

# SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES

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# SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES

## EXECUTIVE SUMMARY

### BACKGROUND AND SIGNIFICANCE

Change is difficult, particularly when one is forced to move to a new location. This is particularly true for vulnerable nursing home residents, most of whom already reluctantly left their homes to move into a long-term care facility and are now dependent on others for all aspects of their lives. For the 1.5 million people residing in the nation's 15,000 nursing homes, being forced to relocate is exceptionally challenging.

Nursing home closures are becoming more frequent, some voluntarily (i.e., owners or boards decide to close for many reasons) and some involuntarily (i.e., state or federal governments force them to close for care or safety issues). Both consumer preference for care in a community setting and state and federal government policy have driven these closings.

Nursing home closings can have serious negative effects on residents. Many residents experience transfer trauma (also referred to as relocation stress syndrome).<sup>1</sup> The response to the stress caused by a transfer or relocation may include depression, manifesting as agitation; increase in withdrawn behavior; self-care deficits; falls; and weight loss.<sup>2</sup> Closures, and these responses to the stress of moving are occurring nationwide, and may be due to the fact that the closure of nursing homes seems to be inadequately addressed in state and federal laws and regulations and/or poor oversight and monitoring by states and the federal government. When closures are inevitable, better policies and practices can be implemented to minimize the negative impact, including transfer trauma, on residents. Failure to protect dependent nursing home residents in these crisis situations undermines the entire framework of nursing home resident protections established in federal law.

### THE STUDY

Given the harm that nursing home closures can cause residents, this study's goal was to make recommendations to lessen or eliminate the possible negative effects on residents of closure.

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<sup>1</sup> Manion, P.S. & Rantz, M.J., *Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions*, 16 Geriatric Nursing, May/June 1995.

<sup>2</sup> Murtiashaw, S. *The Role of Long-Term Care Ombudsmen in Nursing Home Closures and Natural Disasters*, National Long Term Care Ombudsman Resource Center, National Citizens' Coalition for Nursing Home Reform (Now The Consumer Voice), January 2000. *Supported by U.S. Administration on Aging.*

## **Project Objectives**

1. Identify current obstacles to the implementation of well-planned, resident-centered discharge planning when a nursing facility closes, either voluntarily or involuntarily.
2. Identify policies, procedures and specific action to overcome these obstacles.
3. Identify “best practices” to achieve the implementation of well-planned, resident-centered nursing home closures.
4. Translate findings into recommendations for state and national policy makers and long-term care ombudsmen to achieve well-planned, resident-centered discharge when a facility voluntarily or involuntarily closes.

## **Methods**

### **Gathered Information from Stakeholders**

Through the use of on-line surveys, in-depth telephone interviews and archival resources, this study gathered information from those people either directly involved with nursing home closures or who are working with individuals who have been involved: representatives of provider associations, union representatives, representatives of ombudsman associations, state survey directors, a representative of the Centers for Medicare and Medicaid Services (CMS), state and local ombudsmen, organizational and independent advocates, and families and residents themselves. The surveys asked a series of questions related to what makes for a successful transition for residents, what obstacles are limiting this success, what the possible solutions are to overcome these obstacles, the stakeholders’ understanding of the role of the state and whether they believed state and federal requirements for closure are protective enough. This information was then aggregated, categorized and used to develop recommendations for conducting a successful transition for residents. One-on-one interviews posed similar questions, asking for more detail and explanation of ideas.

### **Developed Case Studies of States with “Best Practices” and a Case Study in one State Demonstrating “Poor Practice”**

Three states were selected for individual case studies based upon “best practices” related to nursing home closures. Information from representatives of groups (stakeholders) involved in nursing home closures in these three states was obtained by phone interview. These groups included state and local ombudsmen, state regulatory agencies, disability rights groups, rate setting agencies, providers, and mental health agencies. Each individual was asked a standardized set of questions to determine: their role in their state’s nursing home closure protocols; details about the closure process; how the process began; what they think is unique about their process; what they think are the strengths and weaknesses of their process; how they overcame any problems that arose; if there are any plans for changes; and if any financial resources are used. The case studies described each state’s current closure process and highlighted its best practices and future work.

The case study of an actual closure that led to a negative outcome for residents and families was developed after gathering relevant documents and conducting interviews with: the local ombudsman involved, a family member, an advocacy organization deeply involved in the closure and the follow up, and the state regulatory agency.

A summary of innovative practices from seven other states is also provided.

### *Findings from Surveys and Interviews*

One of the clear messages from the study is that state and federal oversight and enforcement must be stronger to both improve care before a facility is forced to close and to hold providers accountable for following the rules when a facility does close. The suggestion that we need better enforcement was raised repeatedly by those interviewed. Many of the ombudsmen, advocates, family members and residents thought that involuntary closures due to substandard care or immediate jeopardy would not happen if poor care practices were appropriately cited and remedies imposed in a timely manner. Some thought that the threat of closure by the State Survey Agency or CMS is used, and then rescinded, so often that providers don't believe they will ever be decertified or lose their licenses, and thus they continue to tell residents not to worry even when threatened with decertification. Then if the facility is actually forced to close for failure to establish compliance with standards, the residents and families are blindsided. Respondents felt that if enforcement action was taken earlier and more consistent, i.e. deficiencies accurately cited and categorized by scope and severity, the full range of available remedies imposed; and providers were held accountable with meaningful plans of correction developed and implemented to address deficiencies, care might improve before the facility is forced to close.

**Local Ombudsmen:** "...resident belongings being trashed-bagged up with no labels as to whom it belongs to." "Possessions, chart and meds not going with resident." "Residents sent without proper discharge paperwork." "Moving day chaos." "Families not knowing where residents are moved." "The closure was one of the worst experiences of my life!"

### *Findings from the First On-Line Survey and Interviews*

Responses from the first on-line survey, sent to State and Local Ombudsmen, residents, advocates, and family members, revealed the following:

- Nursing home closures are problematic for residents.

- Generally voluntary closures go more smoothly, although some ombudsmen, advocates, families, and residents found problems with voluntary closures.
- Success in voluntary closures must include ombudsman involvement, accurate information, and good discharge planning.
- Success for involuntary closures involves participation of the ombudsman and proper monitoring by the State.
- There are 6 (six) major obstacles to a successful transition for residents, both voluntary and involuntary closures:
  1. Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.
  2. Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.
  3. Lack of communication, including accurate communication, by providers.
  4. Poor notice/not enough time to find new placements.
  5. Staffing issues such as staff leaving, staff stress and bitterness.
  6. Transfer trauma.
- There must be better requirements for closure, more provider accountability and better state or independent monitoring are needed.
- The State should be more proactive and take the initiative in helping residents transition to both an appropriate and desired new home for care and services.

### *Ideas for Overcoming the Obstacles*

A second anonymous on-line survey was sent to all ombudsmen, advocates, families and residents who received the first survey. Respondents were asked to share any ideas they had to solve the problems or overcome the obstacles or barriers to a successful transition for residents raised by the majority of respondents in the first survey. Below is a table listing the obstacles and possible solutions they raised:

OBSTACLE	SUGGESTIONS TO OVERCOME
Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.	<ul style="list-style-type: none"> <li>• Give the receiving facility monetary incentives to take a resident.</li> <li>• More fines, regulations and oversight.</li> <li>• Encourage the receiving facility to take residents who are difficult to place.</li> </ul>
Lack of communication, including accurate information, with residents and families.	<ul style="list-style-type: none"> <li>• Obtain participation of the Ombudsman early.</li> <li>• Require new protocols and rules.</li> </ul>
Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.	<ul style="list-style-type: none"> <li>• Require an outside entity to conduct the discharge planning.</li> <li>• Ensure that ombudsmen participate in informing residents/families about rights, options.</li> <li>• Require that the State Ombudsman see and comment on closure plan before state approval.</li> <li>• Give the ombudsmen a list of all residents being moved, including what new location and when movement occurred.</li> <li>• Promulgate new rules related to how discharges are handled on day of transition.</li> </ul>
Staffing issues such as staff leaving, staff stress and bitterness.	<ul style="list-style-type: none"> <li>• Provide/require more training and education on closure issues.</li> <li>• Be sensitive to staff who may be frightened or bitter due to the closure.</li> <li>• Provide assistance and referrals for new job opportunities once the facility has closed.</li> <li>• Promulgate new rules related to staffing numbers, closure plans, staff payment accounts, state supplement of staff if needed, bonuses and severance pay.</li> <li>• Ensure effective enforcement, including fines, if resident care and quality of life is compromised due to inadequate staffing levels.</li> </ul>
Transfer trauma experienced by residents.	<p><b>BEFORE MOVE</b></p> <ul style="list-style-type: none"> <li>• Give residents control over where they move.</li> <li>• Prepare residents for relocation.</li> </ul> <p><b>AFTER MOVE</b></p> <ul style="list-style-type: none"> <li>• Assist residents in adjusting to new location.</li> </ul>
Poor notice/ not enough time.	<ul style="list-style-type: none"> <li>• Require more notice to residents and families of an impending closure.</li> <li>• Put notice rules into statute.</li> </ul>

## *Findings from Case Studies*

**Best Practice Examples:** Three state nursing home closure processes have been selected to highlight: Connecticut, Ohio and Wisconsin. All three have a number of innovative practices, some of which seem to respond to the obstacles to a successful transition for nursing home residents identified by the survey respondents. Wisconsin and Connecticut's case study focuses on their process with voluntary closures and Ohio's on involuntary closures.

All three states developed and continue to improve their systems by bringing together pertinent state agencies to focus on nursing home closures.

Ohio was selected because of its creation of a resident relocation team that meets to continuously communicate and develop solutions to problems in homes that may be threatened with closure; its advance work, long before a nursing home is forced to close, at the time a facility is in danger of being terminated from the Medicare and Medicaid programs; its focus on the least restrictive setting; its help for facility staff; and its significant follow up with all relocated residents.

Connecticut's best practice centers on its use of its certificate of need process. It can deny the ability of an owner to close a facility if it finds it is not in the public's best interest. In addition, the state requires a public hearing before it will make a decision to approve or disapprove a request by a facility to close. Lastly, the State Legislature passed a statute that mandates that the State Ombudsman send a notice to all residents at the same time the provider applies to the state for approval to close to explain rights that residents have. Thus, they will get this notice at the same time they learn the possibility of closing.<sup>3</sup>

Wisconsin, the third best practice state, has put all its closure rules in statute which gives residents more protections. It has created a "relocation specialist" within the Office of the State Ombudsman who gets involved whenever five or more residents are moved and in all closures in the state; it has developed a relocation team comprised of relevant state, local and advocacy agencies; it has held "lessons learned" meetings to discuss what it has learned from complicated closings; and has put a major focus on transfer trauma and staffing issues, developing a detailed manual for providers addressing these issues.

**Poor Practice Example:** Also highlighted is a case study of an involuntary closing in New York State that demonstrated practices which resulted in significant negative experiences for residents. Residents and family members were provided inadequate or inconsistent information about the facility's closure and thus had little time to find appropriate alternate placements; local facilities were permitted to refuse to accept certain residents, resulting in a number of residents being sent a significant distance from friends and family; residents were

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<sup>3</sup> Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman's Notice to Nursing Home Residents.

not provided with a choice of facility, but instead were pushed to accept any open bed, or placement in poor performing facilities.

## DISCUSSION

The state case studies reinforce the data collected in the on-line surveys and the one-on-one interviews. Many of the obstacles to a successful transition for nursing home residents have the potential to be overcome by the processes in the best practice states.

The state case studies reinforce the data collected in the on-line surveys and the one-on-one interviews, as they show that several of the obstacles to a successful transition for nursing home residents have the potential to be overcome by the implementation of specific processes and requirements at the state level, and from quick and concerted action by the appropriate State Agencies and the Long-Term Care Ombudsman Program. Developing processes for timely communication with residents and families, delineating roles and responsibilities for all state agencies, creation of state-developed closure manuals that outline the processes to be followed by the closing facility, as well as the state agencies and programs overseeing the closure, are all strategies being employed by states to assure that a nursing home closure occurs with the least amount of negative impact on residents as possible.

Through the data collection and analysis, and interviews with state program representatives, we were able to identify a range of recommendations for CMS, for State Agencies, and for State Long-Term Care Ombudsman Programs that would enhance protections for residents facing relocation, and help better prepare them for the moving experience.

## RECOMMENDATIONS FOR CMS

On March 19, 2013, CMS finalized its requirements for long-term care facilities closures.<sup>4</sup> In response to public comments urging more specific requirements, CMS stated, “We appreciate the commenter's suggestion; however, we do not believe it is necessary to include specific requirements for the plan in the regulation text. We want to allow each LTC facility the flexibility to develop a plan that would most effectively protect the residents' health, safety, and well-being.”

**The experiences of our study respondents and interviewees - residents, family members and ombudsmen - clearly indicate that more specific requirements are indeed necessary.**

Although the final rule states that “the administrator (must) include in the written notification of closure assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs,

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<sup>4</sup> <https://www.federalregister.gov/articles/2013/03/19/2013-06276/medicare-and-medicaid-programs-requirements-for-long-term-care-ltc-facilities-notice-of-facility>.

choice, and best interests of each resident;” and, “the plan must include assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident,” **we found that in many cases this does not happen. Far too often the closure process forces residents to move to locations they do not choose or want.**

**We therefore make the following recommendations that CMS require of the state regulatory agency:**

***General Recommendations:***

**1. Require states to develop a coordinated state team focused on closure and relocation.**

We recommend requiring states to develop a “relocation team,” consisting of all relevant state agencies/programs, including the regulatory agency, the Office of the State Ombudsman and the agency that deals with community care, or manages the Money Follows the Person (MFP) program. This team should create a state closure protocol and manual defining the different roles of each agency, the specific closure process, the responsibilities of the closing facility, the responsibilities of the receiving facility and the rights of residents and family during a closure. The team should meet regularly regardless of whether there is a closure pending. The model described in the Ohio case study should be followed.

**2. Require states to include the State Ombudsman in the closure plan review and require the state to consider State Ombudsman comments before its approval of the plan.**

Our study indicated that one of the most important elements of a successful transition for nursing home residents is active participation of the long-term care ombudsman.

**3. Make available Civil Money Penalty funds to support residents during the closure process.**

Federal law permits the use of Civil Money Penalty funds to be used to support and protect residents of a facility that closes or is decertified. These funds should be used to support state efforts to more effectively plan for and coordinate the closure process by, for example, establishing a Relocation Team, or developing a closure manual. Additionally, the funds should be made available if needed during the closure process for assisting residents’ transition to other facilities or home and community based settings, or in some instances, to impose a management oversight company or temporary manager to oversee the closure.

#### **4. Provide clarity to state licensing and certification agencies about their role in closures.**

Federal law requires the state survey agency to approve a nursing facility's closure plan, but based on responses to the surveys by ombudsmen, advocates, and survey directors on state closure processes, and interviews with directors of state licensing agencies, CMS should provide additional clarity through guidance and training as to the role of the state survey agency during the closure process, which should include not only approval of the closure plan, but also oversight of the plan's implementation, including protection of the rights of the residents forced to move.

#### ***Recommendations Addressing Obstacles to a Successful Transition<sup>5</sup>:***

- 1.** Require that any facility, chosen by the resident, which has a vacancy but chooses not to admit her/him, must document and send to the state the reasons for this denial.

If the facility claims it is unable to care for the resident, the facility must identify specifically which care needs they are unable to meet and why. The state must evaluate the reasons presented by the facility. If the state agrees that the reasons for the denial are legitimate, it must be proactive and try to find a solution to the problem. Refusing facilities should be urged to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs

We further recommend that if the state determines that the documentation presented seems to be a violation of Civil Rights laws, the state must issue a citation that leads to a significant fine. To come back into compliance, the facility must a) admit the resident who was denied admission (if the resident still wishes to live in the facility); and b) change its admission policy to fully comply with the federal Civil Rights laws.

- 2.** Require states to bring in independent discharge planners, hire a management company, or apply for a receivership, if complaints by residents, families and ombudsmen and on-site monitoring by state agencies indicate a lack of appropriate discharge planning on the part of closing facility staff.
- 3.** Require a state to develop a system for residents and families to file complaints about the closure process and receive an immediate response; review all complaints received during the closure to identify problems; perform root cause analysis; make improvements based on analysis; and submit complaint review/analysis to CMS.

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<sup>5</sup> Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

4. Require states to develop a closure manual for providers, which include checklists of tasks they must carry out before any resident is transferred.
5. Require on-site monitoring of the closing facility by the relocation team described above.
6. Require the regulatory agency to hold a facility accountable, through a citation and fine, for knowingly providing inaccurate information regarding closure to residents and families.
7. Make mandatory for providers each of the tasks listed as guidance in the interpretive guidelines. As noted above, our study indicates that many providers are not doing them voluntarily; thus they must be mandated.
8. Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If the state or CMS is concerned about poor care in the closing facility, or the owner runs out of funds, the state must be prepared to impose a receiver, use the federal temporary management remedy in federal law, or hire a management company to manage facility operations.
9. Require a facility to notify all residents and families of an involuntary impending closure at least 60 days before the closure. Currently, the requirement of 60 days is only for a voluntary closing; the Secretary will determine the appropriate time for an involuntary closing. If the Secretary determines the facility must be decertified in less than 60 days because residents are at risk, CMS must require the state to take over the facility in a receivership, use the federal temporary management remedy in federal law, or require the facility to hire independent overseers to monitor and care for residents until all are transferred to an appropriate location of their choosing. Medicaid/Medicare funding must be continued during the relocation process as required under § 488.450.
10. Require the state relocation team to focus on the needs of staff by notifying the State Departments of Labor to help with unemployment insurance and finding a new position.
11. Require the facility closure plan to include how the facility will make sure that there is enough staff to care for the residents and how it may help staff find new employment.
12. Require the facility to report, on a daily basis, the number of registered nurses, licensed practical or vocational nurses and certified nursing assistants providing direct care and also the resident census for each shift to the state relocation team or regulatory agency to ensure adequate staffing.

13. Require the state to hire additional outside staff if necessary, paid for by the closing facility.
14. Require that the facility closure plan submitted to the state delineate how the closing facility will attempt to lessen any transfer trauma.
15. Require both closing and receiving facility to undertake specific tasks to lessen transfer trauma.

## RECOMMENDATIONS FOR STATES<sup>6</sup>

### *General Recommendations:*

1. Create a “relocation team,” consisting of all relevant state agencies/programs, including the regulatory agency and the Office of the State Long-Term Care Ombudsman to a) meet on a regular basis; b) establish a formal state closure process; c) develop a manual that defines roles, responsibilities and timeframes; d) discuss any problems related to closures; and e) be on-site during a closure.
2. Post on the state regulatory agency’s website, the State’s requirements and processes around closure, including requirements of providers, rights of residents, and tasks and responsibilities of the relocation team.
3. Pass legislation to codify the state closure process, including provider requirements, residents’ rights; and relocation team tasks.
4. Develop a system for residents and families to file complaints about the closure process and receive an immediate response; review all complaints received during the closure to identify problems; perform root cause analysis; make improvements based on analysis; and submit complaint review/analysis to CMS.
5. Use Civil Monetary Funds (CMP) to support a successful transition for residents in those instances where the closing facility is unable to fund such activities.
6. Introduce and pass a requirement that a public hearing be held before a facility can voluntarily close to assess the impact of the closure on the nursing home community and the community at large.
7. Pursue sanctions as required under 42 CFR 488.446 against the nursing home administrator if he or she fails to comply with the state and/or federal closure requirements and make necessary changes in state law to hold owners accountable.

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<sup>6</sup> “State” encompasses the State Legislature, Licensing/Regulatory agency, Medicaid Agency, State Administration

### *Recommendations Addressing Obstacles to a Successful Transition<sup>7</sup>:*

1. Introduce and pass laws permitting residents to be admitted to the first available bed in the facility of their choice and to move to a temporary location until a bed opens up.
2. Require facilities to document, in writing, the reasons for not wanting to accept a resident and work with them to find a solution.
3. Work with the relocation team to identify an appropriate placement that is to the satisfaction of the resident.
4. Establish a real time list of open beds in the surrounding area of the facility that is closing and have it accessible to the relocation team.
5. Develop a uniform notice to be sent by providers to all residents and family members that includes: the reason for the closure, the specific steps the facility will take to close, the rights that residents have to choose a new home, the name and contact information of the local ombudsman and the contact information for filing complaints.
6. Require that a letter/notice from the relocation team or from the State Ombudsman, be sent to all residents and family members at the same time the provider is required to send them a notice. The letter/notice from the Ombudsman must explain the closure process and the rights that residents have, including the right to choose their new home.
7. Coordinate discharge planning from an independent planner if a determination is made that the planning is inadequate. The cost should be borne by the closing facility.
8. When the State survey agency finds that the closing facility does not take into consideration the needs, choice, and best interest of each resident as part of the closing planning and implementation process, it should issue a deficiency citation and require the facility to take immediate steps to remedy the situation.
9. Require that the relocation team meet regularly with and provide written updates on the status of the closure to residents and families.
10. Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If the state believes that the facility must close due to poor care, or the owner runs out of funds, the state must take over the facility through a receivership or if the state does not have a receivership statute, it must bring in a management company (paid for by the closing facility) or use the federal temporary management remedy in federal law.
11. Ensure continued Medicare and/or Medicaid payments until residents are successfully relocated.
12. Require the closing facility to report staffing on each shift each day to make sure they have adequate staff to care for the residents.
13. Require the closing facility to hire contract staff if needed.

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<sup>7</sup> Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

14. Notify the state Department of Labor to help staff with filing for unemployment, writing resumes, etc.
15. Consider a tax on ownership licenses to fund a staffing account that might give bonuses to staff that remain until closure.
16. Encourage facilities to hold job fairs for staff of closing facilities.
17. Require all facilities to train staff on transfer trauma.
18. Require the receiving facility to develop a plan to minimize transfer trauma for residents being admitted from the closing facility.

## **RECOMMENDATIONS FOR LONG-TERM CARE OMBUDSMEN**

### ***General Recommendations:***

1. Educate all ombudsman program representatives on state and federal closure rules.
2. Develop a formal written protocol for closure detailing the role of the state and local ombudsmen and how they will work with other state agencies.

### ***Recommendations Addressing Obstacles to a Successful Transition<sup>8</sup>:***

1. Check records of those residents being refused admittance to make sure they are up-to-date so potential facilities or locations can make an accurate assessment.
2. Urge refusing facilities to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs.
3. File a discrimination complaint with the Civil Rights Division of the U.S. Department of Health and Human Services and/or your state civil rights division if applicable if you feel that a resident is being discriminated against on the basis of his/her disability.
4. Share information with residents and families detailing:
  - a. What should be included in appropriate discharge planning.
  - b. Residents' rights throughout the closure process.
  - c. Where to file a complaint or get help.
  - d. Information on how families can help prevent or minimize transfer trauma in residents.
  - e. Residents' rights, including but not limited to the right to have needs and choice taken into consideration; receive appropriate discharge planning; and be included in discharge planning.

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<sup>8</sup> Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

5. Designate a member of the State Ombudsman Office as a relocation specialist to coordinate ombudsman activities related to the closure; train, mentor, and assist local ombudsmen on closures; and oversee closures and certain relocations that might cause resident distress or disorientation.
6. Develop a letter for residents and families describing the closure process, explaining rights and giving ombudsman contact information. This letter should be sent to all residents and families members of the closing facility at the same time the provider announces the closure.
7. Meet one-on-one with each resident or family member to discuss the closure process and their rights either as part of the relocation team or separately. Bring together residents and families in a group with all state agencies to discuss the closure, residents' rights, and to answer any questions.
8. Advocate for facility to remain open until all residents have been relocated to an appropriate location of their choosing.
9. Urge the passage of legislation permitting long-term care ombudsmen to file a request for receivership.
10. Advocate with the corporation of the closing facility (when applicable) for staff to be hired at sister facilities.
11. Advocate with nursing home administration to provide staff with a list of employment resources.
12. Develop in-service training for staff on transfer trauma with input from residents.
13. Create a list of tips for what staff and family can do to help alleviate transfer trauma.
14. Conduct follow-up visits after the relocation to see how residents are doing and provide continuity to residents.
15. Determine the facility's process for tracking residents' belongings to ensure they are moved to the new location with the resident.

## QUESTIONS FOR FUTURE RESEARCH

There continue to be stories reported relating to challenging nursing home closures, including a recent example in which a New York nursing home was closed, without notice to the State, in order to repurpose the land on which the nursing home sat for luxury housing<sup>9</sup>. Continued examples raise additional questions that should be addressed by future research.

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<sup>9</sup> <http://www.wnyc.org/story/nursing-home-de-blasio-flouted-state-rules/>.

# SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES

## BACKGROUND AND SIGNIFICANCE

### Introduction

Nursing homes are closing. Change is difficult, particularly when one is forced to move to a new location. This is particularly true for nursing home residents, most of whom have already reluctantly left their homes to move into a long-term care facility, leaving family and friends, perhaps even a spouse, now being dependent on others for all aspects of their lives. For these 1.5 million people residing in the nation's 15,000 nursing homes, being forced to relocate is exceptionally challenging. Residents reside in a facility that not only provides comprehensive living and healthcare services, but is also their home where they eat and sleep, and their community where they are seen and visited by family and friends. When a facility closes, a great deal is at stake for each of these individuals, their families and the community connections they have. It means starting over, but in a way that for long-term residents is total and at a time when the individual is usually highly compromised and challenged to cope with change. They will face entirely new care workers and nurses, an entirely new community of people, a new arrangement of administrators and service providers, a new location, new routines – and they may be moved to a distant facility far from their family and friends. Just the announcement of a possible closing can cause major upset for residents.

### Transfer Trauma

Transfer trauma, “A wave of disorientation and despair so intense that it can kill,”<sup>10</sup> can affect all residents, whether they are legally competent or not. One state statute defines transfer trauma as “the combination of medical and psychological reactions to abrupt physical transfer that may increase the risk of grave illness or death.”<sup>11</sup> The terminology to identify the effects of relocation has been referred to by many names such as translocation syndrome, transfer stress, transfer shock, transfer anxiety, or transfer trauma. In 1992, “relocation stress syndrome” was approved as a formal nursing diagnosis and is defined as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.”<sup>12</sup> The response to the stress caused by a transfer or relocation may include depression, manifesting as agitation; increase in withdrawn behavior; self-care deficits; falls; and weight loss.<sup>13</sup> When faced with

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<sup>10</sup> Manion, P.S. & Rantz, M.J, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995.

<sup>11</sup> Me.Rev.Stat.Ann. title 22, section 7932 (West 1983).

<sup>12</sup> Manion, P.S. & Rantz, M.J, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995.

<sup>13</sup> Murtiashaw, S. The Role of Long-Term Care Ombudsmen In Nursing Home Closures And Natural Disasters,

relocation, residents with dementia (the majority of nursing home residents<sup>14</sup>) are often confused and do not understand what is happening. Many will suffer transfer trauma. An individual with this trauma may be at risk for isolation and depression, anxiety, resistance to care, and similar behavior disturbances. These behavior disturbances may then be treated with atypical psychotropic drug therapies which come with many side effects and have been determined by the FDA to be dangerous for elderly persons with dementia.<sup>15</sup>

Other residents, understanding that they are moving to a new facility, also can experience transfer trauma that can manifest itself through high anxiety and depression. They wonder: What will the new facility be like? What will the staff be like? What if no one will understand my needs? What if nurses and nurse aides do not answer my calls? Who will I share a room with? What if my roommate and the people I live with are unfriendly or are all suffering from dementia, calling out, and hard to live with? Will the new facility have my medications? What will happen to my clothes and possessions? Will my family be able to find me or visit me? And many other questions.

When their nursing home closes, dependent residents are likely to feel helpless, hopeless, uncared for, powerless and abandoned. Closures, and the negative responses to the stress of moving, are occurring nationwide and result from economic and other factors, as well as the fact that the closure of nursing homes seems to be inadequately addressed in state and federal laws and regulations and/or poor oversight and monitoring by states and the federal government. When closures are inevitable, better policies and practices can be implemented to minimize the negative impact, including transfer trauma, on residents. Failure to protect dependent nursing home residents in these crisis situations undermines the entire framework of nursing home resident protections, places residents at risk and does not hold facilities accountable for appropriate care planning and management. Instead, it promotes disregard by providers of residents' needs, preferences, and choice.

## **Nursing Homes Are Closing and Will Continue to Close**

Based on changes in the delivery of long-term services and supports, it is likely that more and more nursing homes will be closing, some voluntarily (i.e., owners or boards decide to close for many reasons) and some involuntarily (i.e., state or federal governments force them to close for care or safety issues). Both consumer preference for community and home care and state and federal government policy have been major factors in these closings. Consumers

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National Long Term Care Ombudsman Resource Center, National Citizens' Coalition for Nursing Home Reform (now The Consumer Voice), January 2000. *Supported by U.S. Administration on Aging.*

<sup>14</sup> Over 63 percent of nursing home residents have moderate to severe cognitive impairment (2012). See, CMS Nursing Home Compendium - [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium\\_508.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf).

<sup>15</sup> Warchol, Kim, "Transfer Trauma" - A Real Issue for Many Individuals With Dementia," November 12, 2010. <http://www.crisisprevention.com/Resources/Article-Library/Dementia-Care-Specialists-Articles/Transfer-Trauma-A-Real-Issue-for-Many-Individuals>.

overwhelmingly want to remain in their own homes<sup>16</sup> and have demanded options other than nursing homes for receiving care. State and federal programs such as Money Follows the Person (MFP) and Medicaid waivers have increased access to home and community-based long-term services and supports for many individuals. In addition, as Medicaid managed long term care becomes more prevalent, an increasing number of Medicaid residents will be urged to receive services and supports in the community as managed care plans try to keep costs down and meet the desires of consumers.

These trends are resulting in fewer financial resources for nursing homes. Studies and newspaper articles<sup>17</sup> show how declining resources can lead to staff cuts and then to poor care for remaining residents, factors which may result in more voluntary and involuntary closures. Residents who are already suffering from poor care then suffer again when they receive inadequate discharge planning that fails to make sure their relocation goes smoothly and meets their needs and wishes.

### Nursing Home Closings Can have Negative Effects on Residents

Studies<sup>18</sup> have long demonstrated the negative effects of poorly planned nursing home closures on the health and well-being of nursing home residents and their family members. One study reviewed the impact of relocation between 2000 and 2012 and found that, “Ill-planned or casually implemented closures and relocations are stressful and linked to adverse outcomes in terms of symptoms, health and survival. Yet when carefully planned and managed, closures in some studies are linked to better outcomes than disorderly relocations.”<sup>19</sup>

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<sup>16</sup> [http://assets.aarp.org/rgcenter/health/fs\\_hcbs\\_hcr.pdf](http://assets.aarp.org/rgcenter/health/fs_hcbs_hcr.pdf).

<sup>17</sup> Jessica, P.S., Burwell, K.B. and Gold, L., The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. July 2012, prepared for the Centers for Medicare & Medicaid Services (CMS), Disabled and Elderly Health Programs Group under Contract #: HHSM-500-2005-00025I, Task Order No. 0002, [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP\\_White\\_paper\\_combined.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf); “Impact of Payment Reductions on Nursing Facilities,” *Care Context*, The Alliance for Nursing Home Care, Spring, 2012; “Medicare, Medicaid Cuts Squeeze Skilled Nursing Margins,” *HealthCare Payer News*, July 16, 2013; “The Coming Nursing Home Shortage,” January 26, 2012; Pilon, M. “Latest bankruptcies highlight nursing homes’ continued struggles,” *Hartford Business.com*, August 29, 2016, <http://www.hartfordbusiness.com/article/20160829/PRINTEDITION/308259939/latest-bankruptcies-highlight-nursing-homes-continued-struggles>; and Houston, W. “State to review closure of three local nursing homes,” *Eureka Times-Standard*, August 25, 2016, <http://www.times-standard.com/article/NJ/20160825/NEWS/160829923>.

<sup>18</sup> Friedman, S. et al, “Increased Fall Rates in Nursing Home Residents After Relocation to a New Facility,” *Journal of American Geriatrics Society*, Vol. 43(11), pp. 1237-1242 (1995), Rogers, J.C. et al, “Functional Health Status of Relocated Nursing Home Residents,” *Journal of American Board of Family Practice*, Vol. 33, pp. 157-162 (1990), Inter-Institutional Relocation and Its Effects on Health, *supra* at 286 (citing N. Bourestom & L. Pastalan, The Effects of Relocation on the Elderly: A Reply to Borup, J.H., Gallego, D.T. & Heffernan, P.G., 1 *Gerontologist* 4 (1981).

