Planning for Successful Discharges and Transfers – Plus a walk through the F Tags and the New CMS Initiative

Presented by
Sean Fahey, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.

Disclosure of Commercial Interests
I have commercial interests in the following organization(s): (or I consult for the following organizations)
Health Law and Estate Planning Attorney at Hall Render Killian Heath & Lyman, P.C.
List the Name of Your Employer:
- Attorney
- Hall Render Killian Heath & Lyman, P.C.
Indianapolis, IN 46204
www.hallrender.com
What the company does?
- Advise health care institutions on legal matters.
If consultant for organizations, only list the names of the companies for which you consult.
List all commercial interests. Note if you are employed by a company, you have a commercial interest in that company.
Hall Render Killian Heath & Lyman, P.C.
Indianapolis, IN 46204
www.hallrender.com

Hall Render
Hall Render

- Hall Render’s Post-Acute and Long-Term Care section is focused primarily on providing services to nursing facilities, home health agencies, hospice providers and related entities, such as assisted living facilities.

- AREAS OF FOCUS
  - Compliance Programs - Development and Implementation
  - Plans of Corrections
  - Settlement Negotiations (Citations, Fines and Remedies)
  - Administrative Appeals (State and Federal)
  - Medicare and Medicaid Reimbursement Issues
  - Collections and Medicaid Applications and Appeals
  - Guardianships
  - Acquisitions and Mergers
  - Licensure & Certification
  - Employment Law

Goals and Overview

- Federal law governing involuntary discharges in SNFs.
- CMS Focus.
- Discharge procedures and hearing process.
- F Tags.
- Best practices for SNFs.

In the News

Complaints About Nursing Home Evictions Rise, and Regulators Take Note

Md. gets $2.2M in settlement with nursing-home operator over evictions
The company sent out at least 1,261 eviction notices between Jan. 1, 2015, and May 31, 2016, more than twice the number issued by Maryland’s other 225 licensed nursing homes combined, the attorney general’s office said.

Lawsuit claims Camarillo nursing home evicts residents when Medicare coverage expires
Complaints Rise in California as Nursing Homes Evict Poor Patients
In the News

• Discharge complaints made up 10 percent of caseload of Indiana ombudsman's office -- double the national average and the third-highest among the 50 states.

In the News

• In March 2017, a California facility was sued for wrongful death related to a resident discharge.

Nursing Homes – Trauma

• “Transfer from a facility for an individual who is so helpless can be a traumatic – even life endangering experience – and, for that reason, the regulations impose on a facility’s management and staff the obligation to do the utmost to protect its residents and their family members from the trauma associated with transfer.” Oakwood Nursing Center v. CMS (2009)
Regs – What is new

Old Regs Sec. 483.12 addressed resident admission, transfer, and discharge rights.

New Reg

- moved Section 483.12 to 483.15 and
- retitles it from “Admission, transfer, and discharge rights” to “Transitions of care.”
- The new Section 483.15 revises some sections from the old Section 483.12 and adds others.

Regs – Endangerment / Payment

- Clarifies that a resident may be discharged when the safety of others is endangered due to the clinical or behavioral status of the resident.
- Clarifies that discharge for failure to pay will not apply unless the resident did not submit that necessary paperwork for third party payment or until the third party, including Medicaid and Medicare, denied the claim and the resident refused to pay for his or her stay.
**Regs - Appeals / Documents**

- Specifies that a facility may **not** transfer or discharge a resident while the appeal of the discharge is pending.
- When discharging a resident because the transfer is necessary for the resident's safety and welfare, **the facility must document the specific resident needs that cannot be met**, the attempts to meet those needs, and the services available at the new facility that will meet the resident's needs.

**Regs – Orientation / Notice**

- Facility **must provide the resident with an orientation** regarding his or her transfer in a form and manner that the resident can understand.
- If a resident is hospitalized or placed on therapeutic leave without any expectation of returning to the facility, **the facility must notify** the resident in writing when the determination is made that the resident cannot be readmitted to the facility.

**CMS S&C MEMO 18-08-NH (DEC 2017)**
CMS S&C MEMO 18-08-NH (DEC 2017)

- Titled “An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations”
- Facility-initiated discharges continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs
- Considers some discharges “unsafe and/or traumatic” for residents and their families

CMS Focus

- Considering a variety of interventions, including surveyor and provider training, intake and triage training, CMP funded projects that may help prevent facility initiated discharges that violate federal regulations, and enforcement.
- State survey agencies must transfer any case involving facility-initiated discharge deficiencies to the CMS regional office for review in certain cases (questionable or unsafe setting, resident remains hospitalized, facility pattern, etc.)

