DISCHARGES & TRANSFERS

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Discharge vs. Transfer

DISCHARGE

- Resident leaves the facility on a permanent basis.

TRANSFER

- Movement to Acute Care Facility with the intent that the resident will return to the facility.

- When a resident is moved from one room to another within the facility.

Transfer/Discharge

- Movement to another Nursing Home. Resident is involved in the choice of facility.

Types of Discharges

- Skilled Stay Completion Discharge
- Resident Initiated Discharge
- 30 Involuntary Discharge
- Emergency Discharge (5 Business Days)

Skilled Stay Completion Discharge

- Discharge date was set at beginning of stay.
- Resident must be given a Notice of Discharge. NOMNC can be used. Proper Discharge Planning must be completed.

Notification to Ombudsman is not required at this time.

Resident Initiated Discharge

A competent (BIM 12+) Resident or POA/Conservator, has discussed with the facility that the resident will be leaving the facility.

Facility completes proper discharge planning.

Notification to Ombudsman is not required, however how to notify the Ombudsman is outlined on the website.

NOTE: Resident Initiated Discharges

Resident-initiated transfers or discharges occur when the resident or, if appropriate, his/her representative has given written or verbal notice of their intent to leave the facility. A resident’s expression of a general desire or goal to return to home or to the community or the elopement of a resident who is cognitively-impaired should not be taken as a notice of intent to leave the facility.

30 Day Involuntary Discharge

This is a discharge that is initiated by the facility.

- The resident must be given the discharge notice, and it should be explained to him/her.
- Per Federal Regulations (42 CFR § 483.15), the Involuntary Discharge Notice must be given to the SLTCO at the same time as the resident. This is why it must be emailed on the same day the resident is notified.
- The Involuntary Discharge Notice must contain all of the required information. It is recommended to use the State Approved template to ensure compliance.

Who Gets the Discharge Notice?

- The Resident
- The Resident's Representative/POA/Conservator
- The State Long Term Care Ombudsman
- The District Long Term Care Ombudsman
- The HCFA Commissioners Designee
- The Regional Office of Health Care Facilites Licensure

*See attached for contact info

30 Day Involuntary Discharge

There are only 6 reasons why a resident can be involuntarily discharged from a Nursing Home:

- **The Resident did not pay his/her bill.**
  - *This will be documented and notification of the overdue amount will be attached to the discharge notice.*
  - *NOTE: A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending*

- **The Resident got better and no longer requires a NH level of care.**
  - Proof of this will be documented in the Nurses Notes and MUST be signed off on by the Medical Director.

30 Day Involuntary Discharge

There are only 6 reasons why a resident can be involuntarily discharged from a Nursing Home:

- **The Nursing Home is closing-Voluntary or Involuntary.**
  - If the NH is closing, then the resident will be notified with a letter explaining the process of the closure. In the case of a closure, the LTC Ombudsman, MCO Care Coordinators, DOH, Tenncare and others are all involved to help the transition.

  - In the event that the Nursing Home chooses to Voluntarily close, the Office of the Ombudsman should be notified immediately, so that they can assist the residents with transferring out of the facility.

30 Day Involuntary Discharge

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident

- The health of individuals in the facility would otherwise be endangered

IF THE FACILITIY CHOOSES TO DISCHARGE FOR ANY OF THESE THREE REASONS THE FOLLOWING MUST BE DOUCMENTED:

- The specific resident needs the facility could not meet;
- The facility efforts to meet those needs; and
- The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.
- Appropriate and timely notice must be given to all required parties.

5 Day Emergency Involuntary Discharge

1200-08-06-.05 (14) No involuntary transfer or discharge shall be made until the nursing home has first informed the department of health and the long-term care ombudsman. No involuntary transfer or discharge shall be made until five (5) business days after these agencies have been notified, unless they each earlier declare that they have no intention of intervening.

Immediate Discharge

Unless the resident is removed from the facility by law enforcement for committing a crime, the facility MUST do a 30 or 5 day involuntary discharge. The facility can TRANSFER a resident to an acute care facility for emergency treatment of physical or behavioral symptoms, but it is expected that the resident will return to the facility once stabilized.