<sup>19</sup> Jacquetta M Holder and David Jolley (2012). “Forced relocation between nursing homes: residents' health outcomes and potential moderators.” *Reviews in Clinical Gerontology*, 22, pp 301-319.

In addition to being well-planned, a nursing home closure plan must be “resident-centered.” According to the Centers for Medicare and Medicaid (CMS), it must assure “...that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.”<sup>20</sup>

Newspaper coverage<sup>21</sup> of some closings indicates problems that both residents and families may face, such as residents being sent far away because nursing homes closer are permitted to refuse to take a resident even if there are appropriate vacancies. These problems show that resident-centered plans are not being implemented for many residents. When other nursing homes do not want to take residents who they may consider “a problem,” residents may also be transferred to other poor performing facilities, who are willing to take them.

## THE STUDY

Given the harm that nursing home closures can cause residents, this study’s goal was to make recommendations to lessen or eliminate the possible negative effects on residents of closure.

### Project Objectives

1. Identify current obstacles to the implementation of well-planned, resident-centered discharge planning when a nursing facility closes, either voluntarily or involuntarily.
2. Identify policies, procedures and specific action to overcome these obstacles.
3. Identify “best practices” to achieve the implementation of well-planned, resident-centered discharge planning.
4. Translate findings into a report and other materials and resources geared to state and national policy makers and influencers to achieve well-planned, resident-centered discharge when a facility voluntarily or involuntarily closes.

### Methods

Through the use of on-line surveys, in-depth interviews, and archival resources, the study gathered information from long-term care ombudsmen (local and state), advocacy groups, residents, family members, state survey directors, provider representatives, a representative of CMS, representatives of the Service Employees International Union (SEIU), a representative of

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<sup>20</sup> Final Regulations (March, 2013) from CMS: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-19/pdf/2013-06276.pdf>.

<sup>21</sup> <http://blogs.mprnews.org/ground-level/2013/11/nursing-home-closure-rocks-small-town-of-hoffman/>; Singer, P., “Democrat and Chronicle,” March 15, 2014; and Van Zandt Newspapers, August, 2013, <http://vanzandtnews.com/heritage-manor-residents-to-find-new-homes/>.

the National Association of State Long Term Care Ombudsman Programs (NASOP), and a representative of the National Association of Local Long Term Care Ombudsmen (NALLTCO).

## 1. On-line Surveys

Three online surveys were created and distributed.

### *On-Line Survey One: Ombudsmen, Advocacy Groups, Residents, Family Members*

An on-line survey was developed and pilot tested for state and local ombudsmen, residents, family members and other advocates. The intent of the survey was to find out their experiences with nursing home closures and identify what makes these closures successful or unsuccessful for nursing home residents. In addition, we wanted to see whether there were differences between involuntary and voluntary closures. The questions were asked in a variety of ways to determine obstacles and how to overcome them.

Using the database from the National Consumer Voice for Quality Long-Term Care, requests to fill out the anonymous on-line survey were sent to state (52) and local (1062) ombudsmen, 64 nursing home residents, 252 family members and 101 members of citizen advocacy groups.

- 175 individuals participated in the survey:
  - 23 State Ombudsmen and 2 assistant state ombudsmen
  - 90 Local Ombudsman
  - 18 family members
  - 7 nursing home residents
  - 22 members of advocacy organizations and independent advocates

At least 28 states were represented (since the survey was anonymous, we cannot be sure which states were represented unless the respondent identified the state).

### *On-line Survey Two: Solutions: Ombudsmen, Advocacy Groups, Residents, And Family Members*

A second on-line survey was developed using data from the first survey. Respondents were asked to think of solutions to the six obstacles to a successful closing identified by respondents on the first survey. Fifty-two individuals responded to this survey.

### *On-Line Survey Three: Survey Directors*

A short survey was created for survey directors. It was distributed through their association, the Association of Health Facility Survey Agencies (AHFSA), and through a list of survey directors found on the internet. Three solicitations were made and six state survey directors participated in the anonymous online survey. The low participation in this survey after numerous attempts to solicit responses may indicate that those who participated were those who were most interested in the issue of nursing home closures. This number, while quite low, does provide information about how these six directors see their role in closures. Questions were asked about both voluntary and involuntary closures. Demographic information was not requested on this survey.

## 2. Individual In-Depth Phone Interviews

Additional information was elicited through phone interviews with the individuals listed below. Interviews ranged from 30 to 60 minutes. For those individuals who responded to the first on-line survey discussed above, the interview focused on more details related to their answers. For those who were not survey respondents, the questions were similar to those on the survey with more time for in-depth responses.

- 16 ombudsmen (5 state and 11 local)
- 2 nursing home residents
- 1 family member
- 3 members of advocacy organizations
- 1 representative from NASOP
- 1 representative from NALLTCO
- 2 representatives from SEIU
- 1 representative of the American Health Care Association (the for-profit nursing home trade association)
- 1 representative of Leading Age (the non-profit nursing home trade association)
- 2 private practice lawyers working in the area of nursing home closures
- 1 representative from CMS

## 3. Case Studies of “Best Practice States”

Respondents to the first online survey were asked if they thought their state was a candidate for one of the “best practice states.” If they said yes, they were asked to explain why they believed that. The identified states were researched to see what might make them a best practice state. Public information on all other states was also researched for possible inclusion. While a number of states<sup>22</sup> may have been excellent choices for a best practice state, the three selected highlighted different best practices. Information from representatives of groups involved in nursing home closures in these three states selected for their best practices related to nursing home closures were obtained by phone interview. These groups included state and local ombudsmen, state regulatory agencies, disability rights groups, rate setting agencies, regulatory agencies, providers, and mental health agencies. Each individual was asked a standardized set of questions to determine: their role in their state’s nursing home closure protocols; the closure process itself; how the process began; what they think is unique about their process; what they think are the strengths and weaknesses of their process; how they overcame any problems that arose; if there are any plans for changes; and if any financial resources are used. The case studies described each state’s current closure process and highlighted its best practices and future work.

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<sup>22</sup> You will find information on some of these other states in the Appendix.

#### 4. Case Study of a “Poor Practice” Closing

The case study of an actual closing that led to negative outcomes for residents and families was developed after gathering relevant documents and conducting interviews with: the local ombudsman, a family member, an advocacy organization deeply involved in the closure and the follow up, and the state regulatory agency.

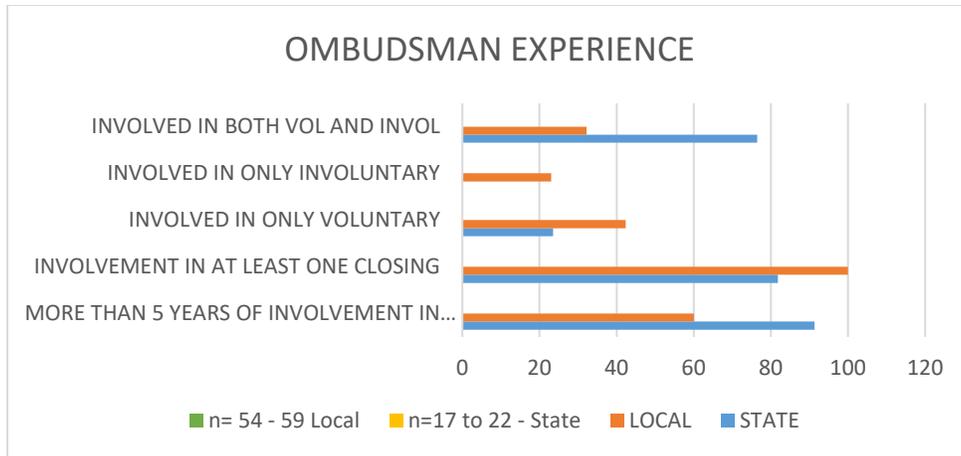
## Demographics of Respondents

### On-Line Respondents Are Experienced and Knowledgeable

#### *Ombudsmen*

The ombudsmen that participated in the survey had served as ombudsmen for several years and were very experienced with nursing home closures. Ninety-one (91) percent of the state ombudsmen and almost eighty (80) percent of the local ombudsmen who participated in the survey had more than five years’ experience. Over eighty-two (82) percent of the state ombudsmen had been involved in a closing, with sixty-nine (69) percent of these involved in more than three closings. Sixty (60) percent of the local ombudsmen had been involved in closings, with forty-five (45) percent of those involved in three or more closings. In addition, one state ombudsman who had not been involved in a closing stated she had information, gathered from media and family stories, to share, and five local ombudsmen who had not been involved stated that they had information to share from others – colleagues, family of residents, residents, ombudsmen, state officials, and the media.

Most of these closings were recent. Eighty-six (86) percent of state ombudsmen said that homes had closed in their state within the last three years, as did sixty-eight (68) percent of the local ombudsmen. These ombudsmen were experienced in both voluntary and involuntary closures: seventy-six (76) percent of state ombudsmen who were involved with closings were involved with both voluntary and involuntary closings, and thirty-two (32) percent of local ombudsmen were also involved in both. An additional twenty-two (22) percent of those local ombudsmen involved with closures were involved with involuntary closures and forty-three (43) percent with voluntary closures.



*\*Note – No responding State Ombudsmen indicated that they only had been involved with involuntary closures*

### Advocacy Groups

Of the fourteen representatives of advocacy groups who responded, thirteen were involved with nursing homes for over 5 years; six were involved in at least one nursing home closure, while one had information to share from a family member. Of the six involved in closures, four were involved in one; one was involved in two; and one was involved in more than three. Three advocacy group representatives were involved in voluntary closures, and four were involved, or had information from families or news media, in involuntary closures.

### Independent Advocates

Of the eight independent advocates participating (individuals advocating without being a staff member of an organization), all had more than five years' experience with nursing homes. Three had direct experience with at least one closure, and two had experience to share from news media. Two of the three that had experience with closings had experience with more than three closings; these closings were both voluntary and involuntary.

### Residents

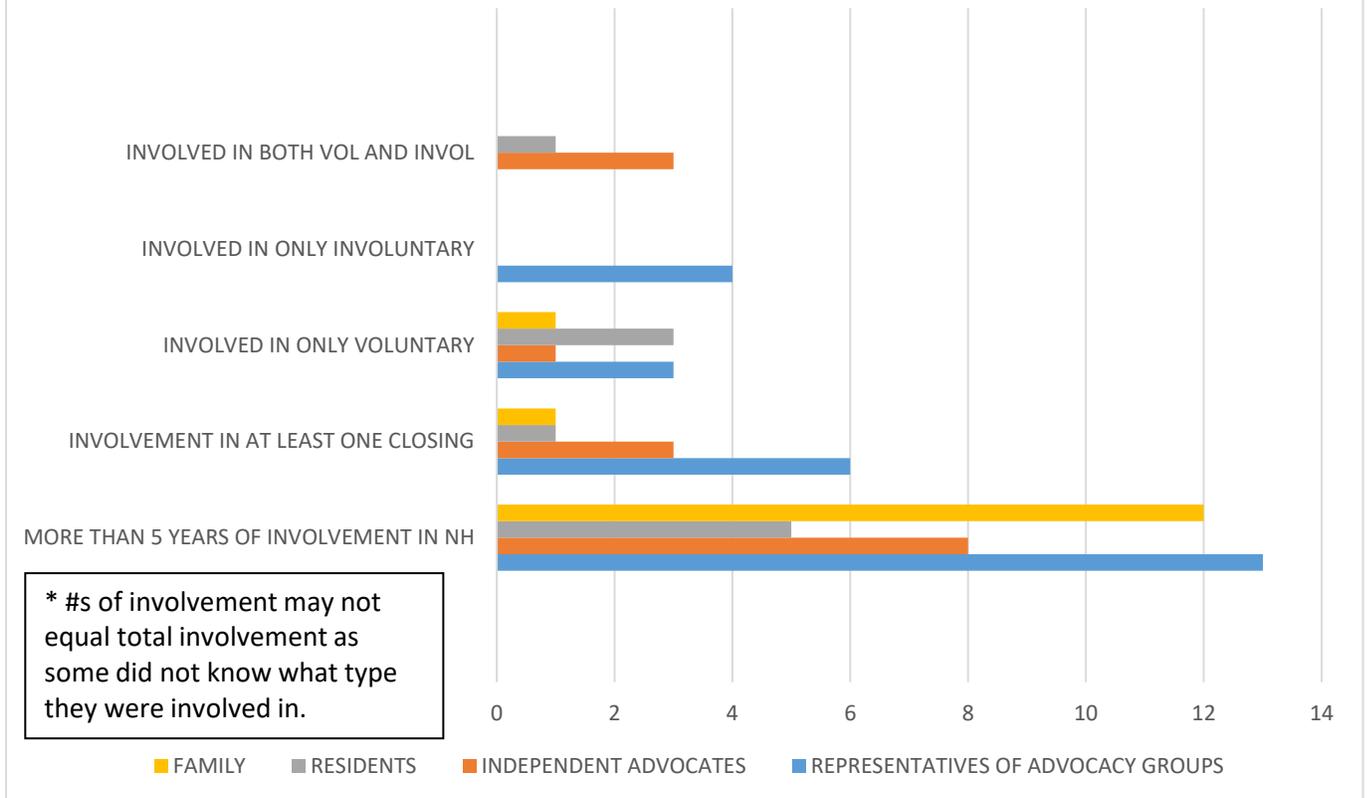
Five of the seven residents participating were involved with nursing homes for over 5 years. Although only one resident said s/he was involved in a closing, 3 residents said they were involved in only a voluntary closing and one said she was involved in both voluntary and involuntary. Perhaps the discrepancy is explained by the fact that the question asking if they were involved in a closing was skipped by some.

### Family

Of the 18 family members that participated, twelve had at least 5 years' experience with nursing homes. Only one responded that s/he was involved in a voluntary closing.<sup>23</sup>

<sup>23</sup> Most of the information from families comes from interviews.

## EXPERIENCES OF ADVOCATES, FAMILIES AND RESIDENTS\*



## FINDINGS

Listed below are all the findings gathered/generated from our surveys, interviews, and case studies. The recommendations, based on these finding, at the end of the report are the ones that we deemed, at this point, without further research, are practical and achievable. Some of these suggestions will need further research. Further, we are defining a successful closure as one with a comprehensive, organized, and acceptable plan in place which includes residents’ receipt of person-centered discharge planning that results in their moving to appropriate locations of their choosing as often as possible, and that negative impact on residents is minimized.

### On-Line Survey One: Ombudsmen, Advocates, Residents and Families

#### 1. Stop Involuntary Closures Before They Become Necessary: Enforce Rules!

Although respondents were not asked whether closures could be stopped, a number of respondents brought this up themselves and felt strongly that involuntary closures could be stopped before they became necessary. This could be done by state and federal government enforcement of rules. Respondents asked why action against nursing homes with poor care had not been taken so that closure would not be necessary.

A number of the ombudsmen, advocates, families and residents felt that many of the involuntary closures did not have to happen and were very upset that so many facilities had gotten to this point. They felt that states were not adequately enforcing the laws and rules and picking up problems early on.

**Ombudsmen:**

“Facilities get so much due process that they can be non-compliant and residents can suffer horrific outcomes for years before closure is a real threat. We need to **fix the enforcement system** - residents deserve as much, if not more, due process than providers.”

“If there is an immediate jeopardy closure, the question is why wasn’t this picked up earlier on complaints or survey and interventions put in place to improve the facility?”

Their anger is obvious:

- “If there were deficiencies cited on a powerful and meaningful basis and were backed by withholding of Medicaid payments and steep fines - closures would not have to happen. To me, the **lack of enforcement** on nursing homes, the **lack of oversight** is the major obstacle in holding facilities accountable, and running with a modicum of decent care. The Department of Health has no teeth, and the Federal Agencies are completely lacking in simple and meaningful enforcement.”
- “If the deficiency could be more, and happen sooner, it might have an effect on improving.”
- “Go for the throat.”

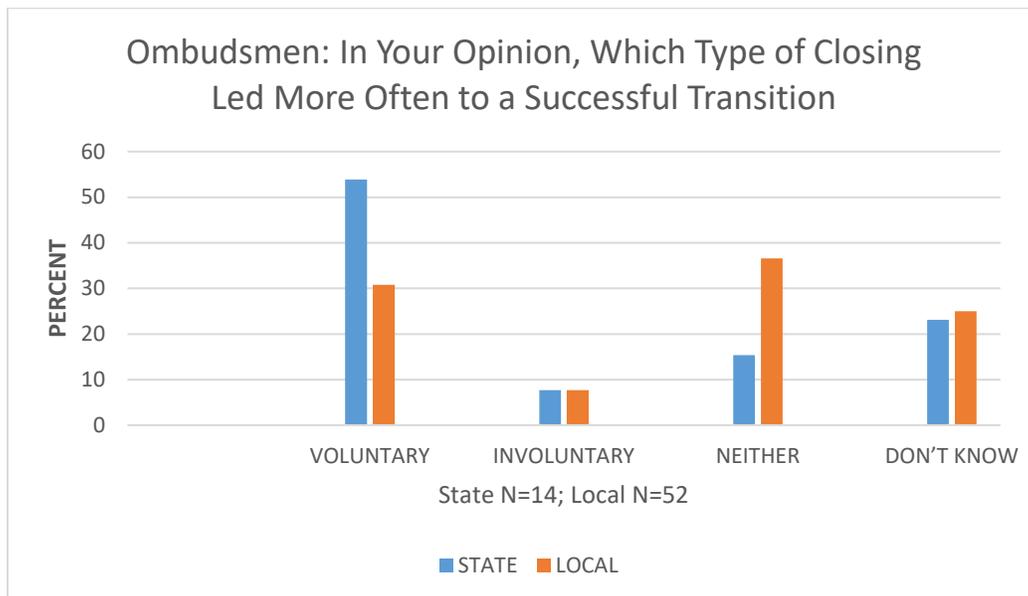
## 2. Nursing Home Closures Are Problematic

While a few respondents on the initial survey stated that the closures they had been involved in were successful, many others believed that all the closures, whether voluntary or involuntary, were unsuccessful transitions for residents who experienced negative effects from the closure.

**Local Ombudsmen:** "...resident belongings being trashed-bagged up with no labels as to whom it belongs to." "Possessions, chart and meds not going with resident." "Residents sent without proper discharge paperwork." "Moving day chaos." "Families not knowing where residents are moved." "The closure was one of the worst experiences of my life!"

### 3. Generally Voluntary Closures Go More Smoothly: Less Stress, Better Planning; When Involuntary Does Go More Smoothly, it is Because of Better State Oversight

While many ombudsmen felt that neither voluntary or involuntary closures led to successful transitions for residents, most of the ombudsman respondents believed that there are differences between a voluntary and an involuntary closing. Many of those with experiences with closures believed that voluntary closings were more successful transitions for residents.



Their experiences with involuntary closures indicated lack of planning, lack of notice, and less time and information given to families and residents.

**Local Ombudsman:** “In a voluntary closing there is generally adequate time built in to transfer residents in a safe and systematic way. In an involuntary closing we found that residents were being transferred out of county or to whatever facilities would take them, without full regard to the residents’ wishes or wellbeing.”

**State Ombudsman:** “Involuntary prompts an increase in stress to residents and families due to shortness of notifications, urgency environment and is related to an overall extreme poor performance of the facility, therefore resident, family members and staff have endured an intensity for a lengthy period of time prior to the involuntary closure process. Emotions are significantly increased and create higher risk of mistakes.”

**Local Ombudsman:** “Involuntary closing - sometimes hostile, facility does not always want to cooperate, residents are being traded like possessions to sister homes with no option to go any other place. Possessions and money is [sic] not always sent with resident; families were not aware facility was being closed until we contacted them.”

**State Ombudsman:** “A voluntary closure allows facility management to communicate in an orderly fashion with critical agencies and develop a plan for meeting with residents and families to prepare them that a move is pending, reassure them that each resident will be involved in choices for where they want to move to, and reassure dedicated staff about plans to assist with their future employment.”

The advocates, family members and the residents who responded to this question agreed with the ombudsmen’s opinion that voluntary closings were more successful.

Respondents believing that involuntary closures are more successful seem to have had experiences with voluntary closures due to financial issues where there was little money left and/or the state had little control over the closure. Their experiences were also in states where the state regulatory authority played an important role in protecting residents during the involuntary closures, but not the voluntary closures.

**Local Ombudsman:** “Voluntary is usually financially based. If a company is going bankrupt or workers fear it is, they worry about getting paid. They might be less apt to show up for work or call off which of course impacts resident care. Also, purchase of needed equipment/supplies would also be impacted. I believe in an involuntary discharge there is more regulatory oversight. There is more of a gradual planned process.”

#### 4. Success in Voluntary Closures Includes Ombudsman Involvement, Accurate Information and Good Discharge Planning

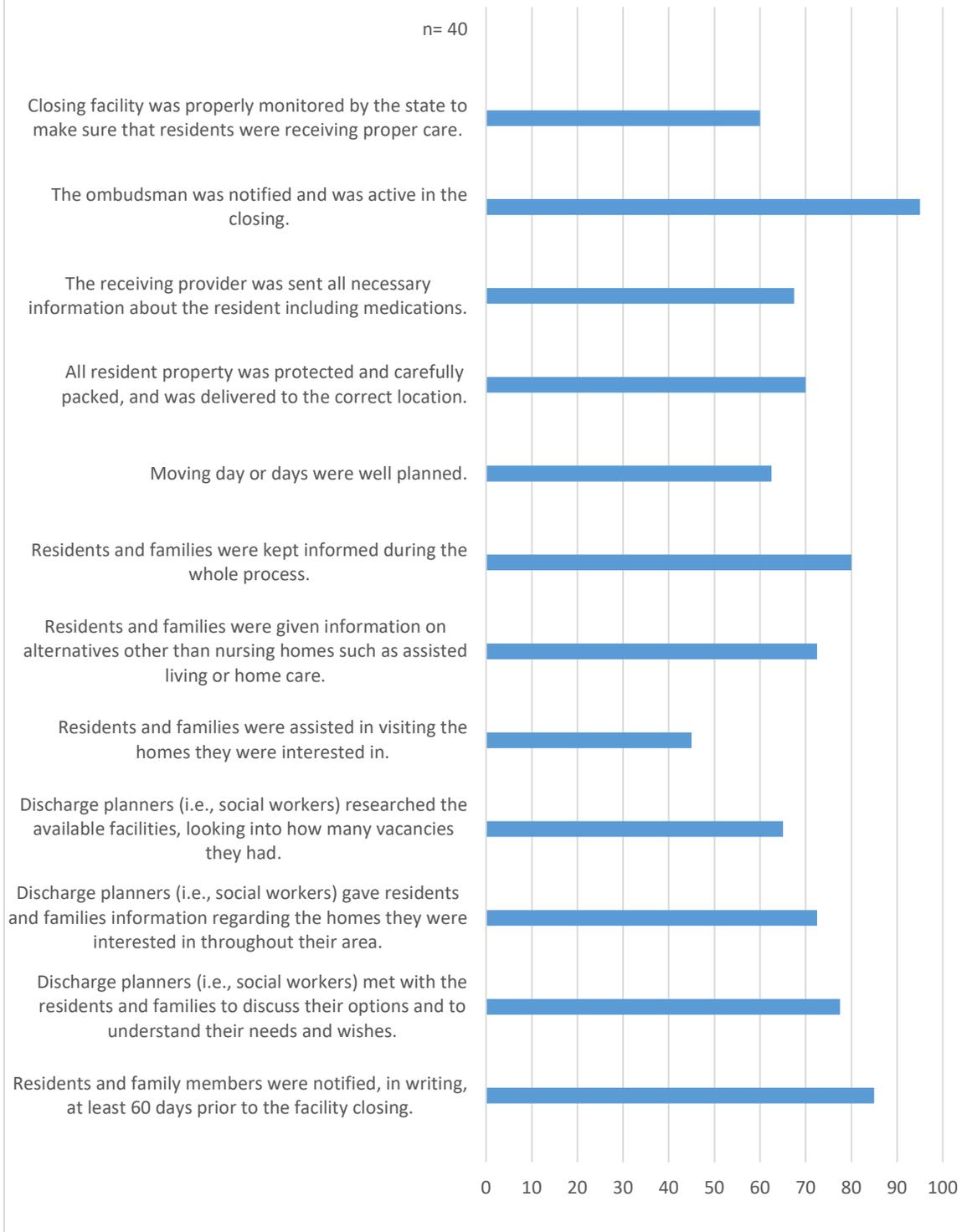
We asked respondents, who had been involved in a successful closing, what made a closure successful for residents. Respondents were asked to select from a list of choices and add any other issues they wanted. The two charts below list the choices made by a majority of the respondents for voluntary and involuntary closures.

The top six reasons given for success in a voluntary closing by at least seventy-three (73) percent of the respondents were:

- The ombudsman was notified and active.
- Residents and families were notified, in writing, at least 60 days before the closing.
- Facility discharge planners met with residents and families to discuss their options and to understand their needs and wishes.
- Residents and families were kept informed.
- Residents and families were given information on alternatives other than nursing homes.
- Discharge planners gave residents and families information regarding the homes they were interested in.

**Local Ombudsman:** “There needs to be open communication-frequent and transparent. Time given for questions and answers. This helps squelch rumors and misinformation which take on a life of their own.”

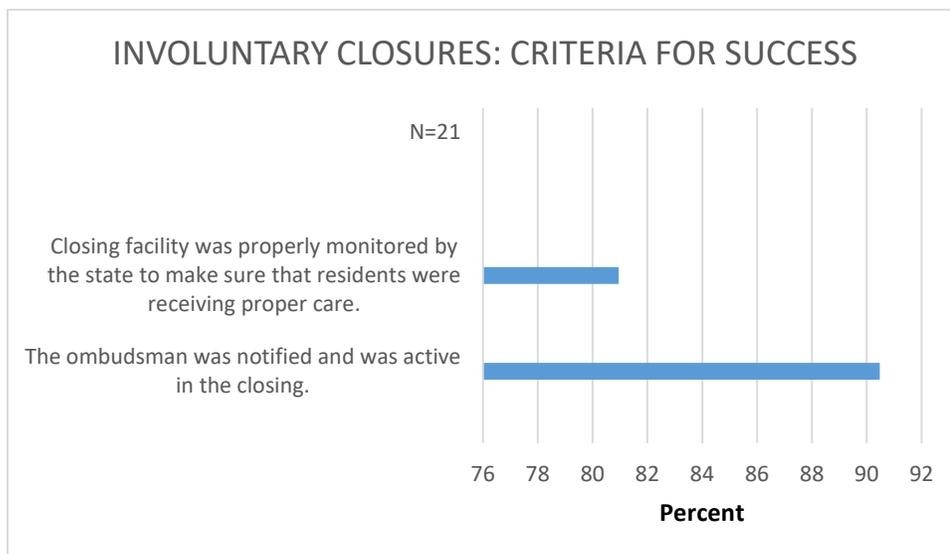
## VOLUNTARY CLOSURES: CRITERIA FOR SUCCESS



## 5. Success for Involuntary Closures Involves Participation of the Ombudsman and Proper Monitoring by State

For involuntary closures, a majority of respondents who had been involved in a successful closing chose only two activities that they felt made the involuntary closures successful: notification of the ombudsman and proper monitoring by the state. Perhaps this is because few involuntary closures were found to be successful. As we will see later, respondents listed a number of issues they believed were obstacles or impediments to a successful involuntary closing.

**Local Ombudsman** “With an involuntary closing, the State agencies are directly involved and the facility cannot keep them out. With a voluntary closing, the facility might not notify the State agencies of the plan to close and may try to stonewall the agencies as they try to monitor the closure and assist the residents.”



## 6. There are Six Obstacles to Successful Closing for Voluntary and Involuntary Closures

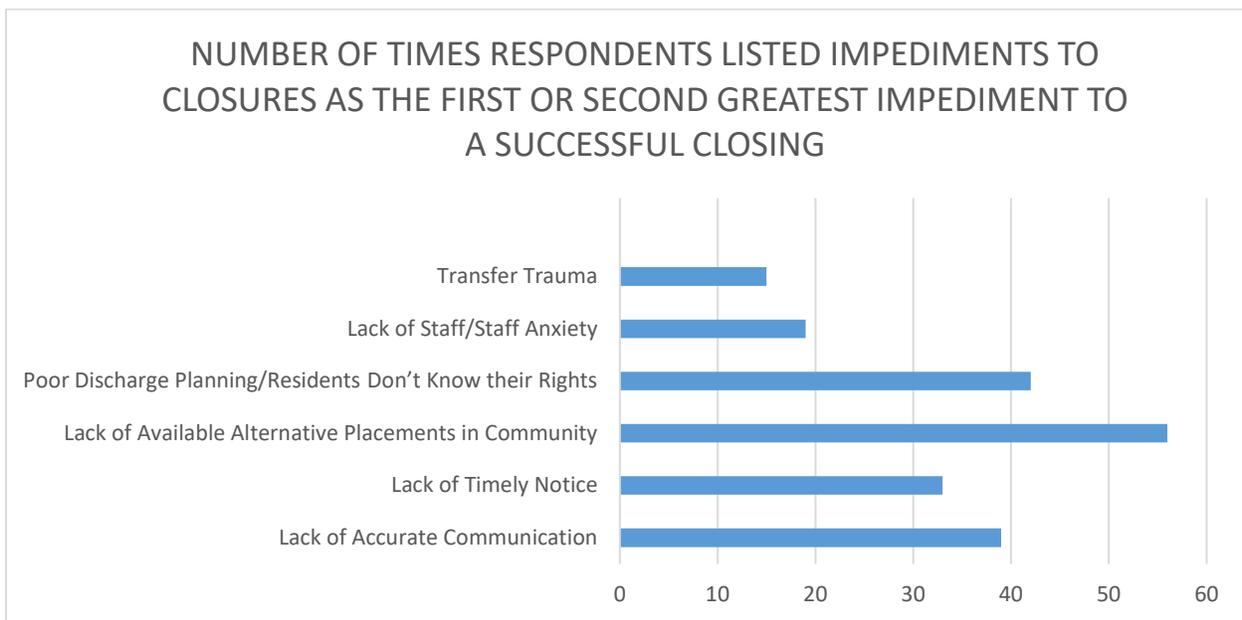
We asked ombudsmen, advocates, families and residents who had participated in closures to list the most important impediments to a successful closing for residents in both a voluntary and involuntary closing.

### OBSTACLES TO A SUCCESSFUL TRANSITION IN ORDER OF NUMBER OF TIMES LISTED

- Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.
  - Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.
  - Lack of communication/accurate communication by providers.
  - Poor notice/not enough time to find new placements.
  - Staffing issues such as staff leaving, staff stress and bitterness.
  - Transfer trauma.
- responses

N=51 to 69

The chart below demonstrates how many times the respondents on the on-line survey listed these impediments as their first or second major impediment.



A number of survey respondents shared their firsthand knowledge and experience with these obstacles.

### *Lack of Available Alternative Placements in Community*

- **Family Member:** *“My daughter, who is ‘slow,’ was transferred three hours from my home. I am 67 and sick. I have no car. For three weeks I did not know where my daughter was transferred. I was called a half hour before she was transferred. I could not get there in time to say goodbye. I haven’t seen my daughter in 2 years. I can only speak to her on the phone.”*
- **Attorney:** *“My client had substantial needs and was harder to find a place for. The facility told the guardian after a month that her sister would have to leave by the end of the week. The facility did not help with this resident. The state did not help. The ombudsman was there but gave no practical help. The guardian was threatened by the facility; told she had to leave whether she found a place or not. She finally found a place.”*

### *Lack of Timely Notice*

- **Local Ombudsman:** *The residents were not aware they were leaving because the notice was sent to the families, not to the residents... There was no planning. I told them they have to have 30 day notice...”*

### *Poor Discharge Planning*

- **Local Ombudsman:** *“Residents were not told they had choices and were transferred to facilities which would take them. Several residents were transferred to a “sister” facility in another county, which was purchased by another corporation.”*
- **Local Ombudsman:** *“In facilities with weak social services to begin with, this vital component and resource becomes even harder to maneuver when a facility is shut down. Getting adequate case management support from (state regulatory) is really important...and needs to occur rapidly.”*
- **Local Ombudsman:** *“There was no discharge planner on site. It was chaotic. The staff did not know what to do ... The CEO became upset and yelled at me. Told me that I should do the transfer paper work. S/he did nothing to help the residents. The facility would not permit the residents to take any property such as walkers, etc. and did not provide transportation; the family had to do it; it was almost vindictive. I told them to take their time, etc. Some did not have families – the facility determined where to send them. I was disappointed that the state regulatory agency did not get more involved.”*
- **Advocate:** *“Once the news is out that the facility is closing, residents and families panic and move as soon as possible without adequate preparation.”*
- **Local Ombudsman:** *“The first resident to be ready to leave was being denied the pain and psychotropic medications by the nurse until the Ombudsman stepped in and tactfully expressed that the medications went with the resident, which they did comply [sic] at the end.”*

### Transfer Trauma

- **Local Ombudsman:** “Though we live in \_\_\_\_\_, we found that residents were to be placed as far away as the \_\_\_\_\_ border (6 hours away) -- on the recommendation from Department of Public Health who claimed they were the closest MediCal beds available, a distance of 6 to 8 hours’ drive. The result is that not only residents suffered from transfer trauma, but Mr. Jones, for example, who shuffled down the street daily to visit his wife of 60 years now found himself separated from her and suffers transfer trauma too -- trauma that is immeasurable.”
- **Local Ombudsman:** “I am working with a resident who is legally blind and the transition was and is extremely difficult as the resident has to learn new ways, where things are, and the room. It takes time. In the meantime, the new facility fears the resident will fall and the resident’s level of activity has decreased.”