Terms

- “Transfer or discharge” (Regs)
  - Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.
  - Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
Terms
• “Transfer or discharge”
  – Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.
  – Specifically, **transfer** refers to 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.
  – **Discharge** refers to 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**.

Terms
• “Facility-initiated transfer or discharge”
  – A transfer or discharge to which
    • the resident objects,
    • did not originate through a resident's verbal or written request, and/or
    • is not in alignment with the resident's stated goals for care and preferences.
  – App PP

Terms
• “Resident-initiated transfer or discharge” App PP
  – The resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility
  – Note: Does **not** include the general expression of a desire to return home or the elopement of residents with cognitive impairment.
## Reasons for Discharge – 483.15(c)

### F 622 Transfer and Discharge Requirements

- Federal – six reasons
  - The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;
  - The transfer or discharge is appropriate because the resident’s health has 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; or
  - The facility ceases to operate.

### Citations F 622

- F622 – Permit residents to remain in the facility and not be transferred or discharged without adequate reason
  - 264 total old 201 (now F622) deficiencies recorded nationwide
    - 242 deficiencies with scope and severity of F or below
    - 21 deficiencies G or above
  - 389 total old 202 (now F622) deficiencies recorded nationwide
    - All at a scope or severity of F or below

---

### Table: F Tags

<table>
<thead>
<tr>
<th>F TAGS</th>
<th>TAG SUBJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F660</td>
<td>Right to Refuse Certain Transfers</td>
</tr>
<tr>
<td>F620</td>
<td>Admissions Policy</td>
</tr>
<tr>
<td>F622</td>
<td>Transfer/ Discharge Requirements</td>
</tr>
<tr>
<td>F623</td>
<td>Notice Requirements Before Transfer/ Discharge</td>
</tr>
<tr>
<td>F624</td>
<td>Preparation for Safe/ Orderly Transfer/ Discharge</td>
</tr>
<tr>
<td>F625</td>
<td>Notice of Bed Hold Policy Before/ Upon Transfer</td>
</tr>
<tr>
<td>F626</td>
<td>Permitting Residents to Return to Facility</td>
</tr>
<tr>
<td>F661</td>
<td>Discharge Summary</td>
</tr>
</tbody>
</table>
• F622 – Have a written policy that permits a resident to return to the nursing home after hospitalization or therapeutic leave
  – 154 total F206 (now F626) deficiencies recorded nationwide
  – 151 deficiencies with scope and severity of F or below
  – 3 deficiencies G or above

**F623 Notice Requirements Before Transfer/ Discharge 483.15(c)(3)**

- Before the facility transfers or discharges a resident, the facility must:
  - Notify the resident and the resident representative of the transfer/discharge and the reasons for the move in writing, and in a language/manner they understand
  - The facility must send a copy of the notice to the State LTC Ombudsman
  - Record the reasons for transfer/ discharge in the resident’s medical record.
- Notice of transfer/ discharge must be made by the facility at least 30 days before the resident is transferred or discharged
  - **EXCEPTIONS.** 30 day notice is not require, only notice must be made as soon as practicable:
    - If the health or safety of individuals would be endangered
    - If the resident’s health improves sufficiently
    - required by the resident’s urgent medical needs
    - The resident has not resided in the facility for 30 days

**F 623 - Documentation**

- 42 C.F.R. § 483.15:
  - Resident’s medical record must always include the reason for discharge.
  - For resident’s discharged for the resident’s welfare and the resident’s needs cannot be met in the facility, documentation must include:
    - Specific resident need(s) that cannot be met
    - Facility attempts to meet the resident needs, and
    - Services available at the receiving facility to meet the need(s).
**Citations F 623**

- F623 – Provide timely notification to the resident before transfer or discharge
  - 675 total F203 (now F623) deficiencies recorded nationwide, the highest among transfer/discharge-related deficiencies
  - 669 deficiencies with scope and severity of F or below
  - 7 deficiencies G or above

**Contents of Discharge Notice**

- Written notice must include the following:
  1) Reason for action taken
  2) Effective date of proposed transfer/discharge
  3) Location to where resident is to be moved
  4) Statement that resident has right to appeal
  5) Name, address & telephone of LTC Ombudsman program (plus email address)

**Notice Form**
Timing of Notice – In advance

• Generally 30 days in advance of proposed transfer/discharge

• "As soon as practicable" notice of less than 30 days allowed in certain circumstances
  — the safety of individuals in the facility would be endangered;
  — the health of individuals in the facility would be endangered;
  — the resident’s health improves sufficiently to allow a more immediate transfer or discharge;
  — an immediate transfer or discharge is required by the resident’s urgent medical needs; or
  — resident has not resided in the facility for 30 days.