NOTE:

In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors would review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return. If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs. (See §483.20(b) (2) (ii), F637 for information concerning assessment upon significant change.)

Non-Compliance with Care

While the resident also has the right to refuse any treatment or services, the resident's refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

> *For example, facility staff would still be expected to provide appropriate measures for pressure injury prevention, even if a resident has refused food and fluids and is nearing death.*

A resident may not be transferred or discharged for refusing treatment unless the criteria for transfer or discharge are otherwise met. Facility staff should attempt to determine the reason for the refusal of care, including whether a resident who is unable verbalize their needs is refusing care for another reason (such as pain, fear of a staff member, etc.), and address the concern, if possible. Any services that would otherwise be required, but are refused, must be described in the comprehensive care plan.

Documentation

§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

- In this documentation that facility must document all interventions tried to meet the needs of the resident. This includes care plan meetings, medication changes, medical or behavioral interventions, etc…
- In the event of a Transfer/Discharge to another Nursing Home based on the fact that the current facility cannot meet the needs of the resident, the facility must document how the receiving facility will be able to meet the needs of the resident.

Documentation

Information provided to the receiving provider must include a minimum of the following:

1. Contact information of the practitioner responsible for the care of the resident.
2. Resident representative information including contact information
3. Advance Directive information
4. All special instructions or precautions for ongoing care, as appropriate.
5. Comprehensive care plan goals;
6. All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

INTENT To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation. Additionally, these requirements specify the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting.

Appeals

- The resident has 30 days to appeal the discharge notice.
  - 5 days if given a 5 day notice
- The resident has protections from being discharged under the appeals process.
- Anyone can contact the HFCA Designee (Audrey Seamon) to begin the appeals process on behalf of a resident.

NOTE:

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger 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.

Assess well at Admission Time

We call them Residents because this is their home…

Section §483.15(c) (1) (i) provides that "The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." 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). There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Transfers & Resident Rights

A resident can decline relocation from a room in one institution's distinct part SNF or NF to a room in another institution's distinct part SNF or NF for purposes of obtaining Medicare or Medicaid eligibility. Facility staff are responsible for notifying the resident or resident representative of changes in eligibility for Medicare or Medicaid covered services and of what the resident's financial responsibility may be. If the resident is unable to pay for those services, then after giving the resident a discharge notice, the resident may be transferred or discharged under the provisions of §483.15(b), F621, Equal Access to Quality Care.

A resident has the right to refuse a transfer if that transfer is solely for the convenience of staff. For example, a resident may experience a change in condition that requires additional care. Facility staff may wish to move the resident to another room with other residents who require a similar level of services, because it is easier for staff to care for residents with similar needs. The resident would have the right to stay in his or her room and refuse this transfer.

CMS guidance-State Operation Manual

What the Surveyors Ask Us

Ask representatives of the Office of the State Long-Term Care Ombudsman if they have information that could indicate the facility treats residents differently in transfer, discharge and covered services based on source of payment.

If concerns arise regarding equal access to care, ask the resident or representative:

- Were there any changes to care or services when their payor source changed, for example did they notice fewer staff available to meet their needs when their payor source was due to change or had changed?