### Lack of Accurate Information

- **Family, former ombudsman and individual advocate:** “More than one licensed nursing home administrator announced at meetings for residents and family members ‘nothing will change.’ Where I come from, this is known as “a lie.”
- **Resident:** “I didn’t know anything until I saw it written up in the papers. Residents were rushed out. The facility staff did nothing to help me. My son packed me up and moved me. My medical records and medication records were not sent to my new home. I had to wait 10 days for medication orders to be rewritten. I was without medications for 10 days.”

### Lack of Staff/Staff Anxiety

- **Advocate:** “If staff is worried about their own paychecks, they have a new conflict of interest with respect to providing the care and services residents are entitled to.”
- **Ombudsmen:** “Staff anxiety could add to the anxiety of residents and families.”  
“Bitterness on the part of staff also adds to the frustration of families.”  
“Staff may find it difficult to help when they are upset themselves.”

**Local Ombudsman:** “There doesn't [sic] seem to be any penalties for owners who go bankrupt, fail to pay employees, and cause a same-day closure once they are closed and out of business. Essentially, they don't seem to be held accountable for the massively negative impact on the lives of the residents--loss of dignity, loss of belongings, the sometimes traumatic disruption, landing in a place that is inappropriate for care and opens them up to further exploitation.”

## 7. There Should Be Better Requirements for Closure: More Provider Accountability and Better State or Independent Monitoring Are Needed

According to respondents, one of the ways to encourage more successful transitions for residents would be to improve the state and federal requirements for closure. Some states mirror federal requirements, while others have additional requirements as we shall see in the case studies of the “best practice” states. A quarter of the ombudsmen respondents to the initial survey did not know if their state requirements were protective or skipped the question (this was true for both state and local ombudsmen).<sup>24</sup> However, those ombudsmen who were familiar with their state rules made a number of suggestions to improve the requirements related to better accountability and monitoring by the state:

- “Making owners more responsible.”
- “The facilities should not be allowed to close without clearance from the state that all necessary documents and needs of the residents have been met.”
- “Proof of adequate discharge plan for each resident relocated must be given.”
- “There needs [sic] to be more on-site visits by the regulatory agency during the closures as opposed to phone calls. There must be better enforcement capabilities by state agencies to ensure compliance for the facilities that do not follow state requirements.”
- “Maybe a longer notice time so that residents have more opportunity to get into more appropriate placements.”
- “More frequent monitoring during the transition period.”
- “A letter from the Office of the State Ombudsman should go out at same time/with the letter of intent to close. This letter will give the residents/families the information about the process, options, and assurances that the Ombudsman will assist to be sure they have an opportunity to make informed decisions should the facility be granted closure.”
- “Closer monitoring by an independent entity. If a home is already closing, they have nothing to lose and it is very difficult to hold them accountable for making the transition smooth for residents.”

Although most of the ombudsmen seemed unaware of the federal regulations or skipped the question,<sup>25</sup> two state ombudsmen that were familiar made a few suggestions for improving the federal regulations.

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<sup>24</sup> Lack of knowledge about their state’s rules for closure can significantly impact an ombudsman’s ability to effectively advocate for residents facing a closure situation.

<sup>25</sup> Ten state ombudsmen skipped this question, and eight of those that did answer stated they were not familiar with the rules and of the sixty-two local ombudsmen that answered the question, thirty-seven stated they were not familiar with these regulations. This is a similar problem to not knowing the state rules.

“Specific regulatory language that accommodates for resident choice in subsequent placement but also assures placement even for residents that may be more difficult to place (challenging behaviors or outstanding bills, etc.).”

“Emphasis on the administrator as the responsible person is overly emphasized, when likely, the administrator had little role in the decision to close. Owner/operators should be held accountable.”

## 8. The State Should Be More Proactive

Respondents were asked to choose from a number of options related to the state’s role. It is clear that respondents want the state to be more proactive in order to help make the transition more successful for residents.

The two activities chosen most often by the respondents were that the state should:

- Hold regular meetings with all agencies/programs involved in the closure to ensure coordination and communication.
- Establish an easy way for residents and their families to report problems related to the closure.

**Local Ombudsman:** “If special equipment is needed, the state should assist in acquiring this equipment.”

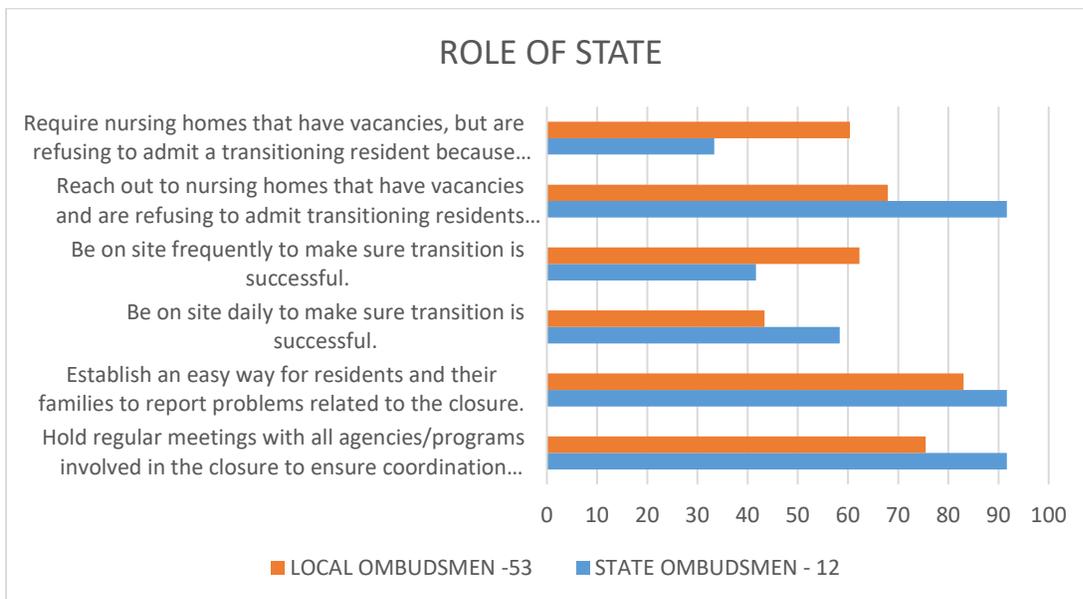
### *Be proactive:*

Most respondents also believed that the state should take the initiative in helping residents transition to an appropriate and desired new home for care. The four residents and seventy-five (75) percent of the sixteen families who responded felt that the state should require nursing homes that have vacancies, but are refusing to admit a transitioning resident because they say they cannot care for the resident, to document why they believe they cannot care for the resident. A majority of the other respondents (50 to 67 percent of the advocates and local ombudsmen and a third of the state ombudsmen) felt documentation would make a difference. Most respondents agreed that the state should contact nursing homes under these circumstances to find out why the facilities are denying admission and help solve any potential issues (e.g. bariatric residents need larger wheelchairs). Almost ninety-two (92) percent of state ombudsmen believed such outreach by the state should be conducted.

**Advocate:** “The state should demand that nursing homes that have vacancies accept their fair share of Medicaid residents or suffer the consequence of a reduced Medicaid rate for their existing residents on Medicaid.”

However, being proactive did not necessarily mean that the state should be onsite frequently or every day to make sure transition is successful. Less than half of state ombudsmen indicated frequently, while fifty-eight (58) percent choose every day. Sixty-two (62) percent of local ombudsmen selected frequently and less than half chose every day. Even fewer families and advocates felt the need for frequent state monitoring. Three residents believed the state should be on site frequently, with one choosing every day.

**State Ombudsman:** “Our State Agencies visit the closure home frequently during the process. It is not necessary for them to be there daily unless it’s for business or financial issues. We can always get them right away if there is an issue.”



**Local Ombudsman:** “The state and other relevant agencies should review any potential closures and determine whether there are out-of-the-box solutions for continued operation of the home. I also think a "post-mortem" assessment should be performed and results made public when a closure is unavoidable. “

**State Ombudsman:** “The state should put the facility into receivership. Residents who allege abuse/neglect should be taken seriously during closure. Residents may finally feel safe to disclose their concerns because they know the facility is closing and they will be leaving. Resident records should be secured immediately. Access to records, financial and resident records, should be seized until all investigations are completed.”

**State Ombudsman:** “The state should have someone from the licensing agency in the building daily, not just the state staff who are responsible for helping Medicaid resident placements. There should be a daily debriefing offered to all stakeholders, for implementation of closures, including the LTC Ombudsman and the Adult Protective Services Agency. A briefing should be offered for all residents and their legal decision makers on a daily basis.”

## FINDINGS

### On-Line Survey Two: How to Overcome Barriers and Obstacles to a Successful Transition for Residents

A second anonymous online survey was sent to all ombudsmen, advocates, families and residents who received the first survey. Respondents were asked to share any ideas they had to solve the problems or overcome the obstacles or barriers to a successful transition for residents listed by the majority of respondents in the first survey. Fifty-three individuals responded to this survey. Below is a table listing the obstacles and possible solutions. Details of these ideas follow the table.

<b>OBSTACLE</b>	<b>SUGGESTIONS TO OVERCOME</b>
Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.	<ul style="list-style-type: none"> <li>• Give the receiving facility monetary incentives to take a resident.</li> <li>• More fines, regulations and oversight.</li> <li>• Encourage the receiving facility to take hard to place residents.</li> </ul>
Lack of communication/accurate communication with residents and families.	<ul style="list-style-type: none"> <li>• Obtain participation of the ombudsman early.</li> <li>• Require new protocols and rules.</li> </ul>
Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.	<ul style="list-style-type: none"> <li>• Require an outside entity to conduct the discharge planning.</li> <li>• Ensure that Ombudsmen participate in informing residents/families about rights, options.</li> <li>• Require that the Ombudsman see and comment on closure plan before state approval.</li> <li>• Give the Ombudsmen a list of all residents being moved, including what new location and when they were moved.</li> <li>• Promulgate new rules related to how discharges are handled on day of transition.</li> </ul>
Staffing issues such as staff leaving, staff stress and bitterness.	<ul style="list-style-type: none"> <li>• Provide/require more training and education on closure issues.</li> <li>• Be sensitive to staff.</li> <li>• Provide assistance and referrals.</li> <li>• Promulgate new rules related to staffing numbers, closure plans, staff payment accounts, state supplement of staff if needed, bonuses and severance pay.</li> <li>• Ensure effective enforcement, including fines.</li> </ul>
Transfer trauma experienced by residents.	<p>BEFORE MOVE</p> <ul style="list-style-type: none"> <li>• Give residents control over where they move.</li> <li>• Prepare residents for relocation.</li> </ul> <p>AFTER MOVE:</p> <ul style="list-style-type: none"> <li>• Assist residents in adjusting to new location.</li> </ul>
Poor notice/ not enough time.	<ul style="list-style-type: none"> <li>• Require more notice.</li> <li>• Put rules into statute.</li> </ul>

## **Obstacle #1: Lack of Appropriate and Nearby Placements Either Because There Are No Vacancies or Providers Do Not Want to Take a Specific Resident.**

### ***Solutions: Give the Receiving Facility Monetary Incentives to Take a Resident***

This suggestion was made most often by the participants of the second survey. Respondents suggested raising the Medicaid rate for the first month or six months or giving a rate comparable to the Medicare rate for hard-to-place residents.

A few of the survey directors who participated in their on-line survey agreed.

- “A special transition rate could be offered by CMS for a few months to motivate facilities to take these relocated residents into their nursing homes. “
- “For residents with mental illness, CMS could provide a specific regulation set for specialty care within a nursing home with additional funding for the maintenance of trained staff in such facilities. Specialty regulations for dementia, mental illness, and possibly other conditions.”
- “State Medicaid or CMS could look at 'hardship payments' for taking difficult residents, if this would allow a facility to get the additional staff or equipment to take the resident.”

### ***Solutions: There Should Be More Fines, Regulations and Oversight***

The second most frequently listed solution by participants in the second survey related to imposing sanctions. As shown above, a majority of advocates and local ombudsmen stated on the first survey that requiring facilities to demonstrate why they cannot admit a resident would make a difference. Most respondents on the first survey agreed that the state should contact nursing homes under these circumstances to find out why the facilities are denying admission and help solve any potential issues (e.g. bariatric residents need larger wheelchairs). Almost 92 percent of state ombudsmen believed such outreach by the state should be conducted.

“Facilities are getting away with far too much and they feel they can continue to do so.”

Individuals responding to the second survey asking for solutions to this obstacle felt that facilities should not have the right to refuse the resident unless they can demonstrate that they cannot meet the needs of the individual in some way. The state should request “written justification around denial of admission.”

The need for stronger sanctions and rules was suggested almost as much as providing financial incentives. Solutions included: having more federal oversight; requiring that nursing homes participating in the Medicaid and Medicare programs be mandated to fill a minimum of 30

percent of their empty beds with Medicaid displaced residents; and imposing fines that are meaningful.

Ideas from **Ombudsmen**:

- Facilities within 50 miles must take a resident if someone else in the facility has the same diagnosis.
- If a facility has closed voluntarily, other homes owned by the same owner must be willing to take any of the displaced residents.
- There must be required disclosure of what facilities are owned by the same owner and that the resident has the right to refuse a transfer to any homes owned by the same owner.
- “The facility should be required to accept this resident if they are unable to provide or verify information that acceptance would be a detriment to either this resident or to other residents in the facility.”
- “The nursing facility should always be able to explain their refusal to accept a resident. Simply stating they cannot meet their needs is much too broad for an answer. Reasons for refusal should be specific for the resident in question.”
- “If it is a Medicaid/Medicare facility, I would like to see them cited for failing to properly document the reasons why they cannot care for the resident, but I am not quite sure I would want them to go as far as forcing them to accept the resident.”
- “This sort of refusal should result in a CMP, if not from the state, then from CMS.”
- “Cite them heavily.”
- “Give a deficiency and have it posted and well known for all to see in the communities.”
- “The state and CMS should impose a hefty penalty upon that facility if they refuse to admit the resident. It should be required that all nursing homes that are Medicaid/Medicare certified and licensed that have vacancies take residents. In an involuntary situation state and federally funded facilities should not have the right to refuse a resident who is nursing home level of care. They should not be allowed to cherry pick residents. The state should not be allowed to offer “poorly” run facilities as placement alternatives for victims of involuntary closures!”
- Possibly a fine, but absolutely, the refusal in a time of need should be available to the public on the state survey website.”

A few respondents proposed both the carrot and the stick: incentives and punishments.

A number of the **Citizen Advocates** stated similar ideas:

- “Admit the resident and maintain oversight of the facility, including a more stringent annual survey and reaching out to residents/families/staff as part of the survey.”
- “Close them to admissions, sanction them.”
- “Write a citation of a Federal, not State, and regulatory violation.”

- “Then the regulators should mandate that the facility closest to the patient's family or decision maker should have to admit the transitioning patient...”
- “The state should demand that nursing homes that have vacancies accept their fair share of residents on Medicaid or suffer the consequence of a reduced Medicaid rate for their existing residents on Medicaid.”

The **State Survey Directors** that participated in the survey, however, seem to disagree:

- “I do not think the federal or state governments can tell facilities how to run their businesses, and it is inappropriate to think that the government can/should force a facility to accept a resident that they cannot or do not want to take. Facilities also need to ensure that their existing residents are not put at risk in accepting a resident with behavioral issues.”
- “No facilities should be required to admit a resident they are not staffed to care for.”
- “CMS and the advocates are unrealistic about some of the residents and families which have unrealistic (should I say scheming and manipulative and irresponsible) expectations for care in a certified nursing home. There is absolutely nothing in the rules that allows a facility to effectively deal with such residents. CMS seems to err on the side of residents always. We know why this is their stance - greedy and avaricious operators in the past have set the stage for this! So the only possible response for the "outlier" residents that no one will accept is the Home and Community Waiver process. There is not enough funding by the states for this program to work effectively and quickly when there is a closure. “
- “There needs to be some recognition that a facility cannot remain open indefinitely, particularly if residents are offered appropriate transfers and choose not to accept them.”

#### *Solutions: Encourage the receiving facility to take hard-to-place residents*

A few respondents believed that assisting the receiving facility to be more capable of caring for these individuals could help. They noted that the facility may not have the necessary expertise or think the problem is worse than it is. At the same time, they believed that working with the transferring facility to ensure the resident assessments are accurate is also important. They indicated that sometimes the assessments of the closing facility are outdated or incorrect.

Thus, the respondents made the following suggestions:

- Increase awareness and training on mental health and addiction issues so receiving facility staff are more likely to accept residents with these issues.
- Train all staff to work with residents who seem resistant to care.
- Make sure the assessment of these residents from the closing facility are accurate.
- Urge the receiving facility to assess the resident themselves.

- Urge the receiving facility to meet with the resident in person before rejecting him/her.
- Get better documentation on the needs of these residents.
- Bring in a team with specialized expertise to help the receiving facility.
- Urge a trial period of 60 to 90 days.

***Solutions: Provide more time, information and options related to placement***

- Create an option for a resident to return if a new owner takes over.
- Allow an interim placement.
- Fund and staff more community options.
- Create a list of available beds.
- Get the public involved in the problem.
- Assess for community placement.
- Make sure there is enough time to find a new placement.
- Have state bring together a group to discuss the issue.

**Obstacle #2: Lack of Communication/Accurate Communication with Residents and Families**

***Solutions: Obtain participation of the ombudsman early on in communication***

Many of the respondents listed this as an important solution. Ombudsmen need to be brought in early in the process to help.

***Solutions: Require protocols and rules***

Numerous respondents offered suggestions for making sure there are specific requirements around closing. Many requirements are already mandated by federal rule<sup>26</sup>, including giving notice to residents and families (including rights); having a procedure to follow; requiring information be given to residents and families; requiring a review of the closure plan; posting notices; and holding meetings. However, a few of the suggestions urged more detail than is now required by the federal government:

- Facilities should post within the building and on the front and any exterior entry doors a notice indicating that the facility will be closed and indicate the rights of the residents.
- The state must be better trained on the handling of closures.
- The closing home should meet with each resident/family one-on-one to discuss the residents' wishes and provide several options, if available.

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<sup>26</sup> The closure final rules were published at Federal Register, Vol.78 No. 53, pp.16795, March 19, 2013; they amend sections of 42 CFR 483, 488, 489, 498

- Facilities cannot be permitted to wait for court appeals to be completed before giving notice.<sup>27</sup>

### **Obstacle #3: Poor Discharge Planning by Not Providing Important Information About Alternative Placements or Not Explaining Choice and Rights to Residents and Families**

#### ***Solutions: Require an outside entity to conduct the discharge planning***

A few of the respondents suggested that outside entities should be conducting the discharge planning, and the state should provide supplemental social worker and nursing staff to assure that it is done well.

#### ***Solutions: Ensure that ombudsmen have the resources to participate in informing residents/families about rights, options***

Respondents felt that the Ombudsman must have the resources they need by:

- Funding the Ombudsmen to monitor and conduct discharge planning.
- Requiring that the State Ombudsman see and comment on the closure plan before state approval.<sup>28</sup>
- Giving the Ombudsmen a list of all residents being moved, including what facility and when movement occurred, for the follow-up visit to assure the safety of the resident and to assist resident, family in the new adjustment period.

#### ***Solutions: Impose fines, hold facility owners/operators accountable through their license***

Here too, fines and holding the facility operator accountable by such measures as removing the license, and denying any future license, was a possible solution.

#### ***Solutions: Conduct follow up analyses on the impact of the closure on residents and families***

A few respondents suggested following up after the closure. “The regulatory agency should send out post discharge surveys to residents and families to identify problems.”

#### ***Solutions: Promulgate new rules about discharge planning and discharges***

Some suggested new requirements:

Limit the number of residents that can be discharged from a facility on one day.

Have the resident or resident and family sign off on their individual discharge plan to show that they actually have had a discussion about the specific options offered and are agreeing to the location to which they are being moved.

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<sup>27</sup> As you will see in a later section, the case of a closure in New York was hampered significantly by court challenges.

<sup>28</sup> In a few of the “best practices” state case studies, this is required.

Require a checklist be completed for the items that are packed, sent or that are disposed of and areas to fill in.

***Solutions: Compensate receiving facility for assisting onsite***

Another idea raised by respondents was to give compensation (by the closing facility or by Medicaid) to the receiving facility for staff from the receiving facility to be onsite to help.

***Solutions: Make civil money penalty (CMP) funds available to assist with the needs of residents related to the closure***

Respondents indicated that CMP funds should be made available to residents to be sure their belongings are inventoried, labeled, packed and sent, that such funds are also available to residents to visit other locations, or that such funds can be used to assist the resident to move back home.

**Obstacle #4: Staffing Issues Such as Staff Leaving, Staff Stress, and Bitterness**

***Solutions: Provide/Require more training and education***

A number of the respondents suggested more training and education to be given to staff by the facility:

- Annually give training to all nursing home staff in discharge issues; ombudsmen should be part of the training.
- Train in relocation stress mitigation. Include why it is important for staff not to voice their own concerns and to remain "client-centered."
- Require surveyor review of training documentation, such as the agenda, sign in sheets, certificates and credentials/bio of presenters.

***Solutions: Ensure Sensitivity to Staff***

The facility should:

- Allow time and place for staff to vent.
- Debrief on each shift about their concerns related to the closure.
- Establish a Bill of Rights for staff.
- Have administration meet with staff and residents to discuss.

***Solutions: Provide assistance and referrals***

The facility should:

- Work with other facilities to guarantee a place of employment if staff stay until the facility closes.
- Provide bonuses or incentives for staff to stay until the facility closes.

- Hold job fairs.
- Offer comp time.
- Have the facility assist staff that need help filing for unemployment.
- If the facility is part of a corporation, keep the staff informed of openings in other facilities.
- Pay a living wage.
- Make CMP funds available to pay staff so they will stay and care for residents.
- Consider bonuses for remaining staff.
- Bring in home health agency staff.
- Monitor for adequate staff.

**Local Ombudsman:** “One closure that did things right, actually gave daily cash bonuses to those that stayed to help and held on-site job fairs with county unemployment staff a couple of times a week on every shift.”

**According to members of the Service Employees International Union (SEIU), the facility could:**<sup>29</sup>

- Give severance pay, partial payment of accrued vacation time, and bonuses.
- Coordinate with other providers to help with searching for another job. The staff person would get the new job only when all residents in the closing facility had been taken care of and the facility itself had closed.

SEIU in Massachusetts has a provision in its contract that requires severance pay and an automatic referral to other facilities within the same nursing home chain.

**The state could:**

- Suggest a program for providers by laying a framework for helping providers coordinate with other providers.
- Help employees sign up for unemployment and/or Medicaid (if appropriate).

***Solutions: Promulgate new rules about staffing levels and payment***

- Require facility to report staffing numbers for each shift to State regulatory agencies and to the Ombudsman.
- Require, as part of the closure plan, that a staff payment account be set up and managed by an outside agency to pay the staff during the closure period.

<sup>29</sup> Interviews with Suzanne Clark, SEIU, CT (October 23, 2015); and Jamie Willmuth, SEIU MA (November 24, 2015).

- Establish a licensure requirement for closing and set aside a pot of money the state could access to get staff if needed.
- Require the closure plan to include how to add staff if needed.
- Install (by the State) a temporary manager to take over, if needed, and complete the closure. The owners should then be required to incur the cost.
- Require a legal staffing ratio and adequate support including 24-hour per day RN availability.
- Supplement, by the Department of Health, insufficient nursing home staff as required and bill the owners of the nursing home for the expense.

***Solutions: Ensure effective enforcement, including fines***

Respondents felt strongly that the state should demand accountability. The State should use all available remedies, such as fines, imposing a receiver, or a directed plan of correction, if the closing facility does not comply with closure requirements. Due to the nature of the situation, any lack of compliance should be considered immediate jeopardy and enforcement action should be imposed immediately.

**Obstacle #5: Transfer Trauma Experienced by Residents**

***Solutions: Give residents control over where they move***

- Give control to the resident and family by providing information and options to encourage some control through decision making.
- Have residents tour the potential receiving facilities.
- If residents cannot tour because of frailty, take pictures of the potential receiving facilities so residents could have some idea of the new facility.

“Moves should be gradual over multiple visits with a walk thru [sic] - then joining a meal - then joining an activity or outing - visiting roommate - an overnight - arranging room space - then move-in.”

***Solutions: Prepare residents for relocation***

- Once a receiving facility has been chosen, facilitate several visits for increasingly longer periods of time (tour/visit, meal/activity, overnight) to help the resident acclimate to new surroundings before moving.
- Residents/family should have the opportunity to participate in a care plan meeting with current Director of Nursing Services/Director of Nursing/Administration

(DNS/DON/Administration) and new DNS/DON/Administration so that questions, concerns, preferences, schedule can be discussed with resident.

- Keep roommates and friends together if they want to remain together.
- Make sure all belongings are transferred with the resident.
- Don't rush the transition.
- Have counseling available for residents and families.

“State and federal laws and regulations should require that a [closing] facility facilitate multiple tours and visits to potential new settings, and that familiar staff accompany and support the resident on visits. A relocation team should be installed to monitor. Staff/care-managers should follow up to address concerns or facilitate subsequent moves if necessary.”

### *Solutions: Assist residents in adjusting to their new location*

- Encourage new providers to engage the resident in the familiar setting and to observe/learn his/her routine.
- The new home should know resident's preferences and the way in which s/he liked to be cared for prior to admission.
- Staff of the closing facility should meet with and train new staff to understand their new residents.
- Follow up by ombudsmen, weekly or quarterly for 6 months.
- Put comforting items in new room. Make the residents' rooms very similar at the new place to what they were in the previous place. Photos, mementos and room décor that is similar preserves the familiarity of the old place, in any new place.
- Family members need to step up visiting in the new place and should make sure the residents' favorite activities (bingo, ice cream socials, senior exercise programs, etc.) are available in the new place.
- Require an evaluation for transfer trauma for each resident.
- New facility must have plans for dealing with transfer trauma and this must be monitored by the regulatory agency.
- Have volunteer resident ambassadors at facilities to assist with the transition; this could be other residents or family members or community volunteers.
- Have geriatric therapists in place to assist with the transition problems.
- Ask residents what will help them to minimize trauma, stress and anxiety. Use residents as presenters at regular meetings to discuss the closure process to share their experiences about moving due to facility closures. Make sure residents have a way to maintain relationships with their peers when moved to different locations.

- Department of Health should be required to assign as many social workers as necessary to provide support to residents and families.
- Have a relocation specialist who follows up with residents.
- Staff from closing facility could be paid to visit their former residents.
- Let residents know where their friends are now living.

#### **Obstacle #6: Poor Notice/Not Enough Time**

##### ***Solutions: Require more notice and time before closure***

- Require at least three months' notice.
- Do not permit the facility to close until everyone is transferred to an appropriate place of their choosing.

The representative from CMS seemed to disagree and felt that giving more time to close in an involuntary may be a mistake: "History plays a part (in involuntary closures). Most of the time they (the facility) have a poor history. Residents are probably at risk. We need to move quickly."<sup>30</sup>

##### ***Solutions: Put rules into statute***

- Guidelines and regulations must be in statute in order to better protect residents. Statutes are more protective than guidelines and regulations.

#### **Additional Ways to Achieve Successful Transitions**

Some of the respondents to the second survey, which asked for solutions, did not respond to a specific obstacle. Instead, they made general observations about how to make transitions more successful for residents.

##### ***Solutions: State task force of different agencies must be formed and must begin monitoring early in the process***

- A group of state agencies such as the Regulatory Agency, the Medicaid Agency, the State Long-Term Care Ombudsman Program, and others must begin to monitor compliance and start to plan when any possibility of closure is apparent.
- The group must be well coordinated.

##### ***Solutions: Improve enforcement***

- Regulators and funders need to hold facilities accountable for required notice by citing them and imposing remedies, such as fines, when non-compliant.
- Better sanctions by the State and CMS. Enforcement needs to be improved.
- Hold facility and administrator accountable.

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<sup>30</sup> Conversation with Jay Weinstein, Health Insurance Specialist, CMS, October 26, 2015.

- Citation should be listed at a high severity level for each resident.
- Place a transitional administrative management team to take over the facility.

“The current slap on the hand, if you can even get to their hand, is worthless, meaningless and an insult to those effected [sic].”

### *Solutions: Prepare, plan and communicate!*

- The possibility of closure should be part of an emergency plan.
- Facilities should be informed of closure rules even when there is no possibility of closure.
- Presentation on closure by the State for all facilities twice a year. Keeps families and residents informed.
- Moving drills related to possible closure.

### **Holding Providers Accountable**

Since so many of the suggestions for overcoming the most common barriers to a good transition for the resident related to holding providers accountable, respondents to the second survey were asked how a state can hold an owner accountable. A deficiency may not mean anything to a provider leaving the industry. Owners may have nothing to lose. Below are recommendations.

#### **Regulatory Actions**

- Require facilities to pay any fine they receive even if they leave the industry.
- Prohibit facilities from getting another Medicaid filing number or billing Medicare.
- Require facilities to have a "closing or downsizing reserve fund "to be handed over to the State as a penalty for failing to follow closing procedures successfully and protect residents. Make this mandatory for operating a facility.
- Create a closing fund, paid into by the owners, that is forfeited if the closure plan is not followed.
- Impose harsher penalties for owners.
- Do not allow the owner to keep the certificate of need for nursing home beds.

#### **Licensing Actions**

- Do not issue licenses to operate a facility to individuals who have been a part of ownership in other closed facilities in the past.

- Report the Administrator to the licensing board for a possible loss of license to work in the state.
- The owners or their children/family should not be allowed to get a nursing home license in the future.
- Remove the operator's license and do not permit the operator to get a license in any other state.

### Civil Penalties

- Make the owners, corporate managers, and all supervisors personally liable for carrying out the plan. Ensure they cannot hide behind a corporate shell to protect their own home, savings, investments, licenses, etc. Do not allow them to use any funds from the facility to pay for legal counsel to defend themselves in criminal or civil actions if those funds are identified as potentially being able to pay restitution for residents harmed by the failure of the plan.
- Put a lien on the facility.

### Criminal Violation

- The owners should be taken to Federal and State Criminal Court for endangering the lives of vulnerable adults.
- Look at it as Medicare/Medicaid Fraud.

### Right to Sue

- Laws have to allow residents/families the right to get an injunction against closing and to sue the offending facility for damages related to harm (as well as the companies that have multiple facilities).

### Better CMS Oversight

- Medicare should keep a database on all owners and if closure is due to poor care or resident jeopardy then any facility that is part of the extended company goes on the high profile list.
- CMS should audit state licensing agencies licensing practices and look for fraud, questionable approvals of licenses for owners/companies that have history of real estate transactions in long-term care.

### Publicity

- Let people know! Share information about the facility and the closing with the IRS, state health, unemployment agencies, etc. Notify legislators (state and federal); contact better business bureau. Call the auditor general and the attorney general for state.

Contact credit bureau. Spread the word by voice, mail, community connections, newsletter and newspaper.

### Other

- Do not allow owners to reinvent themselves through new partnerships and corporations hiding past financial dealings and poor care.
- Forensic accountants, experts from the financial housing industry, Department of Justice (DOJ), are needed to audit, and hold corporations accountable...before facilities are licensed.
- Facilities should not be able to sell their holdings to another corporation with seniors in the building as promised revenue/income.

## FINDINGS

### On-Line Survey Three: State Survey Directors (6)

“We should study why the facility involuntarily closed to determine if there is anything that could have been done to keep the facility open.”

**Survey Director**

#### 1. State survey directors who participated felt closures were successful

Unlike the ombudsmen, advocates, family members and residents, 4 of the 6 survey directors who responded to their anonymous on-line survey did not find any of the closures problematic except for unreasonableness of residents and families. They did not seem to see success in the same way that ombudsmen, advocates, residents and family members did. They felt transitions were successful even if the residents and families were not happy about their new placement.