Notice of Transfer / Discharge - Recipients

• Written Notice MUST be distributed:
  — A copy of the notice must be personally delivered to the resident.
  — A copy of the notice must be transmitted to the State.
  — A copy of the notice must be transmitted to the resident’s responsible party.
  — A copy of the notice must be transmitted to the person or agency responsible for the resident’s placement (if different from any of the individuals or agencies mentioned above).
**Notice of Transfer / Discharge**

- Documentation supporting the discharge must be contained in the resident’s clinical records.
- If resident’s health has improved so that the resident no longer needs the facility’s services, physician must provide documentation.
- If based on endangering the health of individuals at facility – need documentation from physician.
- Document adverse impact to resident or other residents
- Deliver a copy to the resident and place in resident’s record.

**CMS S&C Memo 17-27-NH Clarification of Notice before Transfer or Discharge**

**DATE:** May 12, 2017
**TO:** State Survey Agency Directors
**FROM:** Director, Survey and Certification Group

**SUBJECT:** Implementation Issues, Long-Term Care Regulatory Changes: Subacute Quality of Care (QOC) and Clarification of Notice before Transfer or Discharge

**CMS S&C Memo 17-27-NH**

- For Facility-Initiated Transfers and Discharges when a resident is still hospitalized – A discharge notice needs to be sent to the resident, resident representative and the LTC Ombudsman Office at the same time.
- For all other Facility-Initiated Transfers and Discharges – the resident and resident representative, as well as the LTC Ombudsman Office, must be provided with the discharge notice at least 30 days prior to discharge. The LTC Ombudsman Office should be sent its copy of the notice at the same time that the resident/representative are notified.
- **Emergency Transfers** – Notice of transfer may be provided to the resident and resident representative as soon as practicable. Notice to the LTC Ombudsman must also be sent, but can be sent when practicable as well, including in the form of a list of residents on a monthly basis.
- Resident-Initiated Transfers and Discharges – If a resident initiates the transfer/discharge, providers do not need to send a copy of the notice to the LTC Ombudsman.
If a facility TRANSFERS a resident to a hospital on an emergency basis WITH THE INTENT TO READMIT the resident after treatment, the facility MUST provide the resident with a notice of transfer that contains all of the elements listed in Sec 483.15(c)(5).

If the transfer is truly an emergency, the facility may provide notice of the transfer to the resident and resident representative as soon as practicable.

For this transfer, and other similar transfers, the facility can group notices and send them to the Ombudsman office on a monthly basis.
Notices - Examples 1

- Resident initiated discharge to home or other location.
- Notice required.
  - No notice required.

Notices - Examples 2

- Resident initiated discharge against medical advise.
- Notices required
  - No notice required
  - Consider Adult Protective Services
Notices – Examples 3

• Facility-initiated transfer to an acute care facility.
• Notices required:
  – Transfer notice.
  – Bed hold notice.
  – Notice to State Ombudsman (monthly)

Notices – Examples 3 continued

• Then, resident returns OR requests to be discharged to home or another facility?
  – No notice required
• OR, SNF elects not to readmit from hospital?
  – Discharge notice.
  – Notice to Ombudsman at same time as resident

Notices - Examples 4

• Facility initiated discharge.
• Notices required
  – Discharge notice required to resident and resident rep 30 days in advance
  – Ombudsman at same time
Changes to Discharge Notice

-Regs:
  - If the information in the notice changes PRIOR TO EFFECTING the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available (§ 483.15(c)(6))

-App PP
  - 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, in order to provide 30 day advance notification.

F624 Preparation for Safe/Orderly Transfer/Discharge

- Must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
- Orientation must be provided in a form/manner that resident can understand.
- Sufficient Preparation examples
  - inform resident he/she is going
  - arrange safe transportation
- Orientation – trial visits

F660 Discharge Planning Process

- Must develop and implement an effective discharge planning process that focuses on:
  - Resident’s discharge goals
  - Preparation of residents to be active partners and effectively transition them to post-discharge care
  - Reduction of factors leading to preventable readmissions
F660 Discharge Planning Process

- Facility discharge planning process must be consistent with resident discharge rights and:
  - Ensure discharge needs of resident are identified and result in development of a discharge plan for each resident.
  - Include regular reevaluation of residents to identify changes that require modification to discharge plan.
  - Involve the interdisciplinary team.
  - Involve the resident/ representative.
  - Consider caregiver/ support person availability and the resident’s/ caregiver’s capacity and capability to perform required care.
  - Address resident’s care goals and treatment preferences.
  - Document that resident has been asked about interest in receiving information on returning to community.

- Document/ complete timely the evaluation of the resident’s discharge needs and plan.

