becomes responsible for the resident's care and safety whereas a "discharge" results in the resident moving to a non-institutional setting where the discharging facility is no longer responsible for the resident's care.

The conversion of a resident from private pay status to the Medicaid rate does not constitute failure to pay for the purposes of determining appropriateness of a transfer.

It is not uncommon for resident to refuse care in the nursing home. That refusal alone is not sufficient to support a transfer, unless the refusal results in the facility's inability to meet the needs of the resident of protect the health and safety of the resident and others. If the refusal results in a risk to the resident's safety or health, or that of other residents, then discharge or transfer may be appropriate. The risks of the refusals must be thoroughly explained to the resident or responsible party and thoroughly documented.

PROCEDURAL REQUIREMENTS FOR AN EFFECTIVE DISCHARGE OR TRANSFER

I. Documentation

42 C.F.R. § 483.12(a)(3) details specific documentation requirements in the event of a transfer or a discharge of a resident under the circumstances noted above as follows:

The documentation must be made by-

> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

Prior to completing the transfer or discharge, a designated individual (e.g., Administrator or Director of Nursing) should review the record and verify the following elements are documented:

- The reason for the discharge is clear and falls within one of the allowable categories defined above;
- the records tell the story of the events leading to the discharge or transfer including:
    - accurate assessments of the resident's condition and response to intervention,
    - clearly identified resident's needs and care planned interventions developed by the multi-disciplinary team,
    - accommodations of the individual's needs, and
    - engagement of the family/ responsible party or significant others as appropriate and allowed by the resident; and

- the physician documented that the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility or the transfer or discharge was appropriate because the resident's condition had improved and they no longer required the services of the facility.

If the resident's transfer is necessary due to a significant change in condition but it is not an emergency that requires an immediate transfer, then the facility must assess the resident to determine if a new care plan would allow the facility to meet their needs. If the transfer is from one long term care facility to another, the transferring facility's discharge summary should include rationale and justification as to why they were unable to meet the needs of the resident.

Form CMS-20060, linked here, can be utilized to assist you in evaluating your facility's compliance with transfer and discharge requirements. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Dowloads/Admission-Transfer-Discharge.pdf If an open chart review is employed concurrently with the discharge process, this tool can assist your organization in maintaining compliance with the CMS requirements.

II. Timing

Notice of a transfer or discharge must be provided to a resident or their guardian at least 30 days before the effective date in the non-urgent situation. If, however, the transfer or discharge is necessary due to threat to health or safety of the other residents in the facility, the transfer or discharge is necessary due to resident's improvement eliminating the needs for the nursing facility or an urgent medical need of the resident emerges, then the notice of transfer or discharge is to be made as soon as practicable. Additionally, if the resident has not resided in the facility for 30 days, the shorter notice period applies.

If the transfer or discharge is necessitated by closure of the facility, the facility must give at least 30 days notice to residents or their guardians prior to any change in the operation of the facility rendering it unable to care for its resident. California Health & Safety Code §§ 1336-13362. The 30-day period can be extended to 60 days by agreement between the licensing agency and the facility if there are resident placement problems that require additional time to resolve.

Residents and their representatives who have presented a grievance or complaint to government officials must be free from retaliation. Efforts to transfer or discharge a resident who has complained can be scrutinized by the licensing agency thus it is critical that all efforts made to meet the needs of the resident and explanation as to why their needs cannot be addressed with the resident/ representative and thoroughly documented in the resident's record. California Health & Safety Code § 1432 specifically states that a licensee who attempts to "expel" a resident from a facility within 180 days after the resident has filed a grievance or complaint to any governmental entity will raise a rebuttable presumption that the action was taken in retaliation.

III. Contents of the Notice

When giving notice of transfer or discharge to a resident, the following elements must be included:

- the reason for transfer or discharge;
- the effective date of the transfer or discharge;
- the location of where the resident is transferred or discharged to;
- notice of appeal rights; and
- name, address and telephone number of the State long term care ombudsman.

If the nursing home is treating developmentally disabled residents, the mailing address and telephone number of the agency responsible for protection and advocacy of developmentally disabled individuals must be included. If the nursing facility is treating residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals must also be included.

IV. Requirement to Minimize Transfer Trauma

California Health & Safety Code § 1336.2 specifically requires facilities to take steps to minimize possible trauma and maintain safety of the resident in a situation where the transfer or discharge is necessitated by change in the operation of the facility. At a minimum, the facility must do the following, using an interdisciplinary approach, in an effort to protect the resident:

- ensure the resident's attending physician or facility medical director completes the medical assessment, specifically addressing the resident's condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being provided to the resident or guardian;
- the physician's assessment must address recommendations for counseling, follow-up visits, and other recommended services by designated health professionals to prevent or ameliorate potential adverse health consequences of the transfer;
- ensure that the facility nursing staff and activity director complete an assessment of the social and physical functioning of the resident based on the relevant portions of the MDS (minimum data set), before written notice of the transfer or discharge is issued. The assessment must provide recommendations for preventing or ameliorating potential adverse health consequences in the event of the transfer;
- evaluate the relocation needs of the resident including proximity to the resident's representative and determine the most appropriate and available type of future care and services before issuing the notice of transfer;
- discuss the evaluation and medical assessment with the resident or their representative and make the evaluation and assessment part of the medical records for the transfer, unless the resident or the representative chose to transfer prior to completion of the assessments, in which case the facility must inform the resident or their representative, in writing, of the importance of obtaining the assessments and follow-up consultation as recommended.
- inform the resident or their representative of alternative facilities that are available and adequate to meet the needs of the resident at least 30 days prior to the transfer; and
- arrange for appropriate future medical care and services, unless the resident or their representative has made arrangements independently.

The transferring facility is required to provide orientation to the transferring resident to "sufficiently prepare" them for the transfer and minimize potential negative impact of the transfer. The resident and their family should be encouraged to actively participate in selecting the new facility. Preparation of the resident to transfer may include a tour of the new residence, trial visits, a thorough inventory of belongings and discussions about which things will go to the new residence and which will remain with family, a review of activities and schedules at the new facility and orientation of the receiving facility as to the resident's daily patterns and preferences.

When the resident is discharging, they and their family should be engaged in the development of a post-discharge plan of care following a thorough multi-disciplinary assessment of the resident's needs. Elements to consider in developing this plan include the type and amount of care required, pre-discharge preparation and education required and identification of post-discharge resources. A copy of the California Community Transitions Lead Organizations, compiled as part of a Money Follows the Person gran-funded demonstration project with the California Department of Health Care

Services, is found here and can be provided to families to assist them with their transitions: http://www.dhcs.ca.gov/services/ltc/Documents/California%20Community%20Transitions%20Lead%20Organizations.pdf Another resource is "Planning for Your Discharge" developed by CMS. This checklist provides excellent talking points to be explored when transfer and discharge are being considered. http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf

V. Right to Appeal Refusal of Readmission

California Health & Safety Code § 1599(h)(1) provides for the readmission of the resident who has been hospitalized in an acute hospital and asserts their right to be readmitted to the nursing facility pursuant to bed hold provisions, or readmission rights under state or federal law. If the facility refuses to readmit him or her, the resident has the right to appeal that refusal. If the resident is a Medi-Cal resident, they remain in the hospital under the Medi-Cal coverage until the appeal is decided, unless the resident agrees to placement in another facility.

If a resident requires an admission to a freestanding psychiatric hospital, this is not considered an acute care hospitalization and the resident does not have the same readmission rights to the skilled nursing facility. If the admission was to a psychiatric unit of an acute care hospital, however, the readmission rights are preserved.

SUMMARY

Protection of nursing home residents' safety, emotional and physical health extends to where they reside and the manner in which they are transferred or discharged from their nursing home residence. Following the information outlined here will help protect your organization from allegations of retaliation and unlawful transfer or discharge and can minimize the stress of transfer or discharge for the resident.

About the Authors:

A Senior Attorney returning to Wroten & Associates, **Kimberli M. Poppe-Smart** has united her nearly 30-year nursing career with over a decade of legal experience into a health care risk management and compliance specialist. Her most recent experience as an appointed leader in state government, overseeing Medicaid, survey and certification and a myriad of additional state-administered program add a depth of knowledge and experience rarely seen in the litigation arena. Ms. Poppe-Smart earned a diploma in registered nursing in 1983, a bachelor of science in nursing in 1992 and graduated cum laude from Thomas Jefferson School of Law in San Diego, CA in 2002.

Ms. Poppe-Smart is a Wroten & Associates litigation team member as well as an expert in identifying and managing risks and implementing enterprise risk management plans and strategies. She has spoken nationally on health care topics including quality assurance, risk management and compliance.

Contact Kimberli Poppe-Smart directly at kpsmart@wrotenlaw.com

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The Vice President of Regulatory and Consumer Affairs at Skilled Healthcare, LLC, **Joan R. Redden** is responsible to assisting with development and implementation of company policy pertaining to regulatory issues for all facilities managed by Skilled Health Care Administrative Services. Some of these regulatory issues include supporting residents/ families in resolving grievances, medical chart records review, Coordination on Informal Dispute Resolutions (IDR), and input with CMS Region 6 on collaborative efforts surrounding quality of care concerns.

Ms. Redden is a sought after speaker who has spoken at events for organizations such as American Health Care Association (AHCA), California Association of Health Facilities (CAHF), California's Survey Academy, McKnights 2013 Long-Term Care Conference, and Texas A&M University. She is a member of numerous professional societies including Advanced Joint Commission Training, AHCA Nursing Home Wound Management Advisory Board, American Association for Long Term Care & Nursing (AALTCN), CAHF Survey/ Regulatory Subcommittee, CNA in Aides Education (CA State), and Long Term Care Lawyers Association.