**Survey Directors:**

- “We have never seen an unsuccessful transition. (However,) they (i.e., residents and families) may not be happy about the new location and surroundings.”
- “Have not had unsuccessful transitions other than family members not happy they must travel further to visit their loved ones.”
- “Possible entitlement issues brought up by the resident that wants the government to keep the facility open.”
- “Resident/family refusal to accept an appropriate transfer.”
- “Families need to accept the closing is happening and that difficult decisions need to be made by the resident or on behalf of the resident.”

**2. State survey agency directors who responded to the survey believe their role includes monitoring, coordination with other state agencies/programs; assuring safe transfer of residents**

When asked what the role of the state is when a nursing home closes voluntarily, the 6 state survey directors gave somewhat different answers. One saw her/his role as a facilitator of information – not hands-on. Others saw their role as more hands-on.

**Survey Directors stated:**

- “State oversight, with the help of LTCOP and others is essential to ensuring that residents are appropriately cared for. THIS IS NOT EASY!”
- “The entire process needs to be monitored to make sure all steps are followed.”
- “Have the facility provide weekly updates on the progress of finding a new location for each resident.”
- “Work with the owner/operator to facilitate the orderly closure and transfer of residents to an appropriate setting.”
- “To make sure each resident has a place to go to get the care they need. Also to make sure that no new admissions are taken after the notification to close is published.”
- “To coordinate with the Ombudsman's office and assist with placement of residents if necessary.”
- “To ensure that the facility fulfills its obligations under the Certificate of Participation, and that residents are discharged/transferred in a safe and timely manner.”
- “We should be monitoring where residents are going or being sent to ensure that the resident is getting appropriate care.”
- “I see the role of the state as being a facilitator of information. I don't believe our role is to be hands-on with residents or anything else. We are regulatory, and should stick to

that. However, there is a lot of communication that we can support and enhance. Recently our state experienced some voluntary closures due to financial problems. We contacted the state long term care association, the ombudsman and spoke with other interested parties to coordinate information. We gathered as much information as we could so we could also report to CMS. Being a facilitator of information proved to be very helpful in organizing the groups that needed to be involved. In this situation, we were able to be a central communication point. All groups involved checked with us to ensure that everything that happened was compliant with laws and regulations.”

- “All state agencies - Survey Agency, Ombudsman, Medicaid, Human Resources - work together to provide information and assistance to residents and families; work with the various agencies and associations (Nursing Home, Assisted Living, Veterans Administration, Mental Health) to identify availability of beds for displaced residents; meet with families, residents and staff and answer questions about closure and options; work with the fiscal intermediaries to arrange a smooth transfer in funding.”
- “Advocate for the health and safety of the residents. We have never had an involuntary closure.”
- “To coordinate with the Ombudsman's office and assist with placement of residents if necessary.”
- “The State Agency may need to identify a monitor for the closure period, and there must be close supervision of the facility to ensure that residents are safe during the closure process.”
- “Besides monitoring the placement of residents we should also study why the facility involuntarily closed to determine if there is anything that could have been done to keep the facility open.”
- “When closing a nursing facility, the state role is to set the time frames for closure and ensure that all other agencies and interested parties are notified of the issues. I believe this is still a facilitation role and not a hands on role. For instance, our staff are not going to go out and move residents. However, we can be on site to ensure that when the residents are transferred, they have choice and it is being done appropriately. We have communication-lines with Adult Protective Services, the State Ombudsman and others who need to be involved. We can ensure this takes place adequately. We can be on site to ensure compliance with health and safety standards during the closure and transfers.”

### **3. Half of the survey directors who participated (3) found similar obstacles to those listed by the ombudsmen, advocates, family members and residents.**

Three of the **6 survey directors** who participated in the survey listed obstacles that mirrored those identified by the ombudsmen, advocates, families and residents:

- “Poor communication of the plan for transition and failing to adhere to the designed plan. The problem of resident transition trauma is not planned for or dealt with properly.”

- “Making sure they have time to know their choices and then make an appropriate choice of where to go. There is sometimes a short time frame for transferring, so getting the Ombudsman and everyone else involved quickly is key. We have plenty of available beds in our state, so the options need to be made available and let the resident and family move forward. Getting provider involvement is key also. This recent situation in our state turned out very positive. Providers were able to come at certain times to the closing facility and present information to residents regarding their programs. The Ombudsman staff were there to facilitate this and ensure there was nothing unethical happening.”
- “Difficult placements due to resident condition or resident behavior. Unavailability of beds.”

#### 4. A few survey directors gave solutions to the obstacles

##### *Staff Issues:*

- “Offer bonuses if qualified staff stay; use staffing agency staff to complete the closure process; and contract with home health or other qualified service providers to augment the diminishing facility staff.”
- “In terms of staff competency, the state may need to assign a monitor to ensure that staff are providing appropriate care, or a receiver.”
- “The facility should announce to their staff that anyone who leaves before they are asked to end their employment will not get a closing bonus. This prevents staff from jumping ship and leaving the facility without enough staff to care for the remaining residents.”

##### *Need for Team*

- “Have a closure policy and rapid response team.”
- “Communicate and participate with all agencies trying to assist with transfers.”

##### *Timely Notice*

- “Start planning several months before actual closure date. Inform each resident and family individually at least six months ahead of the closure date. Assign a specific person or persons to handle each residents’ transition like a case manager. “
- “Timely communication with residents/families.

## Discussion

One of the clear messages from the study is that state and federal enforcement must be stronger to both improve care before a facility is forced to close and to hold providers accountable for following the rules when a facility does close. The suggestion that we need better enforcement of rules and standards was said over and over again. Many of the ombudsmen, advocates, families and residents thought that involuntary closures due to substandard care or immediate jeopardy would not happen if poor care practices were appropriately cited and remedies imposed in a timely manner. Some thought that the threat of closure by the State Survey Agency or CMS is used and then rescinded so often that providers don't believe they will ever be decertified or lose their licenses, and thus they continue to tell residents not to worry even when threatened with decertification. Then when the facility is actually forced to close for failure to establish compliance with standards, the residents and families are blindsided. Respondents felt that if enforcement was taken earlier, and more consistently, i.e., deficiencies accurately cited and categorized by scope and severity, the full range of available remedies imposed, and providers were held accountable by developing meaningful plans of correction developed and implemented to address deficiencies, care might improve before the facility is forced to close.

Ombudsmen, advocates, family members and residents also clearly felt that any closure caused major problems for residents and families and is problematic due to: a lack of appropriate and nearby placements; poor facility discharge planning; inaccurate information given to residents and families; inadequate time to find appropriate and desirable placements; and staff leaving or under stress. All of this often led to transfer trauma for the residents. It was distressing to see that a number of the survey directors participating did not feel the same way. A few felt that a closure was successful if a resident was appropriately placed, even if the location was one that they did not want. While many ombudsmen, advocates, family members and residents stated that they found voluntary closures more successful for residents than involuntary closures, most believe that success in voluntary closures depends on: the involvement of the ombudsman, informed residents and families; at least a 60-day notification of closing; good facility discharge planning, and residents and families were given information on alternatives other than nursing homes. Success for involuntary closures depended again on the involvement of the ombudsman as well as close monitoring by the state. Since a third of the local ombudsmen respondents stated that neither voluntary nor involuntary closures were successful, it seems that these activities do not always take place.

In order to encourage better transition for residents, respondents and interviewees were of the opinion that there must be better requirements for holding providers accountable and better state monitoring. When discussing the most prevalent cited obstacle to a successful transition for residents - facilities without vacancies or unwilling to take specific residents - they felt that the state had an important role to play. Most families, advocates and residents felt that at least requiring documentation of why a facility cannot care for the resident would help. Most state

and local ombudsmen believed that the state must be proactive if a facility does not want to admit a resident by finding out why and helping to solve any potential issue.

When asked for other solutions to the barriers to a successful transition listed in the first survey, respondents gave many ideas<sup>31</sup>.

- For the obstacle of lack of appropriate and desirable placements, suggestions were related to both monetary incentives and more fines, regulations and oversight.
- For the obstacle of lack of accurate communication with residents and families, the major suggestion was to make sure the ombudsman participated early on in the process. While this is clearly important, the study demonstrates that many state and local ombudsmen do not seem to know the state and federal rules around closures. This can clearly hamper their effective participation.
- Suggested solutions to poor facility discharge planning at closure again related to ombudsman participation. A few of the respondents suggested that an outside entity should be conducting the discharge planning, overseen by the state. Again, new rules, imposition of fines, and holding facility professionals (such as the Administrator) accountable for their actions was given as a possible solution as well.
- For the problem of staff leaving, staff stress and bitterness, suggestions ranged from providing more training and education, to being sensitive to the staff, to providing assistance, bonuses and severance pay, to state supplementing staff if needed at the owner's expense as well as holding providers more accountable.
- For eliminating or lessening transfer trauma, many suggestions were given: giving residents and families control through information, touring facilities, preparation for moving, and assisting residents to acclimate to their new home and to help the new home adapt to the resident.
- For the issue of poor notice or not enough time, suggestions centered on lengthening the amount of time for the move and putting rules into statute to give them more teeth.

Some respondents gave general suggestions related to better enforcement of closure rules, holding the providers accountable, and educating all facilities routinely about the possibility of closure and perhaps making the issue of closure part of a required facility emergency plan.

It is evident from the experiences and opinions of the participants in both the surveys and the interviews that action must be taken. Nursing home closures are often dreadful for residents and their families (and the ombudsmen and other advocates themselves).

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<sup>31</sup> See also the chart on page 36 with survey respondent identified obstacles and suggested recommendations.

## STATE CASE STUDIES

We have chosen nursing home closure processes in three states to highlight: Connecticut, Ohio and Wisconsin. Respondents to the first online survey were asked if they thought their state was a candidate for one of the “best practice states.” If they said yes, they were asked to explain why they believed that. These states were researched to see what might make them a best practice state. Public information on all other states were also researched for possible inclusion. While a number of states<sup>32</sup> may have been excellent choices for a best practice state, the three selected highlighted different best practices. In addition, after the detailed case studies, you will find a list of other states with good practices as well.

All three have a number of “best practices,” some of which seem to respond to the obstacles to a successful transition for nursing home residents identified by the survey respondents. In order to develop these case studies, interviews were held with all stakeholders, including state and local ombudsmen, consumer advocates, residents when possible, state regulatory authorities, Medicaid agencies, union representatives, and representatives of provider associations. Contact information for all individuals interviewed follows each case study.

Wisconsin’s and Connecticut’s case studies focus on their process with voluntary closures, while Ohio’s involves involuntary closures.

All three states developed and continue to improve their systems by bringing together several state agencies to focus on nursing home closures. Thus, Wisconsin brought together a workgroup consisting of the State Ombudsman, the Division of Long Term Care, the Department of Mental Health and Disability Rights to find ways to improve the system. The Connecticut Long Term Care Ombudsman Program, after a particularly complex closure, convened a Nursing Facility Closure Response Coalition. Various state agencies/programs were involved: Mental Health and Addiction Services, Developmental Disabilities, CT Legal Services, and the State Ombudsman. The Coalition’s mission was to develop a protocol to protect resident rights, provide legal representation and monitor the process as the facility closed. Ohio began an examination of its systems by holding a major retreat with a Kaizen event,<sup>33</sup> which brought together all the state agencies together to discuss closure issues.

Ohio’s best practices lie on its creation of a resident relocation team that meets even when there is no home closing to constantly communicate and develop solutions to problems; its advance work, long before a nursing home is forced to close, at the time a facility is in danger of being terminated from the Medicare and Medicaid programs; its focus on the least restrictive setting; its help for facility staff; and its significant follow up with all relocated residents.

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<sup>32</sup> You will find information on some of these states in the Appendix.

<sup>33</sup> Kaizen is Japanese for “*improvement*.” Kaizen refers to activities that continuously improve all functions and involve all parties within the organization or state. It also applies to processes. It has been applied in healthcare, psychotherapy, life-coaching, government, banking, and other industries.

Connecticut’s best practices lie in its use of its certificate of need process. It can deny closure to an owner who wants to close if it finds it is not in the best interest of the public need and other state considerations. In addition, the state requires a public hearing before it can make a decision to approve or disapprove a request to close. It also has a new statute that mandates that the state ombudsman send a notice to all residents at the same time the provider applies to the state for approval to close to explain rights that residents have. Thus, they will get this notice at the same time they learn the possibility of closing.<sup>34</sup> Wisconsin has put all its closure rules in statute which gives residents more protections. It has created, in statute, a “relocation specialist” within the State Ombudsman Office who functions whenever five or more residents are moved and oversees all closures in the state; it has developed a relocation team comprised of state agencies; it has held “lessons learned” meetings to discuss what it has learned from complicated closings; and a major focus is on transfer trauma and staffing issues, with a detailed manual outlining these issues.

The case studies discuss these all in detail. Following the case studies, you will find a list of a number of other states with innovative or interesting systems. The list includes a brief summary of these initiatives with contact information.

## CASE STUDIES: BEST PRACTICES

### OHIO

#### Involuntary Closures

##### Background

##### *Bringing Together All State Entities to Develop New Protocols*

Ohio’s current process began with an examination of its old systems related to involuntary terminations. In 2013, Ohio decided it needed to improve its nursing home closure process and protocols. The state held a Kaizen Event. A Kaizen event refers to activities that continuously improve all functions and processes and involve all parties within the organization or state.

***“The Kaizen event was crucial. It gave us a sense of the mission. You need a major retreat to build a mission.”*** George Pelletier, Community Options Coordinator, PASRR Bureau, Department of Mental Health and Addiction Services

The event focused on the fact that:

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<sup>34</sup> Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman’s Notice to Nursing Home Residents.

“The current Nursing Home Quick Response Team (Team focusing on closures) process within the State Long-Term Care Ombudsman office at the Department of Aging can be unexpected, lacks coordination between several sister agencies and local partners, and has several layers of assessments. This creates a cumbersome process that can cause unnecessary trauma on nursing home residents during the relocation process.”<sup>35</sup>

According to the Ombudsman Project Coordinator, the system was not integrated with the other appropriate state agencies. The state needed a consistent approach from all agencies. In addition to a lack of integration, there was a concern that there was not enough time before a facility closed to help in the relocation.

Members of the core group attending this event included: the State Long-Term Care Ombudsman, the Ombudsman Project Coordinator, and staff from the Department of Medicaid (the primary liaison to the managed care organizations), the Department of Health, and the Department of Mental Health and Addiction Services. Later in the process, other representatives and agencies were added: a member from the Ohio Department of Aging’s Division of Community Living which hosts the senior Home and Community Based Services and Assisted Living Medicaid waivers; and the Ohio Department of Developmental Disabilities.

As a result of this week-long event a number of initiatives were developed:

- A standard process was created that they believed could be applied to any closure or termination;
- A shared web application was proposed to be used across agencies; and
- Primary decision-making was moved to the front of the process by bringing in Home Choice (Ohio’s Money Follow the Person program) to conduct assessments at the beginning of the process.

Specifically, the process was redesigned to ensure that:

- Different roles are played by different people depending on their expertise;
- Documents are shared throughout the process with all agencies;
- Everyone has access to the same information at the same time; and
- Home Choice (e.g., Money Follows the Person) assessments are conducted at the beginning of the process to ensure that residents will have an opportunity to move to the community.<sup>36</sup>

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<sup>35</sup> Lean Ohio Kaizen Event Fact Sheet, Ohio Department of Aging, November 1, 2013.

<sup>36</sup> See, “Lean Ohio Kaizen Event Fact Sheet, November 1, 2013,” for details of the event in the Appendix

One of the initial changes the state made was to delegate the coordination of this new process to the State Ombudsman Office (from the Medicaid Office).<sup>37</sup> This shifted the focus from the payer role to the advocacy role.<sup>38</sup> Local ombudsmen had long been at the ground level in a facility closure, assisting residents in finding new locations and advocating for their rights. In this role, they worked with the regulatory arm of the Health Department to standardize the Team notification when a facility was facing termination. Now the State Ombudsman Office took the lead.

### **Current Process**

A Resident Relocation Team, chaired by the State Ombudsman Office, includes the regulatory arm of the Department of Health (Bureau of Long Term Care), the Department of Aging, the Department of Mental Health and Addiction, the Department of Developmental Disabilities, and the Office of Medicaid. The Relocation Team coordinates the work of all the individual entities. This Team monitors closings.

The process begins when the Ohio Department of Health's Bureau of Long Term Care (regulatory bureau) sends an alert to the State Ombudsman when a facility reaches sixty days of a possible termination date. The Ombudsman Project Coordinator alerts the full Team. This alert starts a "data mining period." No action is taken at this time since the facility still has time to come back into compliance and remain open. Thus, sixty days prior to possible termination for an involuntary closure, the Team begins looking at data on all the individual residents.

The Department of Medicaid pulls together data on all the Medicaid residents in the home using the MDS (Minimum Data Set). This includes names, Medicaid numbers, diagnoses, etc. The local ombudsman adds data for non-Medicaid residents using the facility's census list and resident interviews. The Team looks at this data as well as PASRR (preadmission and resident review) data prepared by the Department of Mental Health and Addiction Services and the Department of Developmental Disabilities. The local ombudsman begins to visit the nursing home weekly. Still not notifying anyone about the possible closure, s/he begins to get to know the staff and residents better during this time.

All collected data is stored in a master spreadsheet by the Office of the State Long-Term Care Ombudsman and shared confidentially via ShareFile as needed. The spreadsheet uses standard headers so that it can be used as a mail merge source document for resident interview forms, resident notification letters, family/guardian notification letters, and follow up lists for post-transition resident activities.

The Team has weekly phone calls to discuss the possible closure as well as other issues related to closure. The regulatory division of the Department of Health keeps the Team up to date on

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<sup>37</sup> This did not include any additional funding.

<sup>38</sup> Interview with Julie Evers, Medicaid Health Systems Administrator 3, Office of Medicaid, Ohio, January 25, 2016.

the possibility of closure and how the facility is doing.<sup>39</sup> If a managed long term care company has clients in the home, they are brought in as well. The Team develops letters that will go to residents if the facility, in fact, will close. The Ombudsman Project Coordinator begins to assign tasks to Team members as the closing becomes imminent. The Team notifies entities such as the agencies' communications and legislative staff, local mental health or developmental disabilities boards, the Social Security office, the facility pharmacy, the Mayor, County Commissioners, workforce development people (who will be speaking to staff), etc. Before the actual termination, the Team meets with the facility Administration to find out what their plan for closure is: how they will notify staff; what the contingency plans are for staff reductions; whether they will have meetings with the residents; etc. The facility is told that the relocation team will need a conference room to use during the closure process, as well as information from the facility.<sup>40</sup>

On the day of the termination, members of the Team visit the home to notify Medicaid or Medicare residents and families that they have thirty days to leave. Every resident is contacted one-on-one by a member of the Team. The Team member delivers the notification letter to each resident, explains the content of the letter and answers any questions. Then, members of the Team interview the residents using a list of uniform questions.<sup>41</sup> If a resident cannot be interviewed, calls are made to the families as quickly as possible. Residents are asked if there is anyone they want to move with and if they have any preference on where they might want to move. They are asked if they have any concerns such as their possessions, medication or special equipment, and whether they are smokers, veterans, etc. Residents who pay privately are given a letter from the State Long-Term Care Ombudsman explaining that the facility is losing their Medicare/Medicaid certification, but that they may be able to stay as long as the facility remains licensed, understanding that the facility will be losing residents and staff quickly.

Relevant findings from these interviews are added to the master spreadsheet for all team members to use in their work.

***“When I was working on a closure, I got to know the residents as people. I was onsite every day or every other day. I got to know the family. Thus, I was able to help them find a placement that is both appropriate and where they wanted to go, where they would thrive. I was worried about transfer trauma. I was a consistent face and person in their life at a time when things did not seem consistent.”*** Tessa Burton, Ombudsman Quality Liaison

<sup>39</sup> Interview with Jill Shonk, Bureau of Long Term Care, January 7, 2016.

<sup>40</sup> Pre-planning takes a lot of time. Many homes come into compliance. We asked if all the work done in the pre-planning phase was worthwhile. According to Julie Evers it is: “More often than not, they do come into compliance, but we may have found other important issues such as related to PASRR or MFP.”<sup>40</sup>

<sup>41</sup> See a copy of the resident form in Appendix

Residents and their families are given lists and descriptions of facilities that meet their needs based on their physical location, services offered and quality information. The Team refers residents and families to the web-based *Long-Term Care Consumer Guide* which includes inspection results and family and resident satisfaction survey scores for all the facilities they might consider.<sup>42</sup>

Shortly after, two teleconferences (one during the day and one at night) are held for anyone needing help; anyone can call in: residents or families. Members of the Team coordinate with one another to try to be onsite every day during the closure. For example, the Department of Health surveyors might alternate with the local long-term care ombudsman over a weekend. They get an updated census and status for every resident still in the home.

Ideally the closing facility then conducts safe and orderly discharges by:

- Giving the new providers resident records, physician orders, advance directives and family information.
- Making sure that the personal needs allowance accounts travel with the residents.
- Making sure that the personal property is packed in a dignified manner.

The receiving facilities arrange transportation.

The State Ombudsman monitors the discharges to ensure that these actions take place and solicits assistance from the Ohio Department of Health if needed. Sometimes the ombudsmen are called upon to engage with families and the receiving facilities to assist with packing and moving. Civil monetary penalties (CMP) monies have been used to purchase boxes for packing when the closing facility doesn't have any or proposes putting residents' things in plastic bags.

During chaotic transitions, it's an all-hands on deck approach for the Team by going through resident face sheets looking for family contact information and making calls to the families; calling neighboring facilities for capacity information and to find places that accept difficult to place residents, such as sex offenders. The Team has facilitated referrals being made to homes when the closing facility is slow to do so. Ombudsmen have sometimes positioned themselves at the door to the facility to direct traffic of moving trucks, families and media. Staff from all the agencies have helped with sorting documents, faxing paperwork, meeting with facility assessors, families, staff, etc. Ombudsmen have sought subpoenas to access residents' personal belongings and medical records after one home abruptly closed without distributing these items to residents upon discharge.<sup>43</sup>

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<sup>42</sup> See copies in the Appendix

<sup>43</sup> Email with Erin Pettegrew, May 2, 2016.

## Best Practices

### *Gathering of All Relevant State Agencies to Develop an Improved Process*

As stated above, Ohio's current process began with an examination of its old systems related to involuntary terminations using an intensive Kaizen event with all relevant entities. Interviewees believe that this was necessary to develop a mission for all state agencies related to nursing home closures.

### *Formation of a Resident Relocation Team That Includes All Entities*

The Resident Relocation Team that includes all the relevant state agencies is coordinated by the State Ombudsman Office. All members of the Team assist as needed. Residents with special needs (mental health diagnoses, developmental disabilities, private pay, and interest in living in the community) are assigned to team members based on their background, if needed. This includes the Medicaid Office, which participates actively – brainstorming solutions for an individual or helping make phone calls to other homes if needed at closure. One time the Medicaid staff had to tell a non-cooperative facility that it would not get reimbursement for its last 30 days if it did not cooperate.<sup>44</sup>

***“There are no hats at that time.”*** Jill Shonk, Bureau of Long Term Care.

***“We focus on the residents. It doesn't matter which entity we come from.”*** Jane Black, Project Director for the MFP.

### *Constant Communication and Team Work<sup>45</sup>*

A weekly call is held by the Office of the State Long-Term Ombudsman with the entire team even if there is no imminent closure. They discuss issues related to closure. This permits them to come up with new ideas. One example: A facility closed abruptly and residents were asked to leave immediately. One of the team members (the local ombudsman) brought up that residents leaving so abruptly might lead to “transfer trauma.” This triggered the decision to develop training for the receiving facility on how to mitigate transfer trauma.<sup>46</sup>

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<sup>44</sup> Interview with Julie Evers, Medicaid Health System Administrator 3, Office of Medicaid.

<sup>45</sup> Interview with Erin Pettegrew. September 29, 2015.

<sup>46</sup> Interview with George Pelletier, Community Options Coordinator, PASRR Bureau, Department of Mental Health and Addiction Services, February 18, 2016.

***“This structure is a forum for ideas.”*** George Pelletier,  
Community Options Coordinator, Bureau of PASSR.

### *Being Prepared: Work before Any Actual Closing*

The Resident Relocation Team is fully prepared for any closing. They begin their work sixty days before a potential closing.

### *Focus on Finding the Least Restrictive Setting*

Before closure, Money Follows the Person (MFP) staff look for anyone who has an application in for community living or who has the potential for community living and flags those residents. They look at PASRR information as well as the referral question on the nursing home assessment (Minimum Data Set – MDS) that asks residents if they want to speak to someone outside the nursing home about receiving care in the community. If the MFP staff find anyone who answered “yes” to the referral question, they make the referral directly. Without mentioning a possible closure, they also look at anyone currently in the process of transitioning or who has started the process and stopped.<sup>47</sup> Mental Health and Developmental Disabilities staff conduct a similar review of residents with mental health needs or developmental disabilities in the home.

During the closure, the PASRR Bureau may need to find a “transitional placement,” in a nursing home for a resident with high acuity mental health needs while the Bureau helps to set up a community placement. In that case, the Bureau follows that resident. The case is not closed until the resident is living in the community for one or two months.<sup>48</sup>

Even if a facility comes back into compliance, interviewees do not believe the work is useless or a waste of time. MFP staff will continue to work to see what residents could live in the community.<sup>49</sup> Similarly, the PASRR Bureau will act on the information it receives. If it finds PASRR non-compliance, it will perform assessments and/or notify the local boards of mental health to bring in providers to participate in determining if some residents could live in the community.

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<sup>47</sup> Interview with Jane Black, Project Director for the MFP, January 4, 2016.

<sup>48</sup> Interview with George Pelletier.

<sup>49</sup> Interview with Jane Black.

### *Help for Nursing Home Staff*

The Team works with the Ohio Department of Job and Family Services which houses the Workforce Development functions in Ohio. This Department has a Rapid Response Office/Unit/Division that is notified by employers whenever there is a mass layoff. The Team takes the initiative and notifies them when a provider is closing. The notification is done informally because the closing may not meet Ohio's 'mass' quantities requirement for notification or the facility may not be aware of the requirement.<sup>50</sup>

### *Follow Up*

State Ombudsman representatives visit all relocated residents in their new homes to ensure they are settled, have all the services and medical care they need and that their personal belongings and Personal Needs Allowance/Social Security and other issues have been addressed. Two visits are the goal. They visit within a week or so of the transfer and again six months post transfer. Any resident still interested in community living who was not able to transition out of a nursing home will continue working with HOME Choice, the program that transitions eligible residents from institutional settings to home and community-based settings.

The state is beginning to apply this entire closure process to voluntary closures.

### **Future**

#### *New Initiative:*

The state has decided it needs to focus on transfer trauma for all residents in all closures. After the training for the receiving nursing home staff on mitigating transfer trauma is piloted, the state will hold a debriefing and then work to incorporate and apply what has been learned to residents in voluntary as well as involuntary closures. This initiative is being led by George Pelletier, Community Options Coordinator, Bureau of PASSR, a member of the Relocation Team.

#### *Issues Needing Discussion:*

1. Sending a letter to the guardians or families if residents cannot understand the issues may be problematic because the Team may not have their contact information until it has access to the residents' face sheets, and the letters take a couple of days to get to them.<sup>51</sup>
2. Meeting with the facility before a closure to ask them their plans may not be as helpful as it could be because staff continue changing as the facility closes.<sup>52</sup>

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<sup>50</sup> Interview with Julie Evers and email with Erin Pettegrew.

<sup>51</sup> Interview with Erin Pettegrew.

<sup>52</sup> Ibid.

## Contacts

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## WISCONSIN

### Voluntary Closures<sup>53</sup>

#### Background

##### *Bringing Together All State Entities to Develop New Protocols*

Prior to the current system, Wisconsin had a method in place for nursing home closures that needed improvement. There seemed to be little protection for residents, and people were being moved hurriedly. The state became concerned about relocation stress, or transfer trauma.<sup>54</sup> To find ways to improve the closure process, the Division of Quality Assurance, of its Department of Health Services, convened a work group consisting of Division staff, the State Ombudsman, the Division of Long Term Care, the Division of Mental Health & Substance Abuse Services, and Disability Rights Wisconsin. Relocation teams (of sorts) predated the workgroup (as did the state statute authorizing them in closing facilities). The workgroup focused on

<sup>53</sup> Wisconsin rarely has involuntary closures.

<sup>54</sup> Interview with Dinh Tran, Division of Quality Assurance, January 7, 2016.

improving the team’s processes by clarifying roles and activities, rewriting the department’s manual and creating some resources. It did eventually result in the creation of (eventually two) relocation specialist positions that added considerable stability to the team process.<sup>55</sup>

The efforts of the workgroup resulted in:

- Shifting responsibility for overseeing a closure from the regulatory agency to the Division of Long Term Care. This Division has a greater focus on community placements and is more directly linked to the funding sources for these less restrictive placements as well as the managed care organizations that are directly involved in the discharges.
- Development of a detailed “resident-centered” relocation manual, based on Wisconsin law.<sup>56</sup> Among the items included in the manual are:
  - Detailed responsibilities of a relocation team (see below).
  - Specific responsibilities for the administrator, Director of Nursing, designated resident relocation coordinator, social services, and the financial/business staff.
  - Resource materials to lessen transfer trauma.
  - A number of creative ways to enhance the closure process, such as: holding going away parties; shopping for things needed in the new setting; and with permission, sharing addresses of relocated residents and giving updates of how relocated residents are doing.

An addendum that includes how to conduct an individualized relocation process is being added to the manual.

### **Current Process**

Under Wisconsin law, facilities relocating five or more residents must file a Resident Relocation Plan with the Division of Long Term Care. The state must respond within ten days or the plan is automatically approved (unless the state needs more information or clarification). The Relocation Team is asked to comment on the proposed plan before approval.

A facility cannot begin discharge planning for any of its residents until the Division of Long Term Care has approved the facility's Resident Relocation Plan.<sup>57</sup> Facilities are urged to meet with the Division of Long Term Care to discuss the requirements before submitting a plan. “It is crucial for facilities to involve and collaborate with the Department of Health Services, Division of Long Term Care, throughout this process. In addition, facilities contemplating closure or downsizing

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<sup>55</sup> Email from Tom La Duke, Relocation specialist, May 3, 2016.

<sup>56</sup> Interview with Tom LaDuke, Relocation Specialist, December 1, 2015.

<sup>57</sup> Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care - <https://www.dhs.wisconsin.gov/relocation/index.htm>.

should thoroughly review all state and federal regulatory requirements, including those of the Department of Workforce Development, which may differ significantly from the requirements in other states.”<sup>58</sup>

The Plan requires facilities to state how they will: mitigate relocation stress syndrome/transfer trauma; address special needs of persons with mental illness, intellectual and physical disabilities; address resident preference/choice for location settings; provide opportunity for the resident to visit potential alternate living arrangements and arrange for transportation; procure any needed medical equipment; involve the physician in the transition plan; work with residents and their families to resolve complaints or concerns; and, provide for all medical records to be transferred .<sup>59</sup>

When a facility submits a relocation plan to the Division of Long Term Care, it includes a roster of residents and their needs. Once the plan is approved, the Relocation Team (Division of Long Term Care Relocation Specialist, managed care staff, Ombudsman Relocation Specialist for residents over the age of 60, Disability Rights Wisconsin for individuals under the age of 60, and Aging and Disability Resource Center(s) (or in some regions, the county human services system), meet to introduce the members to facility administration and discuss the rights of the residents. The provider is also given a chance to update the Team on the closure status and any potential obstacles.<sup>60</sup> The provider then sends a letter to the residents and families inviting them to a meeting. Not until just before the meeting is held, the Ombudsman Office also sends a letter to residents and families that states their rights during a closure.<sup>61</sup>

***“The Team is strong. If a plan is not good, it is sent back.”*** Liz Ford,  
Disability Rights Wisconsin.

All members of the Team participate in the initial (announcement/informational) meeting with residents and their families. Others who may be asked to review the plan or conduct onsite visits include the Division of Long Term Care, the Division of Quality Assurance, the Division of Mental Health and Substance Abuse Services, Area Administration, and the Office of Legal Counsel. Liaisons to the Team are IRIS Independent Consultant Agency (helps individuals under the Medicaid self-directed waiver), and any relevant insurance plans.<sup>62</sup>

At this meeting, the Team discusses the reason for the closure, the kind of relocation assistance to be provided, options to be made available, and funding. Also discussed are the statutory and regulatory requirements (for safe and orderly transfers that avoid/reduce relocation stress); the

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<sup>58</sup> Ibid.

<sup>59</sup> Ibid.