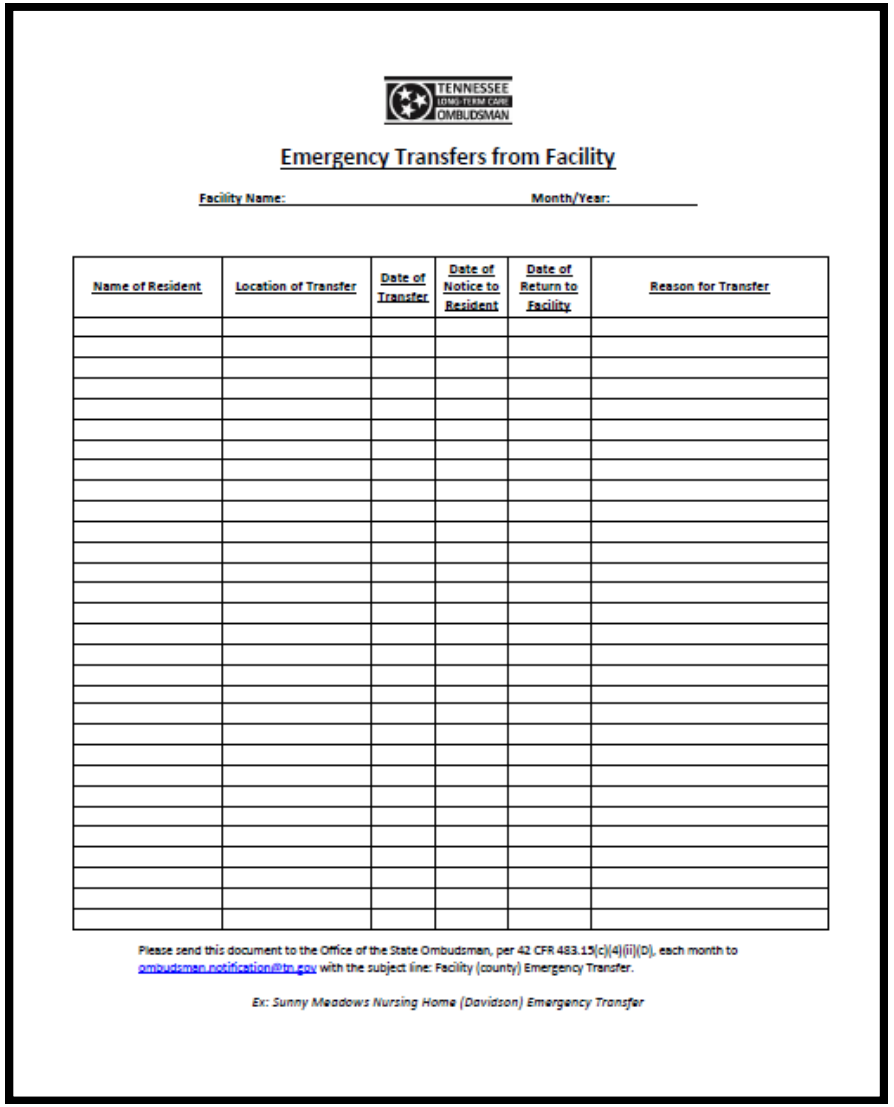
- Did the resident receive notice of changes in charges for services?

- Were they asked to move or were they moved to a different location in the building when their payor source changed?

Emergency Transfer Logs

Emergency Transfer Logs were created as a response to the changes in the Federal Regulations that went into effect in November of 2016.

When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.



TENNESSEE LONG-TERM CARE OMBUDSMAN

Emergency Transfers from Facility

Facility Name: _____ **Month/Year:** _____

Name of Resident	Location of Transfer	Date of Transfer	Date of Notice to Resident	Date of Return to Facility	Reason for Transfer

Please send this document to the Office of the State Ombudsman, per 42 CFR 483.15(c)(4)(ii)(D), each month to ombudsman.notification@tn.gov with the subject line: Facility (county) Emergency Transfer.

Ex: Sunny Meadows Nursing Home (Davidson) Emergency Transfer

Emergency Transfer Logs

Location of Transfer: This should be the name of the facility. (Ex: Jackson Madison Hospital)

Date of Transfer: Date resident left the facility

Date of Notice to resident: This is a copy of the bed-hold policy. There is no template of what this should look like, it is up to the facility to create and provide this. This should include information on the Tenncare Bedhold Policy and what the resident will need to do to hold their bed in the facility.

Date of Return to Facility: This should reflect the date the resident returned. If N/A the comments should explain why. (ie: Expired at Hospital)

Reason for Transfer: This should give a general overview of what the resident went out for. (Ie: flu symptoms, change in mental status)

Email to the SLTCO by the 20th of the month for the previous month. (Ex: on April 20th the entire month of March is due)

QUESTIONS??