Rolling Hills
CARE CENTER

Transfer / Discharge / Bed Hold Policy and Procedure

October 2022

This facility ensures residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source.

Transfer/Discharge/Bed Hold Policy and Procedure

PERTINENT DEFINITIONS:

Facility-initiated Transfer or Discharge: A transfer or discharge which the resident/resident representative objects to – or - 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.

Resident-initiated Transfer or Discharge: Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. (Leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.)

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. 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.

POLICY

It is the policy of this facility to ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source.

RIGHTS/STANDARDS

I. Residents have the right to remain in this facility and not be involuntarily discharged unless:

While it is permissible to discharge a resident under any of these six circumstances, when doing so - - with the exception of emergency cases - **- the facility remains responsible for following the steps required for facility-initiated discharges, which are outlined on pp.2-4 of this policy.**

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility
2. 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 **(SEE P. 10 FOR ADDITIONAL OPTIONS)**
3. The safety of the individuals in the facility is endangered due to the clinical, behavioral status, or condition of the resident
4. The health of individuals in the facility would otherwise be endangered
5. 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. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare/Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. (Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.) **(SEE P. 10 FOR ADDITIONAL OPTIONS)**
6. The facility ceases to operate

SEE P.11 FOR ADDITIONAL STATE REQUIREMENTS FOR A MEDICAID BENEFICIARY

RIGHTS/STANDARDS *con't…*

II. Residents and/or their representatives have the right to:

1. To appeal intended transfers and discharges by the facility;

2. To not be transferred/discharged for refusing treatment unless the criteria for transfer or discharge are otherwise met **(Note:** 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.)

3. To not be transferred/discharged for life sustaining treatment when the resident has documented his/her wishes not to be - - and a physician's order is on the chart.

DISCHARGE PENDING APPEAL:
The facility may not transfer or discharge the resident while the appeal is pending, 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. 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.

There may be rare situations, such as when a serious crime (i.e., murder, rape) has occurred in which the facility may have to initiate a discharge immediately - - and with no expectation of the resident's return.

III. **PROCEDURE PRIOR TO NON-EMERGENCY FACILITY-INITIATED DISCHARGES** ***(steps to be followed when the facility transfers or discharges a resident under any of the six circumstances listed on p.1)***

1. **Assessments/Care Planning**
2. **Notification**
3. **Documentation**
4. **Orientation for Transfer/Discharge**

1. Assessments / Care Planning

Assessments and care plans that address the resident's needs through multi-disciplinary interventions, accommodation of individual needs, and attention to the patient's resident's customary routines will be conducted and revised to determine if the facility can meet the specific needs of the resident.

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 the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs.

2. Notification

The facility will:

A. Notify the resident and the resident's representative(s*)* of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand at least 30 days prior to the discharge or as soon as possible.

B. For residents over age 60, send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

Notification *con't…*

C. Record the reasons for the transfer or discharge in the resident's medical record as described in the Documentation section of this policy.

- **Timing of the Notice:**
  Except when allowable by statute (i.e., when the health and safety of individuals are at risk, medical urgent needs, the resident's health improves sufficiently to allow a more immediate transfer or discharge, the resident has not resided in the facility for 30 days) the notice of transfer or discharge required will be given at least 30 days before the intended transfer/discharge. (For the underlined circumstances, notice must be made as soon as practicable.)

- **Contents of the Notice:**

  The written notice will include the following:
  - The reason for transfer or discharge
  - The effective date of transfer or discharge
  - The location to which the resident is transferred or discharged
  - A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request
  - The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman
  - For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
  - For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. 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.

3. <u>Documentation</u>

The facility will ensure that the transfer/discharge is documented in the resident's medical record (when applicable) and appropriate information is communicated to the receiving health care institution or provider.

- ***Documentation will include:***
  - A. The basis for the transfer/discharge
  - B. Details describing the specific resident need(s) that cannot be met, any attempts by the facility to meet the resident needs, and the service(s) available at the receiving facility to meet the need(s).

Documentation will be completed by:

- ✓ For circumstances 1 and 2, the resident's physician
- ✓ For circumstances 3 and 4, **<u>any</u>** physician
- ✓ For circumstances 5 and 6, the Administrator or his designee

"Circumstances" refers to the six allowable reasons to involuntary discharge a resident.