<sup>60</sup> Ibid.

<sup>61</sup> See sample Introductory Letter (Appendix) to residents and family members.

<sup>62</sup> Relocation Manual.

state's role in monitoring the closure and each resident's relocation plan; the different roles of each team member and the kind of assistance each member can provide. The Team leaves contact information and literature,<sup>63</sup> and various team members follow up with posting and mailing introductory letters as well. The session ends with an opportunity for participants to ask questions and make appointments for subsequent meetings. Relocation planning meetings conducted by the closing facility and in conjunction with any managed care organization discussing resident condition and needs, options and choices are ongoing.<sup>64</sup> The Team meets weekly in person at or by phone with the closing facility and involves other stakeholders to ensure that: options counseling has occurred and that the outcome of that is reported; resident needs and preferences are considered; residents know their rights and those rights are protected throughout the closure. In addition, they seek to follow up on any relocation, particularly those that might have been problematic.

As the closure is implemented, the Team receives weekly reports on all relocations (to monitor for any obstacles and/or changes in condition, planning conferences, notices, referrals and assessments, tours and outcomes, actual transfers and the support given), hospital transfers (that are monitored until a final permanent alternate location is found,) and deaths.<sup>65</sup>

The Team relies heavily on the providers and supports (sending and receiving facilities, care managers, family) to orchestrate the actual move. The Team's role is to monitor and direct the process rather than to actually carry out the responsibilities for the transfer. The advocates (Relocation Specialist from the Ombudsman Office and Disability Rights) try to (and do in large part) follow up on relocated residents and the Division of Quality Assurance (regulatory agency) has done so as well (in particular situations).

Part of the team's regular process for weekly updates is to obtain post discharge reports from both the closing facility and the care managers (for Medicaid enrollees). The Managed Care Organizations have follow up responsibilities at regular intervals after the move outlined in departmental policy and contracts with the state. The regional (local) ombudsmen may have casework as a result of the move that keeps them involved with certain relocated residents for a period of time as well. Volunteer ombudsmen are routinely informed/notified of and asked to follow up on residents relocating to their assigned (receiving) facilities.<sup>66</sup>

## **Best Practices**

### *Gathering of All Relevant State Agencies to Develop an Improved Process*

As noted above, a work group consisting of the State Ombudsman, the Division of Long Term Care, the Division of Quality Assurance, the Division of Mental Health & Substance Abuse

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<sup>63</sup> *Making the Right Choice, You Have Rights, A Voice for Residents Should Your Facility Close and Relocation Stress Awareness*: State Ombudsman Office.

<sup>64</sup> Interview with Kevin Coughlin, Policy Initiative Advisor Executive and Jessica Gross, Relocation Specialist, Division of Long Term Care, Department of Health Services, January 7, 2016.

<sup>65</sup> Email from Tom LaDuke, May 3, 2016.

<sup>66</sup> Email with Tom LaDuke, May 4, 2016.

Services, and Disability Rights Wisconsin, was convened by the Division of Quality Assurance (which had the role of overseeing closures at that time) to find ways to improve the process.

#### *Creation of a Relocation Specialist within the State Ombudsman Office*

The Board on Aging and Long Term Care (State Ombudsman Office) applied to the regulatory agency to use CMP (civil monetary penalty) funds to pay for a new position: a Relocation Specialist, housed in the State Ombudsman Office. This position became permanent with funds from the legislature.

The Relocation Specialist functions whenever five or more residents are moved for any reason such as a closure, closing of a unit, downsizing or renovation. This position lends consistency since it is a statewide position. “We can hit the ground running.”<sup>67</sup>

As well as overseeing all closures in the state, the Ombudsman Relocation Specialist mentors and trains new local ombudsmen in their duties during a closure. The Relocation Specialist keeps an eye on the overall closure process; coordinates all ombudsman activities; and helps local ombudsmen where needed.

#### *Protections are in Statute*

The fact that all of the requirements are in statute is very important. It gives teeth to the rules.

**“If a provider says he cannot manage to help residents tour potential new facilities, I can tell them that it is in the law and they have to follow the law.”**

Tom LaDuke, Ombudsman Relocation Specialist

**“It gives statute protection for residents.”** Liz Ford, Disability Rights Wisconsin

*Fundamentals of the Chapter-Fifty Relocation Plan Process*,<sup>68</sup> created by the Ombudsman Relocation Specialist, lists the essentials of the mandates in the statute:

- The process must be person-directed with a focus on relocation stress mitigation (mitigating transfer trauma), and allow for plans that fully prepare the resident and subsequent providers.
- Residents must be provided with enough options that take proximity to friends/family into consideration.
- No resident can be forced to relocate to or remain in any placement without a court order.

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<sup>67</sup> Interview with Thomas LaDuke, December 1, 2015.

<sup>68</sup> See Appendix for copy. This has been used in training with state agencies and will be added to the official manual in the near future.

- Residents must be offered opportunities to tour alternative living arrangements.
- Residents must be provided assistance and support with moving and should not have to bear the cost of relocation.

### *Relocation Team*<sup>69</sup>

The establishment of a Relocation Team is also in Wisconsin statute.<sup>70</sup> Relocation Team members have divergent roles and responsibilities although all are asked to review the proposed relocation plan.

**“I spend quite a lot of time looking at the plan. I create a document with my comments and suggestions and speak to the Relocation Specialist in the Division of Long Term Care. Generally, my comments and suggestions are accepted.”**

Tom LaDuke, Ombudsman Relocation Specialist.

The whole Team works together to provide the relocating resident with information on how to access and obtain resources, how to collaborate in the discharge planning process, and how to ensure assistance with the successful implementation of the resident’s discharge plan. Team members focus on diminishing the effects of transfer trauma. They educate the facility on what they have to do to mitigate the stress and regularly monitor for this. They discuss ideas such as: tailoring activities to address the changing environment and focus on move related events; arranging to tour examples of various residential options, holding “going away” parties, or shopping for things needed in a new setting such as household goods or arranging “drive-bys” of new living arrangements to help residents become oriented to new and unfamiliar locations. The manual lists a number of other ideas such as: posting, with permission, addresses of relocated residents, giving updates on how relocated residents are doing in their new homes, and providing training on Resident Relocation Stress Syndrome for residents’ families and other representatives.<sup>71</sup>

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<sup>69</sup> Relocation Manual.

<sup>70</sup> Chapter 50, Wis. Stats.

<sup>71</sup> Relocation Manual.

**“We are all in this together. We want the best outcomes for the resident. Everyone comes to the table with their expertise. It is a group effort.”** Otis Woods, Survey Director.

### *“Lessons Learned” Meetings*

The Relocation Team holds “lessons learned meetings” after complicated closures to identify strengths of the process and areas needing further strengthening. At the beginning of the new process, these meetings were held after each closure; now, meetings are held less frequently. To prepare for the lessons learned sessions, the Ombudsman Relocation Specialist uses a worksheet<sup>72</sup> that includes the sex and age of the resident, payment source, concerns during the relocation process, follow up, and any transfer trauma. After each “lessons learned meeting,” the state produces a report listing the issues and the outcomes of the closure.

**“After each of the closures, the state discusses what could have been done better. This has led to changes over time. Collaboration is the key.”** Kevin Coughlin, Policy Initiative Advisor Executive Division of Long Term Care, Department of Health Services.

### *Clear Definition of Roles<sup>73</sup>*

The Relocation Manual clearly details the role of each Team member.<sup>74</sup>

The facility, managed care organizations: Prepare residents for relocation and help find placements that residents want.

Division of Long Term Care Relocation Specialist: Leads the team. Orients team members. Coordinates all activities and monitors the closing. Conducts the “Lessons Learned Meeting” when the closure is completed.

Ombudsman Office Relocation Specialist for residents over 60 years of age: Pulls together resources and keeps an eye on the process from a resident perspective. While the local ombudsman works on a case level, the Ombudsman Relocation Specialist focuses on systems advocacy. Examples of this include: providing communication to all, coordinating with the local

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<sup>72</sup> See Appendix for a copy of this outline.

<sup>73</sup> Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care.

<sup>74</sup> Ibid.

ombudsman, and liaising with the Division of Long Term Care's Relocation Specialist almost daily.<sup>75</sup>

Disability Rights Wisconsin for residents under 60 years of age: Advocates for the placement in the least restrictive setting.

Survey Director: Becomes involved only when there are problems with facilities following the rules. When this happens, he or she would clarify the rules for the facilities.<sup>76</sup> The Survey Director is not a regular member of the Team.

Other members of the Team: Monitor efforts to relocate residents.

#### *Timing: Depends on Number of Residents to be relocated*

State law<sup>77</sup> mandates that the effective date of closing may not be earlier than 90 days from the date a relocation plan is approved if 5 to 50 residents are to be relocated, or 120 days from the date of the relocation plan if more than 50 residents are to be located. The facility must remain open until each resident is properly relocated. If all residents are appropriately relocated before 90 or 120 days, the facility may close.<sup>78</sup>

#### *Unique Inclusions in the Required Relocation Plan:<sup>79</sup> Focus on Resident Transfer Trauma and Staffing Issues*

The "Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities," which includes all nursing home residents, identifies the critical importance of addressing resident transfer trauma and staffing issues.

#### Transfer trauma

The manual focuses on diminishing the effects of Relocation Stress Syndrome (RSS) or transfer trauma by including resources for staff training on how to identify and address RSS.<sup>80</sup> It also talks about designating staff to individual residents to monitor any stress during closure.

In addition, the manual discusses facility and state responsibilities during a closure.

Facility responsibilities: As part of its relocation plan, the closing facility must:

- Train staff on transfer trauma

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<sup>75</sup> Tom La Duke, February 15, 2016.

<sup>76</sup> Interview with Otis Woods, Wisconsin Survey Director, Department of Health Services, February 1, 2016.

<sup>77</sup> Section 50.03(14)e, Wis.Stats , <http://www.legis.state.wi.us/rsb/stats.html>. For regulations - [http://dhs.wisconsin.gov/rl\\_DSL/index.htm](http://dhs.wisconsin.gov/rl_DSL/index.htm)

<sup>78</sup> Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care - <https://www.dhs.wisconsin.gov/relocation/index.htm>.

<sup>79</sup> Ibid.

<sup>80</sup> Ibid.

- Consider proximity to family in the relocation
- Give residents an opportunity to visit alternative settings, with staff to provide transportation and support them
- Make sure all belongings and clinical information have been transferred to the receiving facility

#### State responsibilities

- If a discharge far from family cannot be avoided, the state has to consider ways to alleviate any harm to the resident, such as considering options available for providing transportation to a spouse.

Additionally, the manual addresses the responsibilities of the receiving facility: “For receiving facilities/entities, the goal is to focus on the relocated resident and her/his needs and wishes in order to mitigate or minimize transfer trauma/relocation stress syndrome after relocation.”<sup>81</sup> The receiving facility is given suggestions on how to lessen any trauma.

#### Staffing issues

The manual highlights the need to respond to employee stress and possible staff shortages by requiring the facility to explain how it will inform staff of the plans for facility closure or downsizing and the relocation of residents. The relocation plan must state how the facility will address staff stress at the loss of jobs and relationships and how the facility will act to retain necessary staff to facilitate resident care.<sup>82</sup>

**“We have spoken to staff sometimes before we speak to the residents or families to emphasize their need to help the resident and stay committed to their job.”** Kevin Coughlin, Policy Initiative Advisor and Jessica Gross, Relocation Specialist, Division of Long Term Care, Department of Health Services

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<sup>81</sup> Relocation Manual.

<sup>82</sup> Relocation Manual.

### Use of CMP funds

If the state takes over a facility through a receivership order (in cases where there is an immediate threat to residents), it might use CMP funds to hire a consulting and management firm to help with the closure.<sup>83</sup>

### FUTURE

The state is working to address the following issues:

- How best to advise residents and families. Since the meeting to announce the closing to residents and families occurs about a week after the plan is approved, many residents and families have already heard the rumors. Many leave or are very upset by the time the meeting is held.
- How best to help a resident with dementia to participate in the discharge planning and how to get providers and families to agree to their participation.

### CONTACTS

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<sup>83</sup> Interview with Lisa Thomson, Pathway Health, Independent Consulting and Management firm. Such a firm might also be hired by a facility itself to help, using facility funds.

## CONNECTICUT

### Voluntary Closures

#### Background

##### *Bringing Together All State Entities to Develop New Protocols*

In 1999, during a complicated closing in Bridgeport, Connecticut, the Connecticut Long Term Care Ombudsman Program convened a Nursing Facility Closure Response Coalition. Various state agencies were involved, such as the Department of Mental Health and Addiction Services, the Department of Developmental Disabilities, the Office of the State Long-Term Care Ombudsman, as well as Connecticut Legal Services. The mission of the Coalition was to develop a protocol to protect resident rights, provide legal representation and monitor the process as a facility closed.

A study, conducted by Waldo Klein, Ph.D., MSW, confirmed that the intervention by the Ombudsman Program and the Nursing Facility Closure Response Coalition during this complicated closure that led to convening the Coalition, lessened the difficulties faced by residents. As a result of these findings, the Ombudsman Program developed a Nursing Facility Relocation Plan to act as a guide for future closures. This plan is the foundation of the current process, but will evolve and change as needed.

#### Current Process<sup>84</sup>

Unlike most states, Connecticut can deny a facility's request to close. The facility must send a letter of intent requesting an Application for Approval to Close to the Certificate of Need and Rate Setting Division of the Department of Social Services (Medicaid Agency), Division of Health Care Services. This division evaluates the request on a number of different criteria: the relationship of the request to the state health plan; the financial feasibility of the request and its impact on the nursing home's financial condition; the impact of the closure on quality, accessibility and cost-effectiveness of health care in the region; utilization statistics; the business interest of the owners and partners; and any other factor the Department believes is important.<sup>85</sup>

At the same time the facility sends its request to the state, Connecticut law requires the facility to notify residents, families and the Ombudsman Program of its intent to seek approval to close.<sup>86</sup> The notice letter must state that the Department has 90 days to make a decision to

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<sup>84</sup> Interviews with Dawn Lambert, Project Director for Medicaid Rebalancing Initiative and Mairead Painter, Manager, Department of Social Services, February 1, 2016 and Nancy Shaffer, State Ombudsman, November 23, 2015.

<sup>85</sup> Department of Social Services: Decision in the matter of: Docket Number 10-710, Courtland Gardens Health Center, Inc. July 1, 2010.

<sup>86</sup> Conn. Gen. Stat. §17b-352.

approve or reject the request, that no resident can be involuntarily transferred during this time, and that all residents have the right to appeal any proposed discharge. A notice also goes up in the nursing home and is sent to newspapers in the area.

Next, the nursing home sets up family and resident meetings within a week or two to discuss the request to close. The purpose of the meeting is to explain the process, to assure residents that they have certain rights during the process and that they have the opportunity to make informed choices if the home is granted closure from the Department of Social Services.

The process of bringing together the various state agencies together is in flux. Historically, the Ombudsman Program initiated bringing the various state agencies together for a meeting with the residents and families. Over the years the process has evolved. A few years ago the head of the Medicaid Rebalancing Initiative (Money Follows the Person - MFP) and the Ombudsman Program conducted joint meetings when they had a group of four homes closing at one time. As the state has moved more and more towards encouraging individuals to receive care in the community, the process is changing and the state will be determining whether there is a need to redesign this part of the process. For now, MFP and the Ombudsman Program are undertaking this task.

A public hearing is then held, usually at the nursing home with a two-week notice (notice of the hearing is also put in newspapers). Once the public hearing is completed, the Department of Social Services reviews the hearing testimony and the certificate of need information. If the Department grants approval, the facility generally will close in 3-5 months.

Every resident is assessed and informed of their rights such as the right to choose, right to a discharge notice, the right to appeal the transfer, etc.<sup>87</sup> The Medicaid Rebalancing Initiative, (Money Follows the Person) immediately brings in transition coordinators and case managers, making sure that every individual knows their options to receive care in the community. In fact, MFP staff are often in the facility assessing residents for transition to the community as soon as the request for closure is sent by the facility to the state.

A specialized case manager is assigned to every resident; a transition coordinator develops the community plan if warranted. The case manager and transition coordinator talk to everyone. They do not rely on records. The State also pays for transportation to permit residents to visit other homes and alternative placements. This is part of the state's Informed Choice initiative (see below).<sup>88</sup>

The Ombudsman Program monitors the process and focuses on ensuring residents are not encouraged to transition to other nursing homes prematurely. It provides information on

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<sup>87</sup> See, "Nursing Home Closing – Resident Rights and Options," Connecticut Legal Services, Inc., in Appendix.

<sup>88</sup> Interviews with Dawn Lambert, Project Director for Medicaid Rebalancing Initiative and Mairead Painter, Manager, Department of Social Services, February 1, 2016 and Nancy Shaffer, State Ombudsman, November 23, 2015.

choices to residents and families; assists in their visiting other locations; and monitors the discharge plans, the upkeep of the home and the staffing levels. Ombudsmen make sure that residents understand they have the right to refuse a transfer. If a home the resident prefers has a bed, but doesn't want to take the resident, legal staff from the ombudsman office might call the home and remind them of their responsibility based upon state statutes<sup>89</sup>. In the past, they have also negotiated with a home to take a resident into a short term bed until a long term bed is available; worked with families that might be in disagreement; and monitored discharge plans. The State Ombudsman Office has developed checklists for residents and families on how to compare homes during on-site visits, as well as a Resident Belongings Packing List to help when packing up to leave.

If applicable, the Department of Mental Health and Addiction Services will come in and work with residents to determine their needs and placements.<sup>90</sup> A face-to-face assessment and interview is conducted with the resident and guardian to: discuss needs, give information about resources, and discuss returning to the community. If the resident is going to another nursing home, "we research the homes that have more experience with the needs of these residents."<sup>91</sup> They often take residents to view other living situations, such as residential care homes.

If the Ombudsman notifies Connecticut Legal Services that they are needed, staff will go in (sometimes with the Ombudsman) to talk to residents on Medicaid about their legal rights.<sup>92</sup>

Each agency works separately unless there is a need to coordinate.

***"If a nursing home refuses to take a resident, we might call the home that is refusing. We might set up an appointment with the resident at that home so the facility can meet the resident (before they reject). This might make a difference."*** Jennifer Glick, Director of the Department of Mental Health and Addiction Services

## Best Practices

### *State Can Deny a Facility's Request to Close*

State law requires that a nursing home facility that wants to close receive CON (certificate of need) approval to terminate services.<sup>93</sup> Although it has not been used often, the state can stop a closure. While most states say they cannot stop a provider from closing a home, Connecticut

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<sup>89</sup> Connecticut General Statute 17b-352

<sup>90</sup> Interview with Jennifer Glick, Director, Department of Mental Health and Addiction Services, February 1, 2016.

<sup>91</sup> Ibid.

<sup>92</sup> Interview with Kevin Brophy, Director of Elder Law, CT Legal Services, February 2, 2016.

<sup>93</sup> Conn. Gen. Stat. §17b-352. Massachusetts has recently passed a similar law.

law gives the state the power to say “no” based upon public need as well as other considerations (see above).

There are two situations where the decision-making by the state is limited.

- 1) If a facility files for bankruptcy. When this occurs, decisions are made in federal court.
- 2) When the state believes there is an immediate jeopardy for residents because the facility has run out of money and cannot and is not paying its bills. In these circumstances, the state, with the understanding that the provider will not object, applies to court to put in a receiver who will decide on the closure.<sup>94</sup>

In the last five years, there have been 13 closures: 3 bankruptcies, 5 receiverships and 5 CON requests.<sup>95</sup>

***“We denied one a few years ago; it was determined that it was financially viable and we needed the beds. We forced them to sell.”*** Chris Lavigne, Director of Reimbursement and Certificate of Need, Department of Social Services, Division of Health Care Services

### ***Mandated Public Hearing***<sup>96</sup>

Under Connecticut law, the Department of Social Services must hold a public hearing before making a decision to approve or deny a closure. The hearing is run by a hearing officer and is recorded by a reporter. The application is on the Department’s website for review before the hearing. The provider presents his/her case and can be asked questions by the hearing officer. These questions can range from how the facility tried to become financially viable to how it will conduct discharge planning if it closes. This permits residents and others to speak or submit written information about the closure at the public hearing for consideration by the state. It

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<sup>94</sup> Rich Wysocki, Principal Cost Analyst, Department of Social Services, February 25, 2016.

<sup>95</sup> Ibid, February 2, 2016.

<sup>96</sup> While many people believe this is a best practice because it slows down the process and permits residents and others to let the state know how the closure will impact them, the state’s rate setting director believes that it can put stress on residents and it opens the door for out of state providers to come in and look for a “fire sale.” He is concerned about the fact that if these new owners fail, the residents will have to go through another long process. He has begun to analyze the record of success and failure when the nursing homes are sold to out of state providers. In addition, he believes that Connecticut has too many nursing home beds and the state wants to rebalance. Interview with Chris Lavigne, Director of Reimbursement and Certificate of Need, Department of Social Services, Division of Health Care Services, January 26, 2016.

also slows up the process to permit more time for residents to find new placements if the facility does close. There must be at least two weeks' notice before the public hearing.<sup>97</sup>

***“The public hearing mandate is very helpful. It gives the people most affected the opportunity to participate.”*** Deborah Chernoff, Public Policy Director, New England Health Employees Union, District 1199, SEIU.

If the Department denies a request to close, the facility may be forced to sell at a loss or turn the facility over to the state. While the Department rarely denies a request, it can happen. In one instance, a concerted effort by the residents, families, community and union at the public hearing resulted in the Department refusing to grant a facility closure.<sup>98</sup>

As discussed above, there is a limitation of the best practice of holding a hearing. If a facility is facing possible closure due to a filing of bankruptcy or appointment of a receiver, no public hearing is required. The Federal Court in a bankruptcy proceeding might ask residents and families to testify, depending on the case. In a receivership, as noted above, the receiver makes the decision whether to close the facility. There is no requirement to hold a hearing.<sup>99</sup>

***“We need to hear from you in order to help us make a decision on this nursing home.”***

Hearing officer Rich Wysocki, Principal Cost Analyst, Department of Social Services – Wethersfield Health Center Hearing: November 10, 2011

Here are some selections of testimony by residents at a hearing:<sup>100</sup>

“I'm sure you are aware judge, that if you approve the closure of Wethersfield Health Care Center you are breaking up a family; my family. I don't care where I'm placed, but I want my roommate to come with me. We have a bond. And she has flourished as a result of our being roommates. I worry she will regress once you remove us from our home together.”

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<sup>97</sup> Chapter 368v\* Health Care Institutions, Sec. 19a-486.e.

<sup>98</sup> Interview with Deborah Chernoff, Public Policy Director, New England Employees Union, District 1199, SEIU, February 2, 2016.

<sup>99</sup> **Conn. General Statutes, Chapter 368v\*, Health Care Institutions, 19 a - 545.**

<sup>100</sup>Wethersfield Health Care Center, Date Taken: November 10, 2011

“I don't want to leave because I like the staff. The programs are fun. This is a good place to live. We are going to have to leave our friends. I don't want to leave my home.”

“I am concerned as to where I will be placed. I would like to be placed with my relatives who live in New London. I enjoy my staff and everyone I come in contact with. I would not want to lose that. I don't want my home taken away from me.”

“At this time in our lives we should not have to lose what we have now. We want to stay. This is my home. No one has a right to take it away from me.”

### ***Waiving Wait Lists and Enabling Residents to Move to Their First Choice Facility***

Within the last few years, Connecticut has instituted additional measures to enhance resident choice of facility during a closure.<sup>101</sup> For example, residents who wish to be admitted to a nursing home with a waiting list are permitted to bypass the waiting list. Furthermore, residents seeking admission to a facility with no vacancies can move to that facility within 60 days of their transfer if a room becomes available. While residents in that situation must first transfer to another facility, it still gives them a chance to eventually live in the home of their choice.

### ***Informed Choice Process for Nursing Facilities***<sup>102</sup>

The Department of Social Services has initiated an “Informed Choice” process for nursing homes. The goals are to:

- Find out the client’s individual preference for where they wish to receive care.
- Provide access to information about community options.
- Have the Universal Assessment completed and explore an individualized community care plan option for each individual.
- Provide an opportunity for an individual to move to the desired and most integrated setting appropriate to their needs.
- Consistently document the resident’s preferences.

This initiative focuses on residents generally, not just in situations where facilities close. However, according to Mairead Painter, Manager, Department of Social Services, this initiative frames how they work with residents when a facility gets an approval to close.<sup>103</sup>

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<sup>101</sup> Senate Bill No. 1127, Public Act No. 11-233.

<sup>102</sup> See Appendix for a copy of this initiative.

<sup>103</sup> Interview on February 1, 2016.

### *Letter to Provide Additional Information to Residents on Their Rights and Services Available*

The State Ombudsman has been concerned that once the facility notifies her and residents and families that it has applied for approval to close, many residents and families will panic before she can get in to make sure they understand their rights. The facility may be half empty by the time she arrives to give information. In May 2016, she was successful in getting legislation passed requiring that a letter be sent from the Ombudsman Program at the same time (or with) the facility letter. The ombudsman letter will provide further explanation of the closure process, residents' rights, etc. "Often times, many residents have already discharged to other nursing homes by the time this public hearing is held... The facility's letter presents only the facility/business's perspective and usually has strong language that gives the sense there is no alternative but to close. This initial message can be devastating to the resident and family. Therefore, balancing that message with the assurance that the residents have rights and protections needs to be heard at the same time. The addition of this letter from the Office of the State Ombudsman will present a more balanced picture to the residents and their families of what is happening, their rights and protections and advises them that they can take time and not be rushed into any decisions."<sup>104</sup>

### **FUTURE**

1. Connecticut had a statutorily mandated Nursing Home Financial Advisory Council made up of representatives from the licensure and investigation agency, ombudsman program, provider community, Medicaid agency, and Governor's Office of Policy and Management.<sup>105</sup> This council has been recently convened. Under the statute, the Council will examine the financial solvency of and quality care provided by nursing homes. Committee responsibilities include (1) evaluating any information and data available, including, but not limited to: (A) quality of care, (B) acuity, (C) census, and (D) staffing levels of nursing homes operating in the state, to assess the overall infrastructure and projected needs of such homes, and (2) recommending appropriate action consistent with the goals, strategies, and long-term care needs set forth in the strategic plan developed in statute. This Council has just become active. It meets quarterly. It has begun talking about the climate of homes going into receivership and out-of-state owners coming in. In the future it will examine incentives that can be built into the system related to financial issues, quality and oversight of the industry.
2. New statutory guidelines for Money Follows the Person requires them to get involved early in the Medicaid process. MFP staff have become very adept at nursing home transitions. This has given them an opportunity to regroup and think about a redesign of the closure process and the roles of MFP and the Ombudsman Program. They will be working on this in the future.

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<sup>104</sup> Agency Legislative Proposal – 2016 Session: 11302015\_SDA\_LTCOP/CON.

<sup>105</sup> Public Act 14-55, section 2 [1] and section 17-339 of the Connecticut General Statutes.

3. Union representatives<sup>106</sup> are concerned that once a home requests approval to close, the outcome seems inevitable. It believes Connecticut should think about how it let a home get to the stage where it feels it has to close. The state needs a better plan of assessing needs in the different parts of the state and not just focus on shrinking the number of beds in the state.

## CONTACTS

<p>Kevin Brophy Connecticut Legal Services Director of Elder Law 203-721-8550 <a href="mailto:kbrophy@connlegalservices.org">kbrophy@connlegalservices.org</a></p>	<p>Deborah Chernoff Public Policy Director, Connecticut New England Health Employees Union, District 1199, SEIU 860-251-6042 <a href="mailto:dchernoff@seiu1199ne.org">dchernoff@seiu1199ne.org</a></p>
<p>Jennifer Glick Director Department of Mental Health and Addiction Services 860-262-5818 <a href="mailto:Jennifer.glick@ct.gov">Jennifer.glick@ct.gov</a></p>	<p>Dawn Lambert, Project Director, Medicaid Rebalancing Initiative, Medicaid Agency 860-424-4897 <a href="mailto:Dawn.lambert@ct.gov">Dawn.lambert@ct.gov</a></p>
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<p>Rich Wysocki Principal Cost Analyst Department of Social Services 860-424-5103 <a href="mailto:Rich.wysocki@ct.gov">Rich.wysocki@ct.gov</a></p>	

<sup>106</sup> Interview with Deborah Chernoff, Public Policy Director, New England Employees Union, District 1199, SEIU, February 2, 2016.

## Other Innovative Practices in State Nursing Home Closure Protocols

While Connecticut, Ohio, and Wisconsin have a number of “best practices,” that we described in our detailed case studies, other states offer innovative and interesting systems or procedures related to nursing home closures. We have described some of these practices below<sup>107</sup>. These approaches are certainly not inclusive of all innovative practices around the country, but this information can serve as a resource for advocates and states seeking to improve their nursing home closure process. This list includes a brief summary of these state initiatives with contact information.

### **Iowa**

In Iowa, a closure team handles the process of closing a nursing home. The team consists of the Department of Inspections and Appeals (DIA), the Office of the State Long-Term Care Ombudsman (OSLTCO), Iowa Medicaid Enterprise (IME), and Disability Rights Iowa (DRI). DIA leads the team and conducts weekly meetings.

One of the most common challenges that closure teams face in Iowa is dwindling staff and supplies. DIA monitors staffing levels during the closure process. If staff members are quitting, the team requests the facility obtain temporary staffing for the closure. The facility can obtain the temporary staffing through temporary health care professional staffing agencies.

Iowa also has a unique practice of employing a discharge specialist to handle involuntary discharge/transfer notices. In the nursing home closure process, the discharge specialist participates in the following: (1) family and resident meetings when closure is discussed; (2) on-site visits, and (3) scheduled closure calls. In one-on-one meetings, the discharge specialist assists residents and their decision-makers with how the closure will impact them. In addition, the discharge specialist follows up with the residents after the move to determine if the transition was successful and to help the resident with any issues. Throughout the closure, the specialist provides advocacy for residents to maintain their rights and ensure their desires and needs are met.

Iowa has one another unique practice: during Iowa’s nursing home closure process, the closure team may utilize CMP funds to pay for expenses associated with the relocation to other facilities. Transportation expenses are an example of a covered expense.

For more information, contact:

Cynthia Pederson, JD  
Discharge Specialist  
Office of the Iowa State Long-Term Care Ombudsman

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<sup>107</sup> Most of these states were identified by the respondents to the on-line survey.

515-393-1710

[Cynthia.Pederson@iowa.gov](mailto:Cynthia.Pederson@iowa.gov)

## **Michigan**

A complete guide to Michigan’s nursing home closure practices can be found in, “Best Practices for Regulatory Nursing Facility Closure,” a manual created by the Michigan Nursing Facility State Closure Team.<sup>108</sup>

In Michigan, special emphasis is placed on finding out and fulfilling the residents’ needs and preferences during the closure process. Members of the team, including adult service workers and disability network staff, are assigned residents to work with. After assignment, the team member meets with the resident and family to inform the resident of the relocation options available: (1) relocation to another nursing home, (2) return to the community through a waiver program, or (3) relocation to an adult foster home or home for the elderly. Residents and families are asked to identify their top choices. These choices are then put into a “fax packet” and requests for admission are faxed to the selected places. Residents can choose where they go after being accepted to any of their choices. If none of their choices are able to accept them, team members work with residents to come up with additional choices for relocation. The “fax packet” can be found in the “Best Practices for Regulatory Nursing Facility Closures” manual Michigan created.

The closure team, which sets up a location in the facility to work, ensures that the residents’ needs are being met by having the teamwork area be open and accessible to residents. Often times, team meetings are held in an activity room or a dining room. State team members stay into the evening so that they can walk the halls and get to know the residents better. Team meetings are held daily in order to keep the most current log of information (fax packets, responses from facilities, and requests for additional information). With this updated information, every team member is able to help a resident with any question or problem the resident may have.

In addition, near the end of the closure, the team consolidates the remaining residents in the same hall of the facility. The closure team tries to keep roommates and friends together during the consolidation. To help keep the residents’ spirits up and keep them engaged, the team requests special meals for the residents, including their favorite foods, and they host special activities. In order to ensure that there are never only two residents remaining in the facility, the team holds the last five residents together until the last one has been placed. This way, they can all leave on the same day and no one is the last to go.

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<sup>108</sup> See Appendix.

Forty-eight hours after the resident has moved, a team member does a follow-up by telephone with the Director of Nursing, unit manager, social worker, or other staff member at the receiving facility to make sure the individual is adjusting well to the new setting. Often, multiple residents will move to a new facility together. If there are any questions or concerns, a team member and familiar face will attempt to resolve the problems in person.