F661 Discharge Summary

- When the facility anticipates discharging a resident, a discharge summary must be prepared that:
  - Summarizes the resident’s stay.
  - Provides a summary of the resident’s status at time of discharge that is available to authorized persons with the resident/ representative’s consent.
  - Medication reconciliation – pre-discharge through post-discharge.
  - Post-discharge plan of care.
F 661 Discharge Summary 483.21(c)(2)

• Checklist:
  - Physician Assessment of discharge and rehab potential at time of admission with updates as appropriate.
  - Resident and family goals for discharge and support systems available to resident.
  - Comprehensive care plan reflects discharge goals and goals resident is to achieve.
  - Social services should plan, identify and arrange for post-discharge needs and services.
  - Documentation of referrals and responses to referrals.
  - Discharge summary to receiving care provider including comprehensive overview, final summary of status at discharge and medication reconciliation.

F 560 Right to Refuse

• Right to refuse transfer to another room in the facility, if the purpose of the transfer is:
  - To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF.
  - To relocate a resident of a NF from the distinct part of the institution that is a NF to a part of the institution that is not a NF.
  - Solely for the convenience of staff.

F 620 Admission Policy

• CODE OF CONDUCT
• COMPLIANCE PLAN
• POLICIES AND PROCEDURES
• FACILITY ASSESSMENT TOOL
• RISK ASSESSMENT TOOL
F 620 Admission Policy
• 483.15(a)(6) Disclosure of facility special characteristics/service limitations:
  • Enables informed decisions upon admission
    — Example: Facility has religious affiliation that guides routines and practices.
  • Provides predictability and rationale if medical needs change
    — Example: Resident develops a need for medical care not provided by facility but if the resident was informed of the limitation on admission, the need to transfer or discharge will be more predictable and understandable to resident.

F 625 Notice of Bed Hold Policy
• Before a resident is transferred to the hospital or goes on therapeutic leave, facility must provide written information to resident/representative that specifies:
  — Duration of state bed-hold policy, if any
  — Reserve bed payment policy in state plan, if any
  — Facility’s policies re: bed-hold periods and permitting residents to return (see F626)

F 626 Permitting Return
• Policy must provide that:
  • Resident whose hospitalization/therapeutic leave exceeds the bed-hold period under state plan returns to the facility to previous room if available or immediately upon first availability of a bed in a semi-private room if:
    • Resident requires services provided by the facility
    • Is eligible for Medicare SNF/Medicaid NF services
  • If facility determines that a resident who is transferred with an expectation of returning cannot return to the facility, the facility complies with discharge requirements.
Building Your Discharge Case
- Document Expectations in Beginning
- Document Behavior
- Document Care Plan and Assessments
- Document impact of behavior on Employer
- Employee training
- Document support from others
- Family and ombudsman
- Outside assessments
- Show ongoing efforts

Behavior
• 42 CFR § 483.15 (F622) provides residents with a right to remain in a facility unless one of the six criteria for facility-initiated transfer or discharge have been met.
• 42 CFR § 483.25 (F689) requires that each resident receives adequate supervision to prevent accidents related to resident-to-resident altercations where the resident’s action is not willful.
• Generally, safety tags are more likely to be cited at higher scope/severity, including immediate jeopardy, than transfer and discharge tags.

Behavior Issues – Case Study
**Behavior Issues – Case Study**

- Dix entered facility as a quadriplegic in August 2007.
- Dix required extensive care from the staff—relied on them to perform activities of daily living, including repositioning him every two hours.
- Dix was very particular about the methods and manner the staff used to attend to his care and needs.

**Appeal / Hearing**

- Federal Law:
  - States participating in Medicaid must provide a “fair mechanism” for hearing transfer/discharge appeals
  - 42 U.S.C. § 1396r (e)(3)
  - The hearing must be conducted:
    - (1) at a reasonable time, date, and place; and
    - (2) only after adequate written notice of the hearing.
  - 42 C.F.R. § 431.240(a)
Appeal Hearings

- Hearing generally held at nursing facility.
- Right to introduce evidence and cross-examine witnesses.
- Regs: The facility must convince department by a preponderance of the evidence that the transfer or discharge is authorized.
- Conducted by a hearing officer. Who?
  - State employees, often former surveyors.

Results of Hearing

- After the hearing, the ALJ will review the evidence presented at the hearing and prepare a written decision.
- Decision is then provided to the facility and the resident.
- The department shall issue a decision within thirty (30) days from the date the resident receives the notice.

Appeal Hearings

- If the department determines that the transfer is appropriate, the resident must not be required to leave the facility within a specific number of days after the resident's receipt of the initial transfer or discharge notice unless an emergency exists.
- Both the resident and the facility have the right to administrative or judicial review any decision or action by the department.
Thank You.

• Questions
• Hall Render’s Post-Acute Care Insights, Articles, and News:
  • http://www.hallrender.com/category/long-term-care-home-health-hospice/

Sean Fahey
317-977-1472
sfahey@hallrender.com