- ***Information provided by the facility to the receiving provider must include a minimum of the following:***
  - A. A Universal Transfer form with all fields completed including:
    - Contact information of the practitioner responsible for the care of the resident;
    - Resident representative information including contact information;
    - Advance Directive information;
    - All special instructions or precautions for ongoing care, as appropriate;
    - The comprehensive care plan goals
    - All other necessary information to meet the resident's needs
  - B. A completed discharge plan(see p. 9)

4. <u>Orientation for Transfer/Discharge</u>

This facility will provide and document in the medical record sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation will be provided in a form and manner that the resident can understand. This preparation/orientation will include:

- Trial visits if and when practical/possible
- Information on where the resident is going
- Information on how the resident will be transported
- Information on how valuables will be protected so that they are not lost during the process
- Informing the receiving facility of daily routines
- Making any appropriate referrals

Sufficient preparation and orientation mean the facility informs the resident where he or she is going, and takes steps under its control to minimize depression and anxiety. Examples of preparation and orientation may include explaining to a resident why they are going to the emergency room or other location or leaving the facility; working with family or resident's representative to assure that the resident's possessions (as needed or requested by the resident) are not left behind or lost; and ensuring that staff handle transfers and discharges in a manner that minimizes anxiety or depression and recognizes characteristic resident reactions identified by the resident's assessment and care plan.

IV. **NOTICE IN ADVANCE OF FACILITY CLOSURE**

In the case of facility closure, the individual who is the Administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

V. PROCEDURE PRIOR TO FACILITY-INITIATED:
ACUTE CARE EMERGENCY TRANSFERS, THERAPEUTIC LOA's, AND PLANNED HOSPITAL ADMISSIONS

1. **Notice Before Transfer**
2. **Permitting Residents to Return to the Facility**
3. **Not Permitting Residents to Return to Facility after a Hospital Stay**

1. Notice Before Transfer

When a resident is temporarily transferred on an emergency basis to an acute care facility, it is considered to be a facility-initiated transfer. **Before a nursing facility transfers a resident to the ER - - or the resident go*es* on therapeutic leave or has a planned hospital admission - the** nursing facility will provide written information to the resident and resident representative that specifies—

In cases of emergency transfers which don't allow for prior notification, the resident and the family, surrogate, or representative shall be provided with the written notification within 24 hours of the transfer.

A. The duration of the *state* bed-hold policy for hospital transfers, during which the resident is permitted to return and resume residence in the nursing facility (**NOTE:** At the time of this writing, it is the policy of the State of New Jersey that a Medicaid recipient's bed is to be held for a maximum of ten days.)

B. The reserve bed payment policy in the state plan (**NOTE:** At the time of this writing, the State of New Jersey will reimburse the facility for up to 24 days of therapeutic leave per calendar year.)

C. The nursing facility's policies regarding bed-hold periods

Bed-hold for days of absence in excess of the State's bed-hold limit and reserve bed policy, are considered non-covered services which means that the resident could use his/her own income to pay for continued bed-hold. However, if such a resident does not elect to pay to hold the bed, readmission rights to the next available bed are applicable. Additionally, non-Medicaid residents may be requested to pay for all days of bed-hold.

Copies of all Transfer-Discharge Bed Hold Notices issued to any resident/patient over age 60 must be provided to the Office of the Ombudsman.

For emergent care transfers, Information provided by the facility to the receiving provider must include a minimum of the following:

- A Universal Transfer Form
- Advance Directive Info
- Comprehensive care plan goals It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer.)

2. **Permitting Residents to Return to the Facility After:**

EMERGENCY ACUTE CARE / THERAPEUTIC LEAVE / PLANNED HOPSITAL STAY

This facility will permit residents to return to the facility after they are hospitalized or placed on therapeutic leave. If a resident's hospitalization or therapeutic leave exceeds the bed-hold policy under the State plan, the facility will:

A. Allow the resident to return as soon as a room/bed is available
B. Allow the resident to return to his/her previous room if it is still available
C. Allow the resident to return to an available bed in the particular location where he she resided previously. If a bed is not available in that location at the time of the resident's return, the resident will be given the option to return to that location upon the first availability of a bed there.