For more information, contact:

Alison Hirschel  
Michigan State LTC Ombudsman program  
517-827-8023  
[hirschel@meji.org](mailto:hirschel@meji.org)

### **Minnesota**

Minnesota follows a detailed timeline when a nursing home intends to close. The facility must issue the first notice of closure to the Commissioner of Health, the Commissioner of Human Services, the county social services agency, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and any managed care organizations that contracted with Minnesota health care programs within the county where the nursing facility is located. Within five (5) working days of the first notice, the county must provide the nursing facility with the names, phone numbers, fax numbers, and emails of the persons that will be coordinating the county efforts. Within ten (10) days of the receipt of the first notice, the county must meet with the facility to develop a relocation plan. The Commissioner of Health, Commissioner of Human Services, Ombudsman for Long-Term Care, and Ombudsman for Mental Health and Mental Retardation are all given information about the date, time, and location of the meeting so that they may attend.

Minnesota has a helpful “Closure Planning and Resource Grid”<sup>109</sup> that delineates this timeline and the specific responsibilities that both the facility and county have during the closure process.

For more information, contact

Cheryl Hennen  
State Long-Term Care Ombudsman  
Minnesota Office of Ombudsman for Long-Term Care  
651-431-2555  
[Cheryl.hennen@state.mn.us](mailto:Cheryl.hennen@state.mn.us)

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<sup>109</sup> see Appendix

## **Pennsylvania**

In Pennsylvania, the team responsible for coordinating the closure process includes but is not limited to:

- Department on Aging Bureau of Facility Licensure and Certification (for personal care homes),
- Mental Health Association,
- Disabilities Rights Network,
- Legal Services, and
- Area Agency on Aging.

Depending on the needs of the residents, the relocation team may include representatives from the Office of Adult Protective Services, Salvation Army, Red Cross, the police, or the District Attorney (if criminal charges are being filed). The Department on Aging Bureau of Facility Licensure and Certification leads the relocation team. The Salvation Army & Red Cross find space, provide clothing, and sometimes house residents if there is a need. All other agencies talk to the residents to determine their needs and choices and deal with other issues.

The relocation team tries to coordinate the effort so there is enough time for a smooth and stress-free closure. However, many times, a nursing home closure is an emergency and is very stressful for the residents. Ombudsmen attempt to mitigate relocation stress by planning and preparing for closures in advance.

For more information, contact:

Lori Walsh  
Manager  
CARIE  
267-546-3441  
[Walsh@carie.org](mailto:Walsh@carie.org)

## **Rhode Island**

In Rhode Island, ombudsmen focus on transferring each resident's personal property from one nursing home to another during the closure process. In this way, ombudsmen can ensure that all of the residents' personal belongings go with them on discharge day, including their PNA money and clothes. Residents' clothes are placed in grey laundry bags, which dissolve in the washer. Utilizing these grey laundry bags helps prevent the transfer of bed bugs to the new nursing facility during the relocation process.

In addition to personal property, Rhode Island ombudsmen place a special emphasis on accounting for each resident's medications. If there are scheduled drugs for pain, facility nurses

inventory the remaining medications at the closing facility and bring it to the new facility. This additional step is taken so that each resident does not have to wait for a physician to prescribe the medication at the new facility.

Ombudsmen also assist with completing change of address forms so that any benefits from the government are sent to the new facility.

After the discharge, the ombudsman's office monitors the residents for a month to ensure that their needs are being met at the new facility. If the residents are unhappy with their new placement, they are moved again.

For more information, contact:

Kathy Heren

State Long Term Care Ombudsman

Rhode Island Office of the State Long Term Care Ombudsman

The Alliance for Better Long Term Care

401-785-3340

[kheren@alliancebltc.org](mailto:kheren@alliancebltc.org)

## **South Carolina**

The South Carolina Department of Health and Human Services convenes an interagency Emergency Response Task Force ("task force") when a nursing facility needs to be closed. The state long-term care ombudsman, local long-term care ombudsman, Protection and Advocacy for People with Disabilities, Department of Health and Environmental Control Licensure and Certifications, Adult Protective Services, and Medicaid representatives are frequently on the task force. The task force confirms roles and responsibilities and coordinates development of an action plan for resident relocation.

One of the first steps the task force takes is to compile a list of residents and information. Next, ombudsmen work with Medicaid to develop a letter informing residents, their representatives and family members about the impending closure. Ombudsmen then interview each resident and/or representative in person to find out where they wish to live after the closure, and the task force determines the availability of a bed in the resident's preferred facilities. The task force also considers how to pay for the residents' transportation before relocating residents. Generally, State Long-Term Care Ombudsman or local Long-Term Care Ombudsman Program representative take charge, meet with the team, and keep everyone updated on the status of the residents' placement.

To ensure that residents have at last the basics and their personal items when they move, each resident is given an "emergency relocation bag" that includes toiletries, light clothing, and an extra bag for packing their personal items.

Ombudsmen operating in the receiving region are notified of the transfer and expected to visit with residents within the first thirty (30) days of moving in.

For more information, contact:

Dale Watson

State Long Term Care Ombudsman

South Carolina Lieutenant Governor's Office on Aging

803-734-9898

[dwatson@aging.sc.gov](mailto:dwatson@aging.sc.gov)

### **Washington DC**

Washington DC Ombudsman Program has a team including the assigned nursing home ombudsman, the ombudsman program manager, and about nine volunteers monitoring an ongoing closure. The Program has developed:

- a resident closure packet which includes among other things:
  - A Guide for Resident/Family /Guardian during Nursing Home Closure which includes a checklist and describes the major process.
  - A Resident Preferences Sheet that lists wake up times, sleeping aids, bathing preferences, etc. to help the staff at the new location.
- Volunteer Closure Packet which includes among other things:
  - An intake form
  - A Discharge and Transfer Procedures listing exactly what the volunteer is to do.

The Ombudsman Program is also utilizing regular family council meetings to ensure that the facility provides updates to the residents and family members as well as participation of the regulatory agency, the Medicaid agency and the DC office of Aging. Their office advocated for all these groups to attend so all family members and residents could understand their role during this closure.

Staff also invited Ombudsman from Virginia and Maryland to participate in the meeting to provide information about the nursing homes in neighboring jurisdictions. Through their advocacy, residents can now go to these out of state/contracted Medicaid facilities without having to go through a major process.

In addition, Washington DC's Code gives private right of action<sup>110</sup> to residents, resident's representative and the long term care ombudsman that gives them the right to bring an action in court for a temporary restraining order, preliminary injunction, or permanent injunction to

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<sup>110</sup> Nursing & Community Residence Protection §44-1004.03, Subchapter IV. Private Rights of Action.  
<https://beta.code.dccouncil.us/dc/council/code/titles/44/chapters/10/>.

enjoin a facility from violating any provision of the law. It also gives them the right of civil action for damages.

Subchapter II of this Code gives the resident, resident's representative and the long term care ombudsman the right to ask the Attorney General to petition the court for a receiver, or, if denied, to file the request themselves.<sup>111</sup>

Contact:

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DC Long-Term Care Ombudsman Program

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## **CASE STUDY: POOR PRACTICE**

Blossom South, Rochester, New York State

### **Characteristics<sup>112</sup>**

Blossom South was a for-profit long-term care nursing facility in Rochester, New York known as a chronic underperformer. With 161 beds, 98% of its revenue came from Medicaid. Before its closure, Blossom South had a high population of residents with bariatric and mental health challenges.

### **History**

In a 3.5-year span, the Ombudsman recorded changes of eleven social workers, thirteen administrators, and eight directors of nursing. The facility also had a history of poor surveys and went through eighteen Department of Health (DOH) inspections between 2010 and 2013 that resulted in multiple citations. Nearly 170 deficiencies were cited by DOH in that timespan, 119 of them related to the health and safety of residents. The State also reported that thirty-three of the deficiencies were problems that had been previously cited. As of July, 2013, the facility

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<sup>111</sup> <https://beta.code.dccouncil.us/dc/council/code/sections/44-1002.03.html>.

<sup>112</sup> Power point presented by Alana Russell, Ombudsman Coordinator for Monroe and contiguous counties, to New York State Ombudsman coordinators, June 11, 2014.

had been on The Centers for Medicare and Medicaid Services' (CMS) Special Focus Facility list for 27 months.<sup>113</sup>

### Timeline of Closure

August, 2013: Blossom South faced closure; CMS was ending the agreement to reimburse for Medicare and Medicaid residents, effective Sept. 15, 2013. This sparked a legal battle that the facility pursued, delaying the closure process for several months.

December 2013: Administrative judge and Federal judge ruled against Blossom South in appeals to the termination notice from CMS.

January, 2014: Blossom South sued again to stay open; a Federal judge again ruled against Blossom South.

February, 2014: Blossom owner hoped for reversal; 100 residents remained; the provider agreement with CMS was scheduled to end March 16.

March, 2014: On the 14<sup>th</sup>, the State said that Blossom South must close two days later. There were 68 residents left. Many were targeted to go to a facility in Utica, 130 miles east of Rochester. This was a home they did not choose. The home was a one-star nursing home, listed as much below average in inspections, staffing and quality measures.<sup>114</sup> It had higher-than-average complaints about its quality of care. It was owned by a man whose name was still on the Blossom South's license.

The Ombudsman program received multiple calls from families complaining about the Utica placement; the Ombudsman volunteer visited Blossom South and witnessed mass exodus: 9 vans, no belongings. Blossom South families faced uncertainty of where their loved ones would go.

### Final Placement

After going through many years of poor care at Blossom South and then a disastrous transition, many residents ended up far from their family and community in other poorly performing nursing homes.

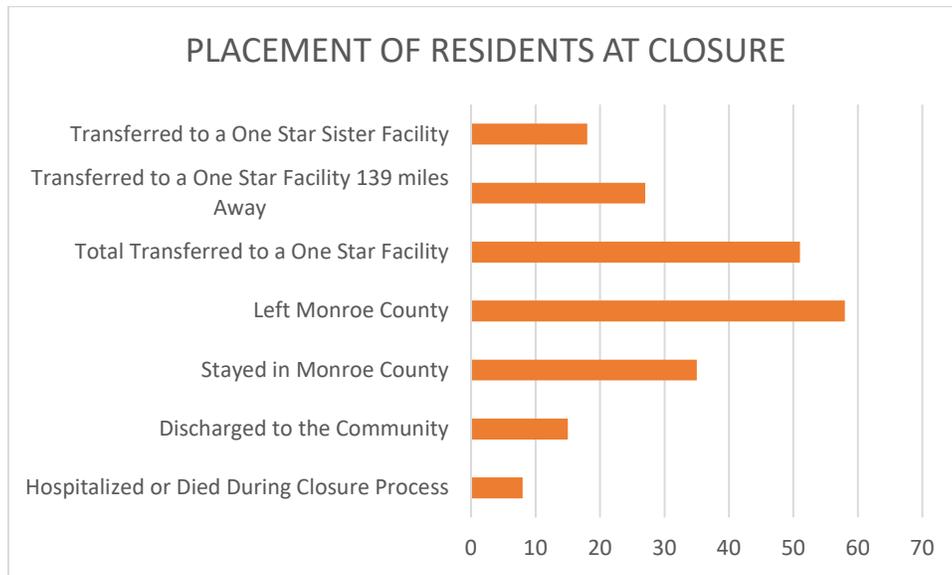
- 58 residents left Monroe County – 27 to a one-star facility, – 130 miles away from family and friends.
- 35 residents stayed within Monroe County: 20 were placed in nursing homes and 15 were discharged to the community.

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<sup>113</sup> Special Focus Facilities are homes that have more serious problems than other homes (about twice the average) and continue to over a long period of time. They often have “yo-yo” compliance – going in and out of compliance. The author of this report has known of the problems at this facility for many years.

<sup>114</sup> See, CMS Nursing Home Compare for this home: November 30, 2015.

- Of the 20 placed in Monroe County nursing homes, all were sent to facilities with poor care and the same or mutual owners. One receiving facility was going through bankruptcy. <sup>115</sup>



## Closure Process

### According to the Long-Term Care Ombudsman Coordinator for Monroe and Contiguous Counties <sup>116</sup>

#### *Problems from the Start*

During the closure process, in mid-February 2014, the New York State Department of Health (NYSDOH) asked the ombudsman to make a presentation to residents and families to discuss the closure on two occasions. When it came time for questions to be asked/answered during these presentations, the facility management/administration took over and told families simply, “not to panic, we are fighting the closure and that we don’t really believe we will close.”

The ombudsman was on-site weekly and reported resident and family complaints to facility administration/management, as well as to NYSDOH. It was not clear, however, that NYSDOH ever acted upon those complaints, nor did the local ombudsman observe a regular NYSDOH presence on site at that facility. The closure plan was published in the local paper on February 16, 2014. This was the first time that the ombudsman was able to see the closure plan, which

<sup>115</sup> Power point presented by Alana Russell, Ombudsman Coordinator for Monroe and contiguous counties, to New York State Ombudsman coordinators, June 11, 2014.

<sup>116</sup> Interview with Alana Russell, Local Ombudsman, Life Span, November 9, 2015.

was dated January 16, 2014. She noted that had she been able to review the plan in January, she would have known what the facility had stated it would do to make the transition for residents a smooth, dignified experience.

The social workers in the facility left within the first few weeks of January 2014, leaving it to the Director of Nursing (DON) to contact other facilities in the area about accepting residents. It's unclear to what degree this was done by the DON.

### *Transfers were Chaotic*

In mid-March, the census of the facility was down to sixty-eight. On March 16th, when arriving at the facility for his regular weekly visit, the ombudsman volunteer witnessed about nine vans outside the facility. Twenty-seven residents were being packed into the vans without their belongings. Residents told the volunteer ombudsman they did not know where they were going except they had heard Utica, NY mentioned. In the days after the transition, the local ombudsman program received multiple calls from upset family members about their loved ones being moved to Utica. Families stated that residents did not have their personal belongings, including one gentleman who was reportedly sent to the new facility without his prosthetic leg. Twenty-seven residents were relocated to Utica - a facility that was owned by one of the Blossom South owners.

**Local Ombudsman:** "I think CMS and the state have forgotten that residents are people... with skin and bones and families and lives." From this experience it appeared to her, "... that the regulatory agencies only cared about rules/regulations."

The Ombudsman Coordinator does not believe that it would have been a good idea to extend the time for the closing for a number of reasons. From her perspective, this was an awful facility. If they had more time, they would not have done any better; they would just have been collecting more public money and continuing to drag their feet in finding appropriate places for residents to go. She felt she was fighting the facility and thought the state could have provided additional guidance/support.

### **According to the Elder Justice Committee of Metro Justice of Rochester<sup>117</sup>**

Founded in 1965, Metro Justice is Rochester's leading grassroots, member-driven, progressive organization working for social and economic justice. The Elder Justice Committee focuses on

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<sup>117</sup> Interview with Ken Traub, Co-Chair of Elder Justice Committee of Metro Justice, October 27, 2015 and emails in 2016.

eliminating issues related to elder abuse, neglect and exploitation, and issues of enabling elders to live purposeful, self-directed, meaningful and dignified lives in their homes and communities.

### *Residents Sent Far from Home to Poorly Performing Facilities*

This committee became outraged when they found out that many residents were placed into one-star CMS rated nursing homes in Utica, New York, 130 miles away from their community and families. Only 20 were moved into the 34 remaining Monroe County nursing homes which had more than 350 vacant beds at the time of Blossom South closure<sup>118</sup>. The Committee wanted to know why the residents could not have been admitted to Monroe County nursing homes.

### *More Time Was Needed*

After a meeting in April, 2015 with NYSDOH Deputy Director of the Division of Nursing Home & ICF Quality & Surveillance, and Western Region State officials, the Committee sent a letter to CMS and the state, urging that more time be given for residents to find places in facilities of their choice. The 60-day period between the receipt of the CMS provider termination letter and cessation of Medicaid and Medicare funding was insufficient to honor virtually all residents' strong preference to stay in their local community of Monroe County.<sup>119</sup> The Committee felt that the state should have put the facility into receivership or CMS should have granted a longer period of time for the facility to close.<sup>120</sup> *"This could have been used to either buy additional time to either place most residents in their community or to sell the home to a better operator."*

During a phone conference call with CMS, the Committee reminded CMS that it could extend the time for closure by referencing CMS's own memos.<sup>121</sup> In addition, the Committee noted that the Code of Federal Regulations Title 42 Public Health Subpart E – "Termination of Agreement and Reinstatement after Termination section 489.55 Exception to the effective date of termination allows for an extension of payment "for up to 30 days after the effective date of [funding] termination."

### *Working to Get Residents Back to Monroe County*

Elder Justice Committee members spent the next year identifying the ex-Blossom South residents still in Utica who wanted to return to Monroe County and attempting to get the

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<sup>118</sup> According to research conducted by Ken Traub on NYDOH's website.

<sup>119</sup> Letter sent to NYSDOH Deputy Director Shelly Glock and CMS Division of Nursing Homes Director Karen Tritz on November 2, 2015.

<sup>120</sup> According to Mr. Traub, NYSDOH stated that CMS rules don't allow for a Special Focus Facility to be placed into receivership but in an email sent August 12, 2015 by CMS Director Karen Tritz to Mr. Traub, "...there are no rules that disallow a Special Focus Facility from being placed into receivership."

<sup>121</sup> CMS/SCG Special Focus Facilities (SFF) Procedures memorandum S&C-10-32-NH.

NYSDOH to help. According to the Committee, a number of activities finally led to the assignment of a NYSDOH social worker and in the Elder Justice Committee Co-chairs being invited to an April 2015 meeting with the NYSDOH. These activities included an Elder Justice staged media event in December 2014, a public letter to NYSDOH Commissioner, articles in the *Rochester Democrat & Chronicle* and interest shown by a *New York Times* investigative reporter. The Committee believes that the media event and the bad publicity led the NYSDOH to reverse its position that its role is only to monitor the process and any transfers from the Utica home was the responsibility of the facility. The Committee believes that the social worker was assigned to work with the home in Utica to help these residents return to Rochester.<sup>122</sup>

The last Utica resident who wanted to return was finally transferred back to Monroe County 19 months after having been sent to Utica against her will.<sup>123</sup>

### *Suggestions for NYSDOH and CMS*

At the meeting with Western Regional NYSDOH staff,<sup>124</sup> the Elder Justice Committee presented a number of suggestions for a better resident placement closure:

- Assure that all residents and their primary family contact(s) express their desire regarding whether they want to remain in a nursing home in their own community (county).
- Provide the closing nursing home with adequate time to place all residents in their own community after all their legal appeals to prevent closure have been denied.
- Obtain CMS approval to adjust the Medicaid funds termination date to accommodate the above objectives.
- Influence 3-5 Star CMS rated local county nursing homes to accept Medicaid residents from the facility that is closing.
- Only approve a nursing home's Closure Plan that can realistically meet the health, safety, psychological, and placement desires of the residents and family members.

In addition, the Committee recommended that the CMS Survey and Certification Group reissue an updated Special Focus Facilities Procedures memorandum (S&C-10-32-NH) reemphasizing the Termination of the Provider Agreement section to all State Survey Agency Directors. This memorandum should reinforce all the options a state agency has in assuring that residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

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<sup>122</sup> Email from Ken Traub, Co-Chair of Elder Justice Committee of Metro Justice, April 7, 2016.

<sup>123</sup> Please refer to Appendix XX Elder Justice Committee "Repatriation of Blossom South Nursing Home Residents sent to Utica from Rochester" November 23, 2015 document.

<sup>124</sup> Elder Justice handout from April 16, 2015 meeting with NYS Western Region Department of Health and Elder Justice Committee of Metro Justice.

The Committee also recommended actions NYSDOH should take to follow up:

- NYSDOH should play a strong role in bringing back Blossom South residents who still reside in Utica nursing homes.
- NYSDOH should increase the number of nursing homes that are designated as a Special Focus Facility, paying special attention to one star CMS rated homes having significantly low licensed nurse + CNA staffing levels.<sup>125</sup>
- NYSDOH should significantly increase deficiency penalties to be meaningful deterrents to repeated occurrences.

### *NYSDOH helps bring residents back to Monroe County*

After the media event held by Elder Justice and the resulting bad NYSDOH publicity, NYSDOH assigned a social worker to work with the facility to help those wanting to return to Monroe County to do so.<sup>126</sup>

### **Family Member Experience**

One mother was called an hour before her daughter was transferred. She was told that her daughter was being discharged to a city almost 3 hours from her home. She did not even know the name of the home her daughter was going to for two weeks after her transfer. She had no time to get to the home to say goodbye to her daughter. She is elderly with medical conditions of her own and does not have a car. She speaks to her daughter over the phone, but she cannot get to visit.<sup>127</sup>

“I feel helpless. I don’t know if I will ever be able to see my daughter again. I didn’t hear much about the closing. I was notified of a meeting. My son went. All I was given was a list of nursing homes given to everybody. I was given no help. They told us to make calls. This has destroyed my health.”

Family Member

### **NYSDOH**

In an interview with NYSDOH staff<sup>128</sup>, they said that they:

<sup>125</sup> CMS makes the rules regarding Special Focus Facilities. However, NYSDOH could argue for designating more than their CMS mandated three nursing homes slots, as can other states. Source: CMS S&C 14-20-NH.

<sup>126</sup> Interview with Ken Traub, Co-Chair of Elder Justice Committee of Metro Justice, October 27, 2015 and emails in 2016.

<sup>127</sup> Interview with a family member October 1, 2015.

<sup>128</sup> Interview with Shelly Glock, Deputy Director, Bureau of Long Term Care, NYDOH, October 22, 2015.

- Were carefully monitoring the closure.
- Tried to get facilities in Monroe County to take residents.
- Convened a call with all the homes and discussed the need to take some of the residents.
- Were proactive in helping to get some equipment from the closing home to a new home that was willing to admit a resident if they got the equipment. They stated that the residents were difficult to place, and they did all they could.

NYSDOH also noted that they cannot force a nursing home to take a resident.

### Follow Up

Both the Ombudsman Coordinator and Elder Justice Committee Co-Chairs met separately and had phone calls with NYSDOH to discuss the closure. According to both, the meetings seemed to have led to little or no lessons learned.

## RECOMMENDATIONS

The recommendations below are based upon the findings of this project.

### RECOMMENDATIONS FOR CMS CLOSURE REQUIREMENTS

On March 19, 2013, CMS finalized its requirements for long-term care facility closures.<sup>129</sup> In response to public comments urging more specific requirements, CMS stated, “We appreciate the commenter’s suggestion; however, we do not believe it is necessary to include specific requirements for the plan in the regulation text. We want to allow each LTC facility the flexibility to develop a plan that would most effectively protect the residents’ health, safety, and well-being.”

**The experiences of our study respondents and interviewees - residents, family members and ombudsmen - clearly indicate that more specific requirements are indeed necessary.**

Although the final rule states that “the administrator (must) include in the written notification of closure assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident;” and, “the plan must include assurances that the

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<sup>129</sup> <https://www.federalregister.gov/articles/2013/03/19/2013-06276/medicare-and-medicaid-programs-requirements-for-long-term-care-ltc-facilities-notice-of-facility>.

residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident,” **we found that in many cases this does not happen. Far too often the closure process forces residents to move to locations they do not choose or want. We therefore urge CMS to make the recommendations described below.**

### **General Recommendations:**

#### **1. Require states to develop a coordinated state team focused on closure and relocation.**

The case studies of Connecticut, Ohio and Wisconsin and the highlighted innovative practices of other states indicate the importance of a coordinated state team in minimizing the negative impact of relocation on residents. See Case Studies and “Other Innovative Practices in State Nursing Home Closure Protocols.”

We recommend requiring states to develop a “relocation team,” consisting of all relevant state agencies/programs, including the regulatory agency, the Office of the State Ombudsman and the agency that deals with community care, such as Money Follows the Person (MFP). This team should create a state closure protocol and manual defining the different roles of each agency, the specific closure process, the responsibilities of the closing facility, the responsibilities of the receiving facility and the rights of residents and family during a closure. The team should meet regularly regardless of whether there is a closure pending.

As soon as the facility is given a closure date, the team would immediately hold a meeting with residents and families to discuss the closure process and rights. One or more members of the team should be on-site daily during any closure to monitor the closure process and meet one-on-one with residents to explain the process, their rights, and answer questions. Even prior to knowing the closure date, community care staff should be in the facility talking with residents about their interest in returning to the community. In Ohio, community care staff go into any facility that is under immediate jeopardy (serious deficiency that may lead to decertification). They do not discuss closure, as the facility may yet come into compliance, but they begin identifying individuals who may want to transition to the community.

#### **2. Require that states include the State Ombudsman in the closure plan review and provide opportunity for the State Ombudsman to provide comments on the plan before approval of the plan.**

Our study indicated that one of the most important elements of a successful transition for nursing home residents is active participation of the long-term care ombudsman. Ninety-five percent of the respondents to the question related to criteria for a successful transition on our

on-line survey stated that the active participation of the ombudsman was needed for success in a voluntary closure and over ninety percent stated ombudsman participation was necessary for an involuntary closure. As the residents' advocate, the ombudsman will work to assure that the needs and preferences of each resident is taken into account throughout the closure process, and that the rights of the residents' are respected and protected to every extent possible.

### **3. Make available Civil Money Penalty funds to support residents during the closure process**

Federal law permits the use of Civil Money Penalty funds to be used to support and protect residents of a facility that closes or is decertified<sup>130</sup>. The funds can be used to assist with relocation of residents to other settings, or be used to protect residents during the closure process.<sup>131</sup> These funds should be used to support state efforts to more effectively plan for and coordinate the closure process by, for example, establishing a Relocation Team, or developing a closure manual. Additionally, the funds should be made available if needed during the closure process for assisting residents transition to other facilities or home and community based settings, or in some instances, to impose a management oversight company or temporary manager to oversee the closure.

### **4. Provide clarity to state licensing and certification agencies about their role in closures.**

Federal law requires the state survey agency to approve a nursing facility's closure plan, but based on responses to the surveys by ombudsmen, advocates, and survey directors on state closure processes, and interviews with directors of state licensing agencies, CMS should provide additional clarity through guidance and training as to the role of the state survey agency during the closure process, which should include not only approval of the closure plan, but also oversight of the plan's implementation, including protection of the rights of the residents forced to move.

## **Recommendations Related to Specific Obstacles to a Successful Resident Transition Raised by Those Experienced in Nursing Home Closures:**

*Obstacle 1:* Lack of appropriate and nearby placements in another facility either because there are no vacancies or providers do not want to take a specific resident.

- 1.** Require that any facility, chosen by the resident, which has a vacancy but chooses not to admit her/him, must document and send to the state the reasons for this denial.

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<sup>130</sup> Sections 1819(h)(2)(B)(ii)(IV)(ff) and 1919(h)(3)(C)(ii)(IV)(ff) of the Social Security Act

<sup>131</sup> CMS Survey & Certification Letter, S&C:12-13-NH

If the facility claims it is unable to care for the resident, the facility must identify specifically which care needs they are unable to meet and why. This recommendation is consistent with CMS's proposed revision to 42 CFR § 483.15(b) (2), even though it refers to discharge and not nursing home closure. It would require that, "when a facility transfers or discharges a resident because the transfer or discharge is necessary for the resident's safety and welfare, the facility would include in its documentation the specific resident needs that it cannot meet, facility attempts to meet the resident needs, and the service(s) available at the receiving facility that will meet the resident's needs." We believe this proposal will discourage facilities from discharging residents inappropriately. We note that facilities are obligated under the Americans with Disabilities Act and the Rehabilitation Act not to discriminate against residents based on the severity of their disability.<sup>132</sup> While focusing on discharges, we believe that the proposed rule requiring "documentation of the specific resident needs that it cannot meet" should apply in situations where a facility with a vacancy is refusing to admit a resident from a closing facility. Refusing facilities should be urged to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs.

The state must evaluate the reasons presented by the facility. If the state agrees that the reasons for the denial are legitimate, it must be proactive and try to find a solution to the problem. For example, if a resident is a bariatric resident and the facility lacks the needed bariatric equipment, the state must attempt to address the situation by helping the facility locate such equipment, perhaps from the facility that is closing. Another possible solution might be for the State Medicaid agency to increase the receiving facility's Medicaid reimbursement rate for a limited time, and to fund experts to help staff learn how to address the needs of the resident. CMS should permit the State Medicaid agency to consider using Civil Monetary Penalties (CMPs) for this purpose.

We further recommend that if the state determines that the documentation presented seems to be a violation of Civil Rights laws, the state must issue a citation that leads to a significant fine. To come back into compliance, the facility must a) admit the resident who was denied admission if the resident still wishes to live in the facility, and b) change its admission policy to fully comply with the federal Civil Rights laws.

**Obstacle 2:** Poor discharge planning occurs when important information about alternative placements, choice, and rights is not provided to residents and families.

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<sup>132</sup> Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/16/2015.

1. Require states to bring in independent discharge planners, hire a management company, or apply for a receivership, if complaints by residents, families and ombudsmen and on-site monitoring by state agencies indicate a lack of appropriate discharge planning on the part of closing facility staff.
2. Require states to develop a closure manual for providers, which would include checklists of tasks they must carry out before any resident is transferred. Wisconsin's manual has samples of many checklists, including one for residents.<sup>133</sup> Michigan's manual is extremely detailed,<sup>134</sup> and includes a number of excellent checklists for the administrator.
3. Require states to: develop a system for residents and families to file complaints about the closure process and receive an immediate response; review all complaints received during the closure to identify problems; perform root cause analysis; make improvements based on analysis; and submit complaint review/analysis to CMS.

Obstacle 3: Lack of communication, including accurate information, by providers to residents and families.

1. Require on-site monitoring of the closing facility by the relocation team described above.
2. Require the regulatory agency to hold a facility accountable, such as through a citation and fine, for knowingly providing inaccurate information regarding closure to residents and families.  
CMS must be prepared to cite a facility and fine the facility for giving false information if the state does not and to hold states accountable for the quality of their surveys as well as the timeliness of surveys.
3. Require providers to do all the tasks listed as guidance in the interpretive guidelines. As noted above, our study indicates that even though these tasks are listed as guidance, our respondents do not find them being implemented by most providers; thus they must be mandated.

Obstacle 4: Poor notice/not enough time to find new placements.

1. Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If Medicaid/Medicare funding is ending, CMS should ask the Secretary to use his/her authority to continue payments until residents are successfully relocated<sup>135</sup>. If the state or CMS is concerned about poor care, or the owner runs out of funds, the state must be prepared to impose a receiver to manage facility operations.
2. Require a facility to notify all residents and families of an impending closure of an involuntary closing at least 60 days before the closure. Currently, the requirement of 60 days is only for a voluntary closing; the Secretary will determine the appropriate time for an

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<sup>133</sup> <https://www.dhs.wisconsin.gov/relocation/relocationmanual.pdf>.

<sup>134</sup> <http://ltombudsman.org/uploads/files/issues/MILTCO-Best-Practices-for-Voluntary-NF-Closure-4-28-05.doc>.

<sup>135</sup> 42 CFR 488.450(c)(2)

involuntary closing. If the Secretary determines the facility must be decertified in less time because residents are at risk, CMS must require the state to take over the facility in a receivership or require the facility to hire independent overseers to monitor and care for residents until all are transferred to an appropriate location of their choosing.

Obstacle 5: Staffing issues occur such as staff leaving, staff stress and bitterness.

1. Require the state relocation team to focus on the needs of staff by notifying the State Department of Labor or Employment Agency to help with unemployment insurance and finding staff new positions.
2. Require the facility closure plan to include ways in which the facility will make sure that there is enough staff to care for the residents<sup>136</sup> and how it may help staff find new employment.
3. Require the facility to report, on a daily basis, the number of registered nurses, licensed practical or vocational nurses and certified nursing assistants providing direct care and census for each shift to the state relocation team or regulatory agency to ensure adequate staffing.
4. Require the state to hire additional outside staff if necessary, paid for by the closing facility.

Obstacle 6: Transfer trauma.

1. Require that the facility closure plan submitted to the state include ways in which the closing facility will attempt to lessen any transfer trauma.
2. Require both closing and receiving facility to undertake specific tasks to lessen transfer trauma.

*Closing Facility:*

- a. Help the resident to tour any potential alternate settings and exercise choice in deciding on a living environment/arrangement.
- b. Provide staff and transportation to permit residents/families to visit possible new homes.
- c. Accompany the resident when the actual relocation takes place. Document resident preferences and aspects of their personality that contribute to their personal uniqueness. Review the resident's care routines, needs and preferences with staff of the receiving facility who will be caring for the resident. Many residents cannot or will not express their preferences.
- d. Update all resident records and ensure their accuracy and completeness. Document the resident's physical and emotional status including reaction to the need to

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<sup>136</sup> This is in CMS guidance section.

relocate. These records will allow the receiving facility to identify any changes in resident condition and accurately assess the resident's current status. Transfer the records with the resident.