3. **Not Permitting Residents to Return to the Facility After a Hospital Stay / Therapeutic Leave**

Residents who are sent to the emergency room, go on therapeutic leave, or had a planned hospital stay will be permitted to return to the facility, unless they meet one of the criteria under which the facility can initiate discharge**.** Before denying readmission the facility will:

A. Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services;
B. Ascertain an accurate status of the resident's condition—this can/will be accomplished via communication between hospital and facility staff and/or through visits by facility staff to the hospital.
C. Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. However, before doing so the facility will:
    a. Work with the hospital to ascertain if changes can be made which would make it possible for the facility to readmit. For example, the facility may ask the hospital to attempt to reduce a resident's psychotropic medication prior to discharge and monitor symptoms so that the facility can determine whether it will be able to meet the resident's needs upon return.

If after completing the above tasks the facility still chooses to initiate discharge, all the non-emergency facility-initiated steps detailed on pp. 2-4 will be carried out.

If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the Office of the Ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, **unless there is documented 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. This facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending will not be based on the resident's condition when originally**

VI. RESIDENT-INITIATED TRANSFERS AND DISCHARGES

1. The medical record must contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility.
2. While a resident's expression of a general desire or goal to return home or to the community or the elopement of a resident who is cognitively impaired should be taken into consideration for the purposes of discharge planning and community placement, it should not be taken as notice of intent to leave the facility and does not constitute a resident-initiated transfer or discharge.

The facility will not treat situations where a resident goes on therapeutic leave and returns later than agreed upon, as a resident-initiated discharge. However, in such cases, if the facility feels readmission would not be appropriate based on one of the six criteria listed on p.1, the facility will comply with the requirements of involuntary discharges. Otherwise, the resident will be permitted to return and will be:

- Appropriately assessed for any ill-effects from being away from the facility longer than expected
- Provided with any needed medications or treatments which were not administered because they were out of the building.

If a resident has not returned from therapeutic leave as expected, the medical record should show evidence that the facility attempted to contact the resident and resident representative. The facility must not initiate a discharge unless it has ascertained from the resident or resident representative that the resident does not wish to return.

VII. ROUTINE DISCHARGE PLANNING

1. **The Discharge Care Plan**
2. **Informed Decision Making for Post-Acute Care Options**
3. **Discharge Summary/Plan**
4. **Discharge to Unsafe Setting**

1. The Discharge Care Plan

The discharge planning process begins at admission and is based on the resident's assessment, goals for care, desire to be discharged, and capacity for discharge; the discharge care plan will:

A. Be developed by the Interdisciplinary Team and involve direct communication with the resident, and when applicable, the resident representative;
B. Address the resident's goals for care and treatment preferences;
C. Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation and caregiver support (including capacity and capability), and education;
D. Ensure an effective transition from the facility to the discharge location and reduce factors that can lead to preventable hospital readmissions;
E. Be re-evaluated regularly and updated as the resident's needs or goals change;
F. Include an assessment of a resident's likely need for appropriate post-discharge services including nursing and therapy services, medical equipment, home modifications, or ADL assistance;
G. Be included in the residents medical record so that it can be used in establishing the final discharge plan;
H. Include assisting the residents, families, and/or reps with choosing post-discharge providers that will meet the resident's needs, goals, and preferences by (see Informed Decision Making below).

2. Informed Decision Making for Post-Acute Care Options

A. Assisting the resident/rep means the facility will compile and present available data on appropriate post-acute care options in an accessible and understandable format;
    a. For residents being discharged to another SNF/NF, HHA, IRF, or LTCH, the facility will provide evidence via documentation that the following provider information was given:
        1. Standardized Patient Assessment Data;
        2. Information on quality measures and resources data (where available).

Information the facility must gather about potential receiving providers includes, but is not limited to:

- ✓ Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and
- ✓ Resource use data, which may include number of residents/patients who are discharged to the community and rates of potentially preventable hospital readmissions.

B. The facility will include in discharge planning any interest the resident has in, and/or any referrals made to, the local contact agency, the ombudsman, and/or other appropriate entities
    a. Interest, referrals, and response to any referrals will be documented accordingly
C. For residents for whom discharge to the community has been determined to not be feasible, the medical record will contain information about who made that decision and the rationale for that decision.

3. <u>Discharge Summary/Plan for Routine and Non-Emergency Facility-Initiated Discharges</u>

When the facility anticipates discharge, a Discharge Summary/Plan will be created that includes at least the following:

The final discharge plan will be developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.