- e. Provide written updates for residents and families on the status of the closure to bulletin boards in the facility and on the facility's website

*Receiving facilities:*

- a. Visit the closing facility and the prospective resident to assess the resident in their environment.
- b. Set up the resident's new physical environment to reflect their preferences and how it appeared and functioned at the closing facility.

*All facilities:*

Develop plans to avoid transfer trauma for residents they admit and to train staff in understanding transfer trauma

## RECOMMENDATIONS FOR THE STATE<sup>137</sup>

### General Recommendations:

1. Create a "relocation team," consisting of all relevant state agencies/programs, including the regulatory agency and the Office of the State Long-Term Care Ombudsman to a) meet on a regular basis; b) establish a formal state closure process; c) develop a manual that defines roles, responsibilities and timeframes; d) discuss any problems related to closures; and e) be on-site to monitor and help residents during a closure. Although the state survey agency is required to "arrange for the safe and orderly transfer of all Medicare and Medicaid residents,"<sup>138</sup> the team should decide what works best in terms of coordination and function.
2. Post on the state regulatory agency's website, the State's requirements and processes around closure, including requirements of providers, rights of residents, and tasks and responsibilities of the relocation team.
3. Pass legislation to codify the state closure process, including provider requirements, residents' rights; and relocation team tasks.
4. Develop a system for residents and families to file complaints about how the closure is being carried out and receive an immediate response. Review all complaints received during the closure to identify problems; perform root cause analysis and make improvements based on analysis. Submit complaint review/analysis to CMS.

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<sup>137</sup> "State" encompasses the State Legislature, Licensing/Regulatory agency, Medicaid Agency, State Administration

<sup>138</sup> 42 CFR 488.426(b)

5. Use Civil Monetary Funds (CMP) to support a successful transition for residents in those instances where the closing facility is unable to fund such activities. CMS permits CMP use for the purpose of: <sup>139</sup> offsetting costs of relocating residents to home and community-based settings or another facility; improving the State's preparedness for transitioning residents in the event of facility closure or to make improvements in the State's process for such transitions; or funding an initial home visit for a nursing home resident to help him or her evaluate the appropriateness of a potential transition to another living arrangement or home or community based setting.
6. Require a public hearing before a facility can voluntarily close. This will permit residents, families and others to communicate to the state the impact the closure would have on them and the community.<sup>140</sup>
7. Pursue sanctions as required under 42 CFR 488.446 against the nursing home administrator if he or she fails to comply with the state and/or federal closure requirements and make necessary changes in state law to hold owners accountable.

### **Recommendations Related to Obstacles, Raised in the Study, to a Successful Resident Transition:**

*Obstacle 1:* Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.

1. Pass laws similar to those in Connecticut permitting residents to be admitted to the first available bed in the facility of their choice and to move to a temporary location until a bed opens up.
2. Require facilities to document, in writing, the reasons for not wanting to accept a resident and work with them to find a solution.
3. Work with the relocation team to identify an appropriate placement that is to the satisfaction of the resident.
4. Establish a real time list of open beds in the surrounding area of the facility that is closing and have it accessible to the relocation team.

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<sup>139</sup> Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group: Ref: S&C: 11-42-NH: September 30, 2011.

<sup>140</sup> Massachusetts has recently passed a similar requiring a public hearing before a facility can close.

Obstacle 2: Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.

1. Coordinate discharge planning from an independent planner if a determination is made that the planning is inadequate. The cost should be borne by the closing facility.
2. When the State survey agency finds that the closing facility does not take into consideration the needs, choice, and best interests of each resident as part of the closing planning and implementation process, it should issue a deficiency citation and require the facility to take immediate steps to remedy the situation.

Obstacle 3: Lack of communication, including accurate communication, by providers.

1. Develop a *uniform* notice to be sent by providers that includes: the reason for the closure, the specific steps the facility will take to close, the rights that residents have to choose a new home, the name and contact information of the local ombudsman, the contact information to file a complaint, and other points outlined in CMS guidance.
2. Require that a letter/notice from the relocation team or from the State Ombudsman, be sent to all residents and family members at the same time the provider is required to send a notice. The letter/notice must explain the closure process and the rights that residents have, including the right to choose their new home. For instance, Connecticut has passed a law requiring the Office of the Long-Term Care Ombudsman to send an informational letter.<sup>141</sup>
3. Require that the relocation team meet regularly with and provide written updates to residents and families.

Obstacle 4: Poor notice/not enough time to find new placements.

Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If the state believes that the facility must close due to poor care, or the owner runs out of funds, the state must take over the facility through a receivership, bring in a management company (paid for by the closing facility) or use the temporary management remedy in federal law. Work with CMS to receive approval for continued Medicare and/or Medicaid payments until residents are successfully relocated.

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<sup>141</sup> Substitute Senate Bill No. 280, Public Act No. 16-8: AN ACT CONCERNING THE LONG-TERM CARE OMBUDSMAN'S NOTICE TO NURSING HOME RESIDENTS.

Obstacle 5: Staffing issues such as staff leaving, staff stress and bitterness.

1. Require the facility to report the number of registered nurses, licensed practical or vocational nurses and certified nursing assistants providing direct care and census for each shift to the state relocation team or regulatory agency to ensure adequate staffing.
2. Require the closing facility to hire contract staff if needed.
3. Notify the state Department of Labor to help staff with filing for unemployment, writing resumes, etc.
4. Consider a tax on ownership licenses to fund a staffing account that could give bonuses to staff that remain until closure.
5. Encourage facilities to hold job fairs for staff of closing facilities.

Obstacle 6: Transfer trauma.

1. Require all facilities to train staff on transfer trauma.
2. Require the receiving facility to develop a plan to minimize transfer trauma for residents being admitted from the closing facility.

## **RECOMMENDATIONS FOR LONG-TERM CARE OMBUDSMEN**

### **General Recommendations:**

1. Educate all ombudsman program representatives on state and federal closure rules. It is clear from our study that many of the ombudsmen that participated in the project did not know their state's or CMS's closure rules.
2. Develop a formal written protocol for closure detailing the role of the state and local ombudsmen and how they will work with other state agencies.  
The State Ombudsman, in conjunction with local ombudsman program representatives, should develop a formal written protocol for closure detailing the role of the state and local ombudsmen and how they will work with other state agencies.

## Recommendations Related to Obstacles, Raised in the Study, to a Successful Resident Transition:

Obstacle 1: Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.

1. Check records (in accordance with Ombudsman Program rules) of those residents being refused admittance to make sure they are up-to-date. Inaccurate information may lead a facility to deny admission.
2. Urge refusing facilities to interview and assess the resident themselves to see if they might change their mind.
3. File a discrimination complaint with the Civil Rights Division of the U.S. Department of Health and Human Services and/or the state civil rights division if it appears that a resident is being discriminated against on the basis of his/her disability.

Obstacle 2: Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.

Create/Identify information for consumers detailing:

1. What is included in appropriate discharge planning.
2. Residents' rights throughout the closure process.
3. Where to file a complaint or get help.
4. Information on how families can help prevent or minimize transfer trauma in residents.
5. Residents' rights, including but not limited to, right to have needs and choice taken into consideration; receive appropriate discharge planning; and be included in discharge planning.

Obstacle 3: Lack of communication, including accurate communication, by providers.

1. Designate a member of the State Ombudsman Office as a relocation specialist to coordinate ombudsman activities related to the closure; train, mentor, and assist local ombudsmen on closures; and oversee closures and certain relocations that might cause resident distress or disorientation. See case study of Wisconsin for an example of this.
2. Develop a letter for residents and families describing the closure process, explaining rights and giving ombudsman contact information. This letter should be sent to all residents and family members of the closing facility at the same time the provider announces the closure. See example of such a letter in Appendix.

3. Meet one-on-one with each resident or family member to discuss the closure process and their rights either as part of the relocation team or separately. Bring together residents and families in a group with all state agencies to discuss the closure and rights and to answer any questions. Lead the meeting.

Obstacle 4: Poor notice/not enough time to find new placements.

1. Advocate for facility to remain open until all residents have been relocated to an appropriate location of their choosing.
2. Urge passage of legislation permitting long-term care ombudsmen to file a request for receivership.

Obstacle 5: Staffing issues such as staff leaving, staff stress and bitterness.

1. Advocate with corporation of closing facility for staff to be hired at sister facilities.
2. Advocate with nursing home administration to provide staff with a list of employment resources.

Obstacle 6: Transfer trauma.

1. Conduct in-service training for staff on transfer trauma with input from residents.
2. Share tips for what staff and family can do to help alleviate transfer trauma.
3. Conduct follow-up visits after the relocation and for several months post-relocation to see how residents are doing and provide continuity to residents.
4. Track residents' belongings and personal funds to ensure they are moved to the new location with the resident.

## QUESTIONS FOR FUTURE RESEARCH

**Recent Issue: In June 2015, the Allure Group, a nursing home provider in New York State, bought the Cabs nursing home in Brooklyn, NY.** In October, residents noticed that a number of residents were being transferred and asked for an explanation. The administrator dismissed rumors the facility was closing, but by then a contractor had already applied for a permit to demolish CABS and replace it with a seven story apartment building.<sup>142</sup>

A resident called the ombudsman program saying that the home was closing. After making inquiries to the administrators of the nursing home and the state Department of Health, the ombudsman reassured the Cabs resident that the owners had no plans to shut down the

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<sup>142</sup> <http://www.wnyc.org/story/nursing-home-de-blasio-flouted-state-rules/>.

170-bed facility. Less than six months later, the home decided to close.<sup>143</sup> Although most residents were relocated by November, a closure plan was not approved until February, 2016. Residents said they were never given any notice of closure or notified of their rights to appeal.<sup>144</sup>

At the same time, the Allure Group, which had promised to preserve a health care facility on the lower east side in NYC, flipped the property to luxury-housing.<sup>145</sup> This home closed without any notification to the state. “When DOH (Department of Health) returned in December 2015 to recertify the facility, it found no residents living in the home. And as required by law, that discovery led DOH to request a closure plan from the Allure Group, which at that point had already eliminated the city deed restriction from the property and signed a private sale contract with developers.”<sup>146</sup>

- 1. What can be done about owners either not following the approved closure plan or closing without getting any approval?**
- 2. When a provider has closed a facility, either after a closure plan approval or without getting approval and has left the Medicaid/Medicare program, does CMS have the authority to put into effect any penalties?**
- 3. If an owner is operating other nursing homes:**
  - a. Can fines be levied against all the homes?**
  - b. Can the owner be automatically stopped from operating any other nursing homes?**
  - c. Can licenses be denied to operate a facility to individuals who have been a part of ownership in other closures with violations?**
- 4. If an owner has left the industry:**
  - a. Can criminal penalties be levied?**
  - b. Can liens be put on other properties? On the closed facility?**
  - c. Can owners be made personally liable?**
  - d. Can laws be passed to allow residents/families the right to litigation against the offending facility as well as the companies that have multiple facilities?**

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<sup>143</sup> <http://nypost.com/2016/04/10/officials-ignored-warnings-about-nursing-home-closures-patients/>

<sup>144</sup> <http://www.wnyc.org/story/nursing-home-de-blasio-flouted-state-rules/>.

<sup>145</sup> [http://www.crainsnewyork.com/article/20160404/REAL\\_ESTATE/160409975/state-department-of-health-got-duped-in-45-rivington-st-nursing-home-closure](http://www.crainsnewyork.com/article/20160404/REAL_ESTATE/160409975/state-department-of-health-got-duped-in-45-rivington-st-nursing-home-closure).

<sup>146</sup> Ibid.

## APPENDIX: RESOURCES

### CONNECTICUT

- Informed Choice Process
- Letter to Nursing Home Residents About Their Rights
- Letter from State Long-Term Care Ombudsman
- Frequently Asked Questions
- Legislative Proposal

### OHIO

- Kaizen Fact Sheet
- Family Letter
- Initial Resident Contact
- Letter to Private Pay
- Long-Term Care Living Options
- Meeting with Administration
- Facility Closure and Relocation Process

### Wisconsin

- Ombudsman residential booklet
- Introductory letter for posting
- Discharge planning guide
- Should facility close brochure
- Voice for residents brochure

### DC

- Mandamus private right of action
- Petition for Receivership

To access the report with full appendices, or for more information, go to [www.theconsumervoice.org](http://www.theconsumervoice.org).

**Department of Social Services**  
**Informed Choice Process for Nursing Facilities**

The goals of this informed choice protocol:

- find out clients individual preference for where they wish to receive LTSS
- provide access to information about community options
- have the Universal Assessment completed and explore an individualized community care plan option for each individual
- opportunity to move to the desired and most integrated setting appropriate to their needs
- consistent documentation regarding the **Residents** preferences

**Procedures for the informed choice protocol are as follows:**

The Department of Social Services, Money Follows the Person Demonstration shall:

- a. Establish project team to assure implementation of informed choice protocol
  - Identify team lead for facility responsible on behalf of DSS for implementation of the protocol at the facility
  - Identify care planning leads representing respective home and community based service packages who report to team lead;
    - Additional care planning staff may be added to the facility as identified by the care planning lead
  - Identify transition coordination and housing coordination staff who report to team lead

**Responsibilities of staff:**

- Team Lead is responsible for
  - Status updates biweekly;
  - Coordinating all activities of care planning staff, transition coordinators and housing coordinators;
  - Serving as contact with NF administrator with respect to community transition process;
  - Assuring all timelines are met on schedule;
  - Assuring coordination with facility staff;
  - Assuring communication of discharge planning meetings to care planning staff and others as appropriate;
  - Attending all discharge planning meetings and other meetings as required at the facility;
  - Assuring standardization of process across all care planning systems;
  - Assuring all protocol paperwork required as part of the informed choice protocol is completed;
  - Meeting biweekly with care planning leads (one individual from each of the agencies or organizations representing community target service plans. (Access agency, DSS social worker, DDS, DMHAS) to assure compliance with protocol timelines;

**Department of Social Services**  
**Informed Choice Process for Nursing Facilities**

- Drafting meeting summaries;
  - Producing written monthly status updates.
- Care planning staff is responsible for
  - Reviewing all charts in preparation for assessment of all residents;
  - Completion of MFP paperwork;
  - 1:1 needs assessment and level of care;
  - Preparing community plan;
  - Attending discharge planning meeting;
  - Follow up with implementation of community care plan
- Transition Coordinators are responsible for
  - Collection of resident identification documentation
  - Locating housing and assisting with apartment set-up and move;
  - Arranging transportation to visit apartments;
  - Completion of MFP paperwork;
  - Assisting with hiring personal care assistants;
  - Arranging for PT assessment of home prior to discharge either through coordination with the nursing home staff or through independent contractor if nursing home staff is not available (prior approval MFP)
  - Determining need for accessibility modifications and coordinating process according to MFP protocol.
  - Assisting lead coordinator with implementation of the protocols as requested
- Housing Coordinators are responsible for
  - Locating at least 2 community housing options
  - Photographing community options
  - Initial measurements for accessibility
  - Completing all housing paperwork
  - Coordinating and communicating with landlord
- Nursing Facility Staff are responsible for
  - Providing input into community care plan
  - Arranging discharge planning meetings and communicating with facility community lead
  - Arranging for 30 day supply of medication upon discharge
  - Arranging for DME and other state plan services upon discharge
  - Arrange facility wide outreach and education
- Ombudsman are responsible for
  - Advocating for the resident
  - Attending education and outreach meetings
  - Participation in care planning meetings as requested by the resident

**Department of Social Services**  
**Informed Choice Process for Nursing Facilities**

- b. Attend facility wide outreach and education
  - Presentation of community options to facility staff, including physicians, regarding community options
  - Attend residents meeting/family meeting to discuss new community options and encourage participation in needs assessment
    - 1:1 outreach with all residents
    - Discuss that all persons will be assessed for options as part of the planning process including community options
    - For conserved residents where conservator does not participate in the meeting, place telephone call to conservator to inform about process
    - If there is an objection to the assessment process designed to inform the resident and family about options, obtain appropriate signatures indicating that the resident or the conservator chooses to remain institutionalized and chooses to forgo opportunity for needs assessment and opportunity to explore community options
      - If conservator disagrees with resident (ward) regarding interest in exploring community options, consider recommending a request to Probate Court for a hearing in order to have the Judge decide or for a new COP/COE named
- c. Complete universal assessment and care plan development
  - 1:1 assessment of all residents by care planning staff of home and community based service package unless resident signs refusal for assessment
    - Complete assessment process and if alternative target home and community based menu of services is more appropriate, coordinate with appropriate key staff
    - Develop care plan
- d. Attend facility discharge meeting with resident (family members and conservator, if appropriate) and care planning staff to present and as client what they think is the most integrated setting appropriate to their individual needs
  - Discuss care plan and community options with resident and, if appropriate, conservator and family
  - Assure that resident, family members and conservator are educated about options, including community options so that they may make an informed choice
  - Outcome assuming community is chosen as most integrated setting, meets residents desired setting and meets their needs:
    - If the resident agrees to pursue community placement obtain signed agreement with care plan, signed informed consent and signed informed risk agreement

**Department of Social Services**  
**Informed Choice Process for Nursing Facilities**

- If the resident disagrees with transition to the community and chooses an institutional placement obtain signed documentation indicating that the resident or the conservator chooses to stay institutionalized and chooses to forgo acceptance of community care plan – begin search for appropriate alternative institution
  - If ward (resident) chooses the community option but the conservator chooses continued institutionalization , request a Probate Hearing in order to have the Judge decide or for a new COP/COE named
- Outcome if after all options are explored team (to include the Client) feel continued institutional placement is least restrictive available
  - If the person agrees with the recommendation to continue institutionalization, facility staff begin search for appropriate alternative institutions;
  - If the person (or conservator) chooses community setting despite team recommendation obtain signed care plan, signed informed consent and signed informed risk agreement addressing risks that the team feels are not mitigated in the care plan – continue transition planning to the community
- Complete team meeting summary including most integrated setting check list, team recommendation, and outcome form.
- e. For those transitioning to the community, collect identification documentation, establish credit in community, establish bank account, and begin independent skills training
- f. Identify housing – assure choice, modify if necessary and coordinate community supports for those transitioning to community
- g. Transition to the community and provide on-going support with additional supports through MFP for the transitional year to ensure successful integration into community
- h. Collect and analyze data regarding service utilization and quality of life data for 2 years subsequent to community discharge
- i. Prepare and distribute semi-annual reports

To: The Residents of XXXXXXXX Health Center  
and Their Families and Friends

From: Attorney  
Connecticut Legal Services, Inc.

**Re: Nursing Home Closing - Resident Rights and Options**

Date:

You have rights as a nursing home resident. Federal and state law strictly controls transfers and discharges of residents from a nursing home. These laws apply even when a nursing home is closing.

#### There Must be a Public Hearing about the Proposed Closing

Even though you have been told that XXXXXXXXXXXX is closing, under Connecticut law the Department of Social Services (DSS) must hold a public hearing before a nursing home is allowed to close. You and others concerned about the closing may speak or submit written information at the public hearing. You should contact your legislators and community leaders and ask them to express their views about the closing to DSS. There must be at least two weeks notice before the public hearing. After the public hearing, DSS has to decide whether to allow XXXXXXXXXXXX to close.

#### You Must Receive a Notice of Discharge

Even if DSS allows XXXXXXXXXXXXXXXX to close, the nursing home must give you a written notice at least 30 days before discharging you to another nursing home or other place. The nursing home must also help you to find an appropriate place to live.

The Discharge Notice must tell you

- The date of the discharge
- The place to which the nursing home plans to discharge you
- The reason for the discharge
- How and when to request a fair hearing

The closing of XXXXXXXX is a valid reason for discharge. However, the closing cannot be used as a reason until after the public hearing and approval of the closing by the DSS.

### You Must Receive a Discharge Plan:

Except in an emergency, the nursing home must give you and your doctor, guardian, conservator or legally liable relative a copy of your discharge plan at least 30 days before the proposed transfer date. The closing of the nursing home is not considered an emergency.

The discharge plan must:

- Be in writing
- Consider placement near your relatives
- Describe the effects of the discharge on you and how the nursing home will make the discharge less disturbing
- Outline the care and services you will receive when you are discharged
- Be developed by your doctor or the medical director together with other nursing home staff, and include you and your family in the planning

### You Can Ask for a Fair Hearing

If you disagree with the proposed discharge or the discharge plan, you can ask the Department of Social Services for a fair hearing. You must request the hearing by writing to:

Department of Social Services  
Office of Legal Counsel, Regulations & Administrative Hearings  
25 Sigourney Street  
Hartford, CT 06106-0380  
Tel: (860) 424-5760  
Fax: (860) 424-5729

If you ask for this hearing within 20 days of the date of the discharge notice, the facility cannot transfer you until a hearing is held and a decision issued. This appeal process may take a few months.

You can represent yourself at the hearing or have a lawyer, relative, friend or other person represent you at the hearing. Connecticut Legal Services, Inc. may be able to represent you. Please feel free to contact us at:

#### Priority admission at another nursing facility:

Other nursing facilities in the area may have admission waiting lists. Residents coming from a facility that is closing, however, get priority. The laws are complicated, but it may be illegal for a nursing home to deny admission to those transferred from XXXXXXXXXXXXX Health Center, if the facility officially closes.

Therefore, you may want to put your name on the waiting lists of other nursing facilities by submitting an application, in case this facility does close. Placing a resident's name on another facility's waiting list does not mean that the resident wants to, or has to, leave XXXXXXXXXXXXXXXX Health Center; it is simply a practical precaution.

#### Alternatives to nursing home care:

Connecticut now has a number of programs that provide medical and support care for the elderly and those with disabilities in private homes. If you would like to live in the community rather than transfer to another nursing home, you can apply for home care or obtain more information on

these programs by calling the Home & Community Based Services Unit of the Department of Social Services at 1-800-445-5394.

There is also a program called Money Follows the Person (“MFP”), which helps nursing home residents transition back to the community. You can get more information about MFP at 1-888-992-8637.

Available assistance:

You can obtain advice, assistance and legal representation regarding transfers and discharges from Connecticut Legal Services. Please feel free to call Attorney \_\_\_\_\_, if you have questions or if you need legal assistance. (If you do not reach Attorney \_\_\_\_\_, please be sure to leave a message with your name and contact information). Connecticut Legal Services, Inc. is a private, non-profit law firm. We are not affiliated with the State of Connecticut. There is no charge for our services.

You can also obtain assistance from the State of Connecticut’s Long-term Care Regional Ombudsman. The local number is



– Growing Older Together –

Telephone: (860) 424-5274

Toll Free: 1-866-218-6631

Website: [www.ct.gov/aging](http://www.ct.gov/aging)



Telephone: (860) 424-5200

Toll Free: 1-866-388-1888

Website: [www.ltcop.ct.gov](http://www.ltcop.ct.gov)

Dear Resident and Resident Representative,

At this time you are receiving a letter from the management of your nursing home informing you they are seeking approval from the Department of Social Services (DSS) to close this home. I know this news raises questions and possibly concerns for you. There are specific steps that must be followed before the Department of Social Services makes a decision about whether to approve a closure and **residents have rights throughout this process.**

The letter from the facility management to the CT DSS is called a "Letter of Intent" (LoI). This is just the beginning of a process that is outlined in Connecticut General Statute 17b-352. The Letter of Intent requests that DSS sends the nursing home the forms for a Certificate of Need (CoN) application. This is the formal application to close the nursing home.

A public hearing will be scheduled and held at the nursing home. I encourage you to participate in the hearing. If you would like to speak at the hearing you will be asked to sign up that day. You may also submit written testimony. Either way you choose, this is an opportunity to say what a potential closing means for you. After the hearing DSS will gather all information related to the request, including all oral and written testimony, and the CoN application and will make a decision within ninety days about granting a closure.

In the coming weeks you may see people visiting the nursing home that you don't know. You always have the right to understand what they want to talk with you about and you may refuse to talk with them if you choose. Importantly, you should not feel pressured to make any choices or decisions immediately. The Ombudsman Program will schedule a meeting with residents and families to talk about the upcoming activities and what to expect. Notification of this meeting will be provided soon.

This is your home and the question of your home possibly closing is upsetting. The Ombudsman Program will support and help you throughout the process. If the home is approved for closing you may choose to move to another nursing home or you may want to consider other options. There are community living options which include long-term services and supports and there will be people available to discuss those alternatives with you. Please contact us with any questions that arise.

55 Farmington Ave.  
Hartford, Ct. 06105



The Long-Term Care Ombudsman Program is responsible to ensure the residents welfare and rights are protected. Members of the Ombudsman Program will be at your home throughout this process to make sure you are extended all your rights and protections under the law. It is my job as your State Ombudsman to ensure that this whole process meets your needs and respects your rights. You should have every opportunity to have the information you need to make informed decisions and not feel rushed or coerced into making premature or uninformed decisions. The Ombudsman contact information is available to you and you are encouraged to contact us with any questions. Please do not hesitate to contact the Regional Ombudsman or the Office of the State Ombudsman.

Best regards,

The Office of the Long-Term Care Ombudsman

55 Farmington Ave.  
Hartford, Ct. 06105





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Website: [www.ltcop.ct.gov](http://www.ltcop.ct.gov)

## FREQUENTLY ASKED QUESTIONS

- **When do I have to move?** You can take the time you need to make a decision about where you will be moving. You are encouraged to think about what you would like in your next home so that you are comfortable once you have moved. There is no set timeframe in which you must move.
- **Who will help me, if I want help, making my decision about where to move?** The Social Worker and other designated staff at your current home can help you as much as you would like. There are many other people who will also be available to help you, including Nursing Facility Transition Coordinators, The Ombudsman Program staff, Legal Services attorneys, the Department of Social Services staff, along with your family or other supportive individuals you trust. The names and addresses of agency and program individuals will be provided to you.
- **Can I go see a facility before I make my decision to move there?** Absolutely! It will probably be best for you to visit a facility, even more than one if you would like, before you make your final decision.
- **How will I get to a facility to take a tour?** Your current facility will assist you with these arrangements. Or, if you have a family member or friend who can take you, you can do that.
- **What if I don't decide on a place to move to right away, do I have the right to turn down an offer for admission if I don't want to move to that facility?** Yes, you can take the time you need to make this decision and are not obligated to accept a room at a facility you do not want to move to.
- **Who will help me with the move?** You may ask your current home to assist you with the move.
- **What if I want to move out of the immediate area?** You can discuss this with the Social Worker. The Nursing Facility Transition Coordinator may also be able to help you in this regard.

55 Farmington Ave.  
Hartford, Ct. 06105



- **Will there be enough staff here to take care of me during this time?** Yes, there should be enough staff to help you. If you have any questions or concerns in this regard, you are encouraged to bring them to the immediate attention of the staff.. The Ombudsman Program is also available to you throughout this transition to help you with any of your issues or concerns.
  
- **Will my personal belongings be safe and will they be moved with me to my new home?** It is a good idea for you to do a new inventory list of all your belongings now. This way both homes will have a record of your belongings and this will help ensure the safety of all items.

55 Farmington Ave.  
Hartford, Ct. 06105





## Agency Legislative Proposal - 2016 Session

**Document Name** (e.g. OPM1015Budget.doc; OTG1015Policy.doc): [Click here to enter text.](#)

**11302015\_SDA\_LTCOP/CON**

(If submitting electronically, please label with date, agency, and title of proposal – 092611\_SDE\_TechRevisions)

State Agency: **State Department on Aging**

**Liaison:** **Pam Toohey**

**Phone:** **860-424-5993**

**E-mail:** **pamela.toohey@ct.gov**

Lead agency division requesting this proposal: **Long Term Care Ombudsmen Program**

Agency Analyst/Drafter of Proposal: **Pam Toohey/Nancy Shaffer**

**Title of Proposal:** **An Act Concerning the State Long Term Care Ombudsman’s Notice to Nursing Home residents regarding the home’s intent to file for closing.**

**Statutory Reference:** **Sec. 17b-352d**

**Proposal Summary:** **The proposed amendment will require that a nursing home facility’s Letter of Intent (LOI) to close, which is the facility’s official notice to the State that it desires to close the home, be accompanied by a letter to the residents and families from Office of the State Long Term Care Ombudsman.**

[Click here to enter text.](#)

### PROPOSAL BACKGROUND

#### ◇ Reason for Proposal

*Please consider the following, if applicable:*

- (1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?*
- (2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*
- (3) *Have certain constituencies called for this action?*
- (4) *What would happen if this was not enacted in law this session?*

**Current legislation requires that a Letter of Intent (LOI) to close a facility be provided to residents/families by the facility. The LOI is sent to the Commissioner of the Department of Social Services and sets in motion the process of the facility’s request to close. The next step is a public hearing at which time DSS hears testimony from interested parties regarding a potential closing. Often times, many residents have already discharged to other nursing homes by the time this public hearing is held (not later than thirty days after DSS receipt of the LOI +/- CON). The LOI presents only the facility/business’s perspective and usually has strong language that gives the sense there is no alternative but to close. This initial message can be devastating to the resident and family. Therefore, balancing that message with the assurance that the residents have rights and protections needs to be heard at the same time.**



The mandate of the Long-Term Care Ombudsman Program is to ensure that residents' welfare and rights are protected. The addition of this letter from the Office of the State Ombudsman will present a more balanced picture to the residents and their families of what is happening, their rights and protections and advises them that they can take time and not be rushed into any decisions. The Ombudsman letter also has the potential to enhance opportunities for Money Follows the Person to engage residents and families in discussing options for community living, thus forwarding the Governor's initiatives to rebalance the State's long-term services and supports systems.

The State of Connecticut is likely to experience more nursing home closures in the future. Enacting this legislation now will provide assurances to residents at a difficult time and will ensure they have greater opportunity to review all their options should the DSS Commissioner decide to grant the home's request to close.

Origin of Proposal       New Proposal       Resubmission

If this is a resubmission, please share:

- (1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
- (2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
- (3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
- (4) What was the last action taken during the past legislative session?

[Click here to enter text.](#)

**PROPOSAL IMPACT**

AGENCIES AFFECTED (please list for each affected agency)

**Agency Name:** Department of Social Services  
**Agency Contact (name, title, phone):** Krista Ostaszewski, Legislative Analyst, 860-424-5612  
**Date Contacted:** 10/13/15, 11/30/15

Approve of Proposal     YES     NO     Talks Ongoing

**Summary of Affected Agency's Comments**  
Discussions between SDA Commissioner, DSS Commissioner, Legislative Analyst resulted in full support.

Will there need to be further negotiation?     YES     NO



◇ **FISCAL IMPACT** *(please include the proposal section that causes the fiscal impact and the anticipated impact)*

<b>Municipal</b> <i>(please include any municipal mandate that can be found within legislation)</i> <b>none</b>
<b>State</b> <b>Anticipated there could be a positive impact to the State if residents are able to exercise informed choice and utilize the resources of Money Follows the Person Program and choose community living rather than a transfer to another skilled nursing facility.</b>
<b>Federal</b> <b>none</b>
<b>Additional notes on fiscal impact</b> Click here to enter text.

◇ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.
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**Insert fully drafted bill here**

Recommend CT General Statute 17b-352 (d) and after (G) insert (H) “the facility shall include an informational letter provided by the Office of the State Ombudsman in the same envelope as the Letter of Intent”.

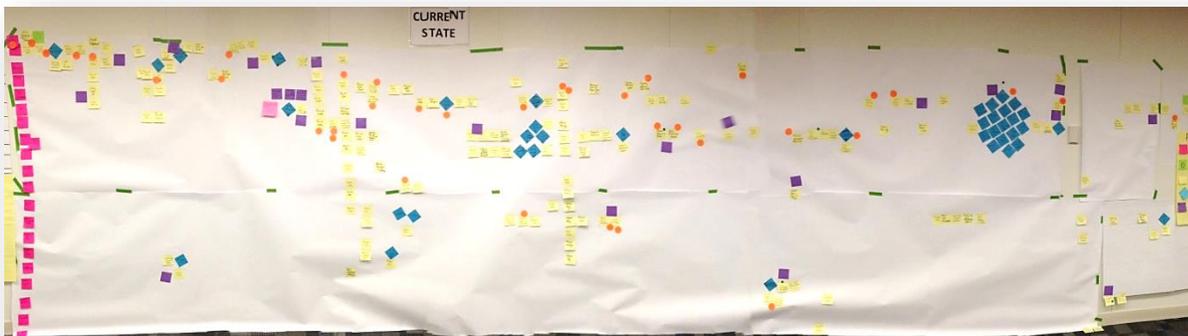
**Lean Ohio Kaizen Event Fact Sheet**

**Ohio Department of Aging, November 1, 2013**

**Issue:** The current Nursing Home Quick Response Team process within the State Long-Term Care Ombudsman office at the Department of Aging can be unexpected, lacks coordination between several sister agencies and local partners, and has several layers of assessments. This creates a cumbersome process that can cause unnecessary trauma on Nursing Home residents during the relocation process.