A. Indication of where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services.
B. All necessary medical information pertaining to the resident's current course of illness and treatment, post-discharge goals of care and treatment preferences;
C. A recapitulation of the resident's stay that includes, but is not limited to:
    1. Diagnoses
    2. Course of illness/treatment or therapy
    3. Pertinent lab, radiology and consultation results
D. A final summary/plan of the resident's status at the time of the discharge that will be released to any providers taking on the resident's post discharge care, as well as resident-authorized persons and agencies;
E. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); any discrepancies or differences found during the reconciliation will be assessed and resolved and the resolution documented in the discharge summary/plan, along with a rationale for any changes;
F. Discharge instructions and accompanying prescriptions (when applicable) provided to the resident and if appropriate, the resident representative , that accurately reflect the reconciled medication list in the discharge summary/plan;
G. Identification of the recipient.

A copy of the final Discharge Summary / Plan will be kept in the medical record.

4. <u>Discharge to Unsafe Setting</u>

Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will at minimum:

A. Discuss with the resident, (and/or his or her representative, if applicable) and attempt to ascertain why the resident is choosing that location;
B. Document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs;
C. Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;
D. Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;
E. Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary; the referral should be made at the time of discharge.

ADDITIONAL OPTIONS WHEN:

CONSIDERING DISCHARGING FOR NON-PAYMENT

In situations where a resident/patient's Medicare coverage may be ending, this facility will comply with the requirements at §483.10(g)(17) and (18), F582, specifically:

1. If the resident continues to need long-term care services, this facility, under the requirements above, will offer the resident the ability to remain, which may include:
   a. Offering the option to stay in the facility by paying privately for a bed
   b. If Medicaid-eligible, providing the necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:
      i. if denied Medicaid coverage, the resident will be responsible for payment for all days after Medicare payment ended; and:
      ii. If found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident will be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.

CONSIDERING DISCHARGE IN CASES WHEN A RESIDENT/PATIENT REFUSES TO LEAVE AT THE END OF SHORT-TERM SUB-ACUTE SERVICES

In certain cases, residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they may communicate that they are not ready to leave the facility; in these situations, all the same options above should be offered.

If after these options were provided - and any needed assistance offered - the resident refuses to leave - then the facility can maintain the option to proceed with a facility-initiated discharge and issue a 30-day notice.

INVOLUNTARY TRANSFER OF A MEDICAID BENEFICIARY

The purpose of this section is to specify the circumstances in which the involuntary transfer of a Medicaid beneficiary in a NF is authorized.

PERTINENT DEFINITIONS

Medicaid Beneficiary: A Medicaid eligible individual residing in a NF which has a Medicaid provider agreement. This includes Medicaid beneficiaries over the minimum number stipulated in the agreement or an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

Long-term Care Field Office (LTCFO): Implements nursing facility level regulations, policies, and procedures to ensure that Medicaid beneficiaries in need of long-term care receive quality services and appropriate service delivery in the least restrictive care setting.

1. This facility recognizes that a Medicaid beneficiary shall only be involuntarily transferred when adequate alternative placement, acceptable to the Department of Human Services is available.
2. A Medicaid beneficiary may be transferred involuntarily only for the following reasons:
    a. The transfer is required by medical necessity
    b. The transfer is necessary to protect the physical welfare or safety of the beneficiary or other residents
    c. The transfer is required because the resident has failed, after reasonable and appropriate notice, to reimburse the NF for a stay in the facility from his/her available income as reported on the PA-3L; or12 N.J.A.C. 8:85-1.10 4
    d. The transfer is required by the New Jersey State Department of Health and Senior Services pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider
3. Where a transfer is proposed, in addition to any other relevant factors, this facility will take the following factors into account:
    a. The effect of relocation trauma on the beneficiary
    b. The proximity of the proposed placement to the present facility and to the family and friends of the beneficiary
    c. The availability of necessary medical and social services as required by Federal and State rules and regulations
4. The procedure for involuntary transfer shall be as follows:
    a. After following all the required steps outlined in this policy, but prior to issuing the 30-day notice, this facility will submit to the LTCFO a written notice with documentation of its intention and reason for the involuntary transfer of a Medicaid beneficiary from the facility
        i. If the LTCFO determines that an involuntary transfer is appropriate, the beneficiary and/or the beneficiary's authorized representative will be given a 30 day and proceed accordingly per policy