Department	Changes to Process	Metrics	As a Result
<b>Ohio Department of Aging Office of the State LTC Ombudsman</b> Nursing Home Quick Response Team Process October 28-November 1, 2013	<ul style="list-style-type: none"> <li>Reduction of steps from 400 to 112 steps: a 72 percent reduction.</li> <li>Reduced decision points from 22 to 6: a 72 percent reduction.</li> <li>Eliminated 21 handoffs to 9: a 57 percent reduction.</li> </ul>	<ul style="list-style-type: none"> <li>The Nursing Home Quick Response Team Aging Staff process time was reduced from a maximum of 12 days to a maximum of 7 days.</li> </ul>	<ul style="list-style-type: none"> <li>Nursing home residents get moved to the most appropriate setting in order to reduce the amount of trauma experienced from relocating.</li> </ul>

Major Improvement	HOW it was accomplished
Created a standard process that can be applied to any closure or termination	Process redesigned to ensure jobs are in the right hands (e.g., HOME Choice, Recovery using expertise rather than nursing home staff)
Developed a shared web application to be used across agencies	Utilize SharePoint to share all documents throughout process with all connecting agencies and everyone has access to same information real time
Primary decision-making moved to the front of the process	Home Choice and appropriate assessments conducted at front of process and will more likely dictate that residents in at-risk nursing homes will have opportunity to move to community



**Team members:**

Bev Laubert State LTC Ombudsman, Erin Pettegrew SLTCO, Felicia Sherman ODA, Rob Feldman ODA, Julie Evers ODM, Jane Black ODM, Adam Anderson ODM, Tamara Malkoff ODH, Melissa Gilligan ODH, Mike Schroeder ODMHAS, George Pelletier ODMHAS, Jeff Ryan ODMHAS

For more information please visit <http://lean.ohio.gov/> or contact Steve.Wall@das.state.oh.us



October 15, 2015

«Family\_Member»  
«Family\_Address»  
«Family\_City», «Family\_State» «Family\_ZIP»

**RE:** Termination of Medicaid Funding for XXX Care Center

**Dear «Family\_Member»,**

This letter is to inform you that the federal Centers for Medicare and Medicaid Services (CMS) recently took action to end XXX Care Center's participation in Medicare and Medicaid. Our records indicate that you are the family member, friend or guardian of a resident at XXX Care Center. If this information is incorrect or outdated, please let us know as soon as possible.

### **About the Termination**

The Ohio Department of Health (ODH) has conducted several health surveys (inspections) at XXX Care Center. The ODH found that XXX Care Center did not meet certain Medicare and Medicaid requirements. As a result, the federal Centers for Medicare and Medicaid (CMS) will terminate XXX Care Center from the Medicare and Medicaid programs effective **Month XX, 2015** in accordance with subsections 1819(h) and 1919(h) of the Social Security Act and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

XXX Care Center's provider agreements for Medicaid and Medicare will therefore be terminated effective Month XX, 2015. Thirty days after that, **Month XX, 2015**, Medicaid and Medicare will no longer pay this nursing home for a person's care.

### **What Does this Mean for Residents of XXX Care Center?**

Residents in XXX Care Center whose care is paid for by Medicaid or Medicare will need to relocate by Month XXnd. As a family member, friend or guardian of a XXX Care Center resident(s), we need your input into your wishes regarding the resident's transition to a new home. The enclosed "Long Term Living Options" document describes some alternatives including care in another nursing home or assisted living or a transition to a community setting.

If the resident's care is not paid for by Medicare or Medicaid, he/she may be able to remain at XXX Care Center but be aware that many residents may be moving out of the home and staffing and services may

be impacted. The administration of XXX Care Center may choose to close the remaining portion of the home.

**Family/Guardian Assistance**

A Resident Transition Team made up of state and local representatives will be visiting residents at XXX Care Center on Month XX, 2015 to deliver a letter describing the termination and discuss alternatives for their care. The Resident Transition Team will be on-site from approximately 11 a.m. until 4 p.m. and would be happy to meet with families in person.

The team will also host teleconferences for residents' family and guardians to answer questions about the termination of XXX Care Center, resident options and other concerns. To protect confidentiality, we ask you call us directly at the toll-free lines below if you have resident-specific questions.

Monday, Month XXth, 11 a.m. or 5 p.m.

Toll-free:

If these times are not convenient, please call our toll-free lines (below) for personalized assistance.

**If You Need Assistance**

The **Long-Term Care Ombudsman Program** is available to address your concerns. The Ombudsman is a client-focused representative who is authorized by federal and state law to assist consumers with questions and problems relating to long-term care -- nursing homes, assisted living, home care, and adult care homes.

XXX is the Long-Term Care Ombudsman Program Director for your area. XXX is the ombudsman assigned to XXX Care Center. They both can be reached toll-free at 1-800-800-331-2644. The resident relocation coordinator in the State Long-Term Care Ombudsman's office is Erin Pettegrew, who can be reached at 1-800-282-1206.

Sincerely,

Beverley Laubert,  
State Long-Term Care Ombudsman  
Ohio Department of Aging

**Name:** «First» «Last»                      **Room #**      «Room\_»

**Payor:** «Program»                      **MyCare Ohio Plan?:**

**Age:** «Age»                      **Possible county of origin:**

**Guardian name** (if applicable/known): «Guardian\_Name\_», «Phone\_»

**Family member name**(if applicable/known): «Family\_Member», «Family\_Phone»

Alz?    «Alzheimers»                      Dementia?    «Dementia»    Anxiety?                      «Anxiety\_»

Depression? «Depression»

Bipolar?                      «Bipolar»                      Psychotic?    «Psychotic»                      Schizophrenia?

«Schizophrenia»                      PTSD? «PTSD»

**S.O. Registry?**

**Proposed discharge:**

**Connected to HC?**                      «Connected\_to\_HOME\_Choice», «HOME\_Choice\_comments»

**RSS eligible?** , «RSS\_Eligible», «RSS\_Comments»

**MH Level II Outcome:** «Initial\_MHAS\_data\_PCS\_record»

**ODA PASRR Review:** «PASRR\_Review\_by\_ODA»

**Next action:**    «Next\_Action»

**Comments:**    «Comments»

## Notification

**Date of notification:**

**Relocation representative:**

Explain letter and termination information: May 23rd is decertification date; June 22nd will be final date of payment from M/M. *Explain that if they have a MyCare Plan, their plan care manager will be in touch with additional assistance.*

Anyone you want to move with? (roommate, family)

Any preference on where you might want to move? (nearness to family, hometown, etc)

Any obstacles to move (either told or observed)

Any concerns – possessions, medication, special equipment?

Anyone other than the person listed as your family contact we should notify?

Before you came to the nursing home did you receive services through any agencies/providers in the community, and if so, who?

Have you been in any other local nursing home(s)?

Veteran? \_\_\_\_\_

Smoker? \_\_\_\_\_

Impression of capacity:

Impression of less institutional possibilities:

Action items for follow up:

HC App DONE / NEEDED

RSS App DONE / NEEDED



October 16, 2015

**Dear Resident of XXX Care Center**

This letter is to inform you that the federal Centers for Medicare and Medicaid Services (CMS) recently took action to end XXX Care Center's participation in Medicare and Medicaid.

**About the Termination**

The Ohio Department of Health (ODH) has conducted several health surveys (inspections) at XXX Care Center. The ODH found that XXX Care Center did not meet certain Medicare and Medicaid requirements. As a result, the federal Centers for Medicare and Medicaid (CMS) will terminate XXX Care Center from the Medicare and Medicaid programs effective **XXX XX, 2015** in accordance with subsections 1819(h) and 1919(h) of the Social Security Act and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

XXX Care Center's provider agreements for Medicaid and Medicare will therefore be terminated effective XXX XX, 2015. Thirty days after that, **XXX XX, 2015**, Medicaid and Medicare will no longer pay this nursing home for a person's care.

**What Does this Mean for Residents of XXX Care Center?**

Residents in XXX Care Center whose care is paid for by Medicaid or Medicare will need to relocate by XXX, 2015.

If a resident's care is not paid for by Medicare or Medicaid, he/she may be able to remain at XXX Care Center but be aware that many residents may be moving out of the home and staffing and services may be impacted. The administration of XXX Care Center may choose to close the remaining portion of the home.

**Resident Assistance**

The **Long-Term Care Ombudsman Program** is available to address your concerns. The Ombudsman is a client-focused representative who is authorized by federal and state law to assist consumers with questions and problems relating to long-term care -- nursing homes, assisted living, home care, and adult care homes.

XXX is the Long-Term Care Ombudsman Program Director for your area. XXX is the ombudsman assigned to XXX Care Center. They both can be reached toll-free at 1-800-XXX-XXXX. The resident relocation coordinator in the State Long-Term Care Ombudsman's office is Erin Pettegrew, who can be reached at 1-800-282-1206.

Sincerely,

Beverley Laubert,  
State Long-Term Care Ombudsman  
Ohio Department of Aging



## Long-Term Care Living Options

The announcement regarding the Medicaid termination of Monroe County Care Center may come as a shock to residents and their families. We want to assure you that many state and local partners are available to assist residents and their families in finding new living arrangements.

The resident relocation team will be communicating with you frequently to keep you informed about this facility's termination. You need to make decisions in a timely manner but do not feel rushed into making choices that are not right for you. Please remember that the relocation team is available to help you and your family explore and make decisions about next steps. The contact information for the relocation team is on Page 2.

You have several long-term care living options depending upon your needs and personal circumstances, including:

- **Moving to another nursing home.** Your local Long-Term Care Ombudsmen, Kim Flanigan and Sue Davidson, can help you locate nursing homes that meet your needs, including those that accept Medicaid, if that is your source of payment. They can be reached at 1-740-373-6400 or 1-800-331-2644. In addition, you or a family member can research nursing homes at either of these websites:
  - <http://www.ltc.ohio.gov> - State of Ohio's Long-Term Care Consumer Guide
  - <http://www.medicare.gov/nursinghomecompare/> - U.S. Department of Health and Human Services' Nursing Home Compare
- **Moving to an assisted living home.** Some residents may be interested in assisted living. Some assisted living homes provide Medicaid home- and community-based services through the Ohio Assisted Living Waiver. Medicaid home and community-based services Assisted Living waiver services include nursing care, personal care, meals, housekeeping, laundry, maintenance, transportation, social and recreational programs, and on-site emergency response.

Your local Long-Term Care Ombudsman can assist you in researching this option or you can contact the Area Agency on Aging to find openings at the assisted living facilities that have waiver openings.

- **Moving back to the community.** Depending upon your long-term care needs and personal circumstances, you may be able to move into a group or family home, your own home or the home of a friend or relative in the community. Once again, the relocation team can help research and navigate this process with you.

For those who wish, and are able, to move back to the community, there are programs that can help you “transition” to a home in the community (finding affordable housing, furnishing and setting up a home, and learning community living skills). Please ask the relocation team for information about the HOME Choice, Access Success and Recovery Requires a Community programs.

There are Medicaid home and community-based services waivers called PASSPORT (for those 60 and older) and the Ohio Home Care Waiver (for those aged 59 or younger), which can provide nursing, therapy, personal care, meal delivery, nutrition counseling, adaptive and assistive devices, home modification, transportation, and emergency response in the home. Developmental Disability Medicaid waivers are also available for those who meet specific criteria.

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**The Office of the State Long-Term Care Ombudsman is coordinating the relocation efforts. You can reach members of the team through Erin Pettegrew, the relocation coordinator, at 1-800-282-1206. The relocation team includes representatives from the following state and local agencies:**

- Ohio Department of Mental Health & Addiction Services
- Ohio Department of Developmental Disabilities
- Ohio Department of Medicaid
- Ohio Department of Aging
- State Long-Term Care Ombudsman’s Office
- Regional Long-Term Care Ombudsman Program
- Area Agency on Aging
- County Board of Developmental Disabilities
- ADAMH Board

## **Meeting with administration pre-notification**

Plan of Correction status?

Staff concerns?

Contingency plans for staff reductions

Notification day plans

Resident meetings, leave letter, discuss options

Team of state and local people. Divide by resident – DD, MH, LTC

Team needs:

Conference room to use

Prep staff for our purpose

Face sheets, offender requirements

Guardian or sponsor information

Family/guardian meeting schedule –teleconference?

Non-ambulatory? Medicaid can transport as a Medicaid covered service

After notification – frequent visits by ombudsmen and AAA. May need to request space to work.

Complete Levels of Care in advance. Prioritize any likely to move out quickly.

Please keep us informed of any changes – staff walk outs, any system not doing what's needed. Difficult transitions.

## FACILITY CLOSURE AND RESIDENT RELOCATION PROCESS

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The State of Ohio utilizes processes designed to facilitate an organized relocation plan that minimizes disruption of medical care and other residents' services in the event of a facility closure or relocation of a number of residents. Circumstances prompting these processes may include voluntary facility closure or relocation, expiration or termination of a facility's provider agreement with Medicaid/Medicare, revocation or non-renewal of a facility's state license and emergency situations such as natural disasters.

### **Partners**

The complexity of a resident relocation involves numerous state and local partners in addition to facility staff. The efforts of these partners ensure that resident moves are coordinated relocations based on resident choice and need. Their roles in short are:

Ohio Medicaid/County Departments of Job and Family Services – Agency maintains compliance with federal regulations regarding payment and certification. Staff reviews resident eligibility and potential for community living through programs such as HOME Choice, confirms level of care for transition to settings requiring it, and verifies payment sources for residents in their chosen living arrangement. Office of Medical Assistance can also provide data based on required resident assessments that assist the team in determining living options based on resident needs and services provided. In the case of an involuntary nursing facility termination, the Office of Medical Assistance notifies residents by letter, typically delivered in person by a member of the team.

Office of the State Long-Term Care Ombudsman– Ombudsman representatives at the state and regional level monitor resident rights, making regular visits to the facility, communicating with residents, families, discharge planners, and local transition resources. They provide “in the field” observations to state partners to alert them to any pending issues. Ombudsman representatives ensure residents have choice in selecting their new home and have safe and orderly discharge plans in place that are followed in a dignified manner to minimize the risk of transfer trauma. Follow-up is conducted with every resident impacted by the relocation.

Ohio Department of Aging/Area Agency on Aging – Representatives administer the preadmission screening process to determine resident eligibility and needs related to home and community-based services, reviews available Assisted Living Medicaid Waiver availability in the region.

Ohio Department of Health – Surveyors are on site as needed to ensure health and safety of residents, determine compliance with state licensure and federal certification standards.

Ohio Department of Mental Health and Addiction Services/Local boards and agencies: Assist in the relocation of any residents institutionalized primarily due to mental illness, conduct any necessary Level II pre-admission screenings, arrange special services for residents with serious mental illness. Assure continuity and follow-up support, especially for residents moving home.

Ohio Department of Developmental Disabilities/local boards and agencies: Assist in the relocation and arrange for the continuity of services for residents with developmental disabilities.

Facility staff – It is expected that the provider comply with all requirements and maintain medical and personal services to residents while cooperating with the relocation team requests for resident information and records.

All partners participate in regular communication, typically through conference calls or interagency meetings locally on a weekly basis or more frequently as needed.

## **Process**

In-person resident notification - The team approaches residents in person with official notification of the pending action, presenting the options available to them while emphasizing the need to act based on the anticipated timeline. In some cases, Medicaid termination may mean that residents could stay with private pay; in licensure action, the facility may be closed and all residents affected, regardless of payment source. For residents without capacity, the team will use family member contact lists provided by the facility to reach out to the decision makers. One successful strategy has been family/guardian meetings held in the evenings for their convenience.

Selection of long-term care providers – Residents and their families are given lists and descriptions of facilities that may meet their needs based on their physical location, services offered and quality information. Partners ensure that facilities do not move residents en masse to related facilities owned or operated by the same company unless residents make that choice. Residents choosing community living are referred for programs like HOME Choice or home- and community-based waiver programs.

Relocation – Facilities provide safe and orderly discharges, ensuring that the residents' new providers are given access to resident records, physician orders, advance directives and family information. Facilities ensure that Personal Needs Allowance accounts, if applicable, travel with the residents. Personal property is packed in a dignified manner by the transferring facility. Receiving facilities arrange transportation. The Office of the State Long-Term Care Ombudsman Program monitors to ensure that these actions take place and solicits assistance from the Ohio Department of Health if needed.

Post-transition follow-up and resident tracking – The Long-Term Care Ombudsman representatives visit all relocated residents in their new homes to ensure that they are settled, have all the services and medical care that they need and that their personal belongings and Personal Needs Allowance/Social Security and other issues have been addressed.

## **Experience**

Recent transition experiences: In the past year, the state transition team has been involved in numerous resident moves due to facility closures. These include:

### ***Voluntary closures***

- Northview Senior Living, Licking County; 40 nursing home residents, 3 residential care facility residents at the time of closure announcement.
- Mercy Franciscan Terrace, Hamilton County; this nursing home had 104 residents and the residential care facility had 19 at the time of closure announcement.
- Bradfield Care Center, Lake County; 67 residents at the time of announcement.

- West Chester Nursing and Rehabilitation, Butler County; 44 residents at the time of the announcement of which 14 used ventilators.

***Mandatory closures***

- Liberty Nursing Center of Toledo, Lucas County, terminated January 2013. Between the facility's August 2012 survey and final revocation date, 105 residents were relocated. Long-Term Care Ombudsman representatives checked on all relocated residents and continued to assist residents even after their moves.
- Meadowood Care Center, Brown County, terminated February 2013; 56 residents were relocated by the transition team in approximately one month; ombudsmen visited all relocated residents and found no outstanding issues.

Utmost attention is paid to resident choice and quality of care throughout the process so that partners are confident that residents do not suffer due to moving necessitated by state action against a facility's license or provider agreement.

# Making the Right Choice:

*Choosing a Residential Facility*



**Board on Aging and Long Term Care  
Ombudsman Program**

*Advocates for the Long Term Care  
Consumer 60 years of age or older*

**MAKING  
THE CHOICE  
THAT IS RIGHT  
FOR YOU OR  
YOUR FAMILY  
MEMBER**

**BE PREPARED.**

Your Aging and Disability Resource Center or a Long Term Care Ombudsman can help you understand the different types of facilities available, and the different funding requirements and options for paying for care. After having decided which type of “home” would best suit your needs, you should make arrangements to visit the choices in your area. You may want to ask that any available written information such as price lists, mission statements, available services, admission agreements and recent regulatory inspection report summaries be sent to you ahead of time to help you prepare your questions and have time to read the “fine print.” Before or during your visit you might review inspection reports (or surveys), which can be found online or prominently posted in the home. Take time to write down the top two or three services or issues that are most important to you as you make this choice.

## **VISIT THE HOMES THAT YOU HAVE IDENTIFIED AS YOUR CHOICES AND ASK QUESTIONS.**

The following questions to ask and things to consider may help you identify whether a home and the services it provides can meet the needs and preferences of you or your loved one. This checklist is designed to provide a comparison between two homes but you should visit as many homes as you think will help you make the best choice. A Long Term Care Ombudsman can help answer any other questions you might have about regulations or licensing, or to clarify things you may have seen or heard during your tours.

During your tour ask questions about the home and how its care is organized; ask about its reputation in the community and what the people that live there say about the care provided there. Notice whether the person who gives you the tour asks about the needs and preferences of you or your loved one, and ask yourself if you are satisfied with their answers. Finally, think about making a second, unscheduled visit, possibly during a meal or social program. This will help you to see for yourself how well the home organizes these important times of the day, allowing you to observe how skilled and welcoming the staff are, and most importantly, how content the people who live there seem to be.

## **AS YOU MAKE YOUR DECISION.**

Compare your notes and decide whether the homes that you visited can fulfill those top two or three priorities that you identified. Be sure you know whether the home can provide the services that you or your loved one may require, and that any questions about how care and services are paid for have been answered. Finally, you should take the time to carefully read completely all of the documents that you or your loved one will be asked to sign when moving in. You may also want to ask an attorney or another trusted person to review these documents with you.

## **USE YOUR VOICE.**

If at any time you or your loved one has questions at any time about the care and services provided, or if you feel dissatisfied with the conditions in the home, please call your Long Term Care Ombudsman. The Ombudsman is there to assist you in getting the care that you need and expect, and works to educate staff, residents/tenants and family members about long term care systems.

**You can reach your  
Ombudsman by  
calling 1-800-815-0015  
or online at  
[longtermcare.wi.gov](http://longtermcare.wi.gov)**

## CHOOSING "HOME:"

### A Checklist of Questions to Ask & Things to Consider

Home Number One	
Home Name	
Address	
Phone Number	
Contact Name	
Contact Phone Number	
Appointment Date	
Appointment Time	

Home Number Two	
Home Name	
Address	
Phone Number	
Contact Name	
Contact Phone Number	
Appointment Date	
Appointment Time	

Items or Services Most Important to Me or to my Loved One
1.
2.
3.

Resident/Tenant Rights				
<p>Most homes welcome families and other visitors into the home and should be receptive to issues being brought to their attention. Agencies like the Ombudsman Program provide advocacy services to long term care consumers and work with homes to improve care and solve problems through careful planning and groups like resident/tenant and family councils.</p>				
QuestiOns TO Ask	Home #1		Home #2	
Did the home provide a written copy of and explain resident/tenant rights and any house rules? Are these acceptable to you or your family member?	Yes	NO	Yes	NO
Does the home involve the resident/tenant and others as desired in care planning sessions? How often do they occur?	Yes	NO	Yes	NO
Does the home have visiting hours or other restrictions on visitors?	Yes	NO	Yes	NO
Does the home provide any orientation and ongoing support to residents or tenants and their families?	Yes	NO	Yes	NO
Is there a resident or tenant council?	Yes	NO	Yes	NO
Is there a family council?	Yes	NO	Yes	NO
Were you shown a bulletin board or other place where resources and other important information were displayed?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Did you discuss advance directives during your tour?	Yes	NO	Yes	NO
Does the home have a social worker or case manager available on staff?	Yes	NO	Yes	NO
Did the home provide any written statement of rules or conditions under which a person could be asked to leave?	Yes	NO	Yes	NO
Do you feel confident that your comments, suggestions or complaints would be listened to and resolved?	Yes	NO	Yes	NO
<b>Notes:</b>				

## PERSONAL CARE and SUPPORTIVE SERVICES

Care and assistance provided should reflect the person's needs, preferences, habits and lifestyle, and should be provided with dignity and respect.

QuesTiOns TO Ask	Home #1		Home #2	
Is help provided with eating, bathing/grooming, toileting/hygiene, dressing, mobility/ambulation, etc. as needed?	Yes	NO	Yes	NO
Is help provided with laundry, housekeeping, meal preparation, shopping, transportation, financial management, etc. as needed?	Yes	NO	Yes	NO
THinGs TO COnsiDeR	Home #1		Home #2	
If you or the person who will live here has special language or other communication needs, how will this be accommodated? Are there people on staff around the clock that speak your language, or are there interpreter services available? Will you be charged for the use of an interpreter or any special communications equipment?	Yes	NO	Yes	NO
Do you feel comfortable that the home can meet your family member's needs and preferences with dignity and respect?	Yes	NO	Yes	NO
Are you satisfied with the home's responses to your questions?	Yes	NO	Yes	NO

Notes:

## MEDICAL SERVICES

Homes should either provide or assist with medication management, arranging and assisting with transportation to medical appointments, managing medical conditions, and responding to emergencies. Nursing homes can be expected to provide a higher degree of skilled nursing service than assisted living facilities.

QuesTiOns TO Ask	Home #1		Home #2	
Is there a nurse available? How often?	Yes	NO	Yes	NO
Does the home manage the person's medications and treatments?	Yes	NO	Yes	NO
Can the person choose his/her own doctor, pharmacy?	Yes	NO	Yes	NO
Does the home provide or arrange for any specialized treatment or therapies if needed?	Yes	NO	Yes	NO
Can the home care for persons with weight challenges?	Yes	NO	Yes	NO
Is there a charge for transportation to appointments or for staff to accompany to appointments?	Yes	NO	Yes	NO
Does the home contract for hospice services or permit you to contract with a private hospice service?	Yes	NO	Yes	NO
THinGs TO COnsiDeR	Home #1		Home #2	
Does the home provide or arrange for enough help with medications/pharmacy services, medical appointments, health monitoring, to meet the person's needs and preferences?	Yes	NO	Yes	NO
Do you feel confident in the staff's ability to meet your or your family member's daily medical needs, as well as the staff's ability to respond to emergencies?	Yes	NO	Yes	NO
Does the home provide or have the ability to arrange for all of the medical needs that you or your family member has?	Yes	NO	Yes	NO

Notes:

## REHABILITATION SERVICES

Homes may or may not be licensed to provide rehabilitation services ordered by a doctor, but should also offer programs and activities designed to help the person maintain or improve upon his/her level of functioning. All service providers should promote the person's independence in the least restrictive and most dignified manner possible.

QuesTiOns TO Ask	Home #1		Home #2	
Does the home provide or arrange for rehabilitation services as ordered by a doctor?	Yes	NO	Yes	NO
Are there programs to help all residents maintain or increase independence?	Yes	NO	Yes	NO
How will the home keep you or your family member informed of how well rehabilitation is progressing and what comes next?	Yes	NO	Yes	NO
Does the home provide a "home" assessment when therapy is completed?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Are you satisfied with the professionalism of the rehabilitation staff?	Yes	NO	Yes	NO
Have you talked with anyone who has used the home's rehab services? Were they satisfied?	Yes	NO	Yes	NO
What did you observe about the mobility and independence of the residents?	Yes	NO	Yes	NO

Notes:

## CAREGIVING AND OTHER STAFF

Homes should either provide or assist with medication management, arranging and assisting with transportation to medical appointments, managing medical conditions, and responding to emergencies. Nursing homes can be expected to provide a higher degree of skilled nursing service than assisted living facilities.

QuesTiOns TO Ask	Home #1		Home #2	
Was the person who toured with you able to tell you how they know that they have enough staff to meet residents' or tenants' needs?	Yes	NO	Yes	NO
Were you told about the type of training and education staff receive and how often? Does it seem to be enough?	Yes	NO	Yes	NO
If you or the person who will live here have special medical or behavioral needs, is the staff educated in that area in order to provide the right care?	Yes	NO	Yes	NO
Are residents/tenants and/or family members encouraged to share what they know about how to provide specific aspects of care?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Is staff prompt and friendly during your tour? Do they greet other residents/tenants, family members or staff?	Yes	NO	Yes	NO
Do they seem concerned about your situation and enthusiastic about describing the home?	Yes	NO	Yes	NO
Do they seem inviting and willing to answer your questions?	Yes	NO	Yes	NO

Notes:

## BEDROOMS/PERSONAL LIVING SPACE

QuesTiOns TO Ask	Home #1		Home #2	
Can the home give you a private room, if needed or desired and is there an extra charge?	Yes	NO	Yes	NO
Is the bedroom or apartment large enough for your or your family member's needs?	Yes	NO	Yes	NO
What is the home's policy on changing rooms if room mates don't get along?	Yes	NO	Yes	NO
Can personal items such as furniture and pictures be used in the bedroom or apartment?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Would you or your family member be comfortable with the bedroom or apartment shown to you?	Yes	NO	Yes	NO
Is the room equipped and ready for a telephone, television/cable, and internet access? Are there enough electrical outlets?	Yes	NO	Yes	NO
Are there any costs associated with these services?	Yes	NO	Yes	NO

**Notes:**

## BATHROOMS

QuesTiOns TO Ask	Home #1		Home #2	
Are bathrooms private?	Yes	NO	Yes	NO
Can persons choose either a tub bath or shower for bathing, is there a preferred time of day for bathing?	Yes	NO	Yes	NO
Can special needs or preferences, such as a whirlpool bath, be accommodated and is there an extra charge?	Yes	NO	Yes	NO
Can the person who will live here have baths or showers as often as he or she likes?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Am I comfortable with staff's approaches to protecting privacy?	Yes	NO	Yes	NO
Are areas for bathing pleasant and inviting or institutional?	Yes	NO	Yes	NO
Do there appear to be enough bathrooms to meet all of the residents'/tenants' needs, and are they handicap accessible?	Yes	NO	Yes	NO
Are bathrooms and the areas around them clean and without unpleasant smells?	Yes	NO	Yes	NO

**Notes:**

## PHYSICAL ENVIRONMENT

When touring, be sure to evaluate whether or not the home is not only attractive, but that it also meets your expectations regarding location, cleanliness, physical accommodation and overall comfort.

QuesTiOns TO Ask	Home #1		Home #2	
Is the home clean, odor free and decorated according to your tastes?	Yes	NO	Yes	NO
Is there a telephone available for public or private use? Is there a charge for its use?	Yes	NO	Yes	NO
Is there a call system for emergencies in rooms or apartments?	Yes	NO	Yes	NO
THinGs TO COnsiDeR	Home #1		Home #2	
Does the home seem to meet your or your family member's expectations for safe and comfortable living?	Yes	NO	Yes	NO
Would you feel proud to have people visit you or your loved one at this home?	Yes	NO	Yes	NO

**Notes:**

## SOCIAL OPPORTUNITIES & COMMUNITY ACCESS

QuesTiOns TO Ask	Home #1		Home #2	
Do the people who live here plan the social programs?	Yes	NO	Yes	NO
Are there chances to do things outside of the home, such as eating out, shopping, sports events?	Yes	NO	Yes	NO
If there is a charge for programs, do I or my loved one have access to my money?	Yes	NO	Yes	NO
Is transportation provided, and is there an extra charge?	Yes	NO	Yes	NO
Are pets allowed to live with residents or tenants and is there an extra charge or restrictions?	Yes	NO	Yes	NO
THinGs TO COnsiDeR	Home #1		Home #2	
Do the planned social opportunities fit with the things I or my loved one like to do? Does there seem to be enough to do, each day and into the evening, including on weekends and holidays?	Yes	NO	Yes	NO
Is there a place to visit privately besides the bedroom?	Yes	NO	Yes	NO
If smoking is a concern, is it managed according to your needs or preferences or those of the person who might live here?	Yes	NO	Yes	NO

**Notes:**

## MEALS AND SNACKS

MEALS AND SNACKS				
QuesTiOns TO Ask	Home #1		Home #2	
Do people eat in a dining room in or near their room or apartment? Are there assigned seats?	Yes	NO	Yes	NO
Can they choose to eat in their room or apartment if they prefer?	Yes	NO	Yes	NO
Is the dining room used for other activities?	Yes	NO	Yes	NO
Are meal times flexible, and snacks and fresh water available between meals?	Yes	NO	Yes	NO
Can visitors eat with the resident/tenant, and is there a charge for doing so? Are reservations needed?	Yes	NO	Yes	NO
Is there a private dining area available for special occasions?	Yes	NO	Yes	NO
Can special diets or personal preferences be accommodated? Can other foods be brought in by visitors?	Yes	NO	Yes	NO
Did there seem to be enough help available for those who need it?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Would I or the person who might live in the home be comfortable eating in the dining room? Does the menu include foods that I enjoy, and does the staff seem to appreciate how important meals are?	Yes	NO	Yes	NO
Do the people who live here give advice about the menus and recipes?	Yes	NO	Yes	NO
Did the meal that I observed look appetizing and smell good?	Yes	NO	Yes	NO
Did the staff serving the meal seem friendly and concerned for how people enjoyed the meal?	Yes	NO	Yes	NO
<b>Notes:</b>				

## MAKING YOUR DECISION

Ask how changes in rates and services are communicated, and what "other charges" you might be responsible for.

If using personal funds, what happens if those were to run out? Ask about advanced notice required, use of down payments or security deposits. Will the staff assist in securing public funding, if needed, assistance in finding another home?

QuesTiOns TO Ask	Home #1		Home #2	
Does the home accept public funds?	Yes	NO	Yes	NO
Are all charges and fees clearly identified?	Yes	NO	Yes	NO
THInGs TO COnsiDeR	Home #1		Home #2	
Are you comfortable that the home can meet your needs? Are there needs that you or your family member has that the home cannot meet?	Yes	NO	Yes	NO
Did you talk with any residents, tenants or visitors about how they like living here? Did they say anything that you need to look into more?	Yes	NO	Yes	NO
Do the people who live here overall look neat and clean, happy and involved in the life of the home?	Yes	NO	Yes	NO
Do the staff that you observe seem to treat others with respect and dignity? Do they seem to like their jobs?	Yes	NO	Yes	NO
Do the staff look neat and clean, alert and energetic?	Yes	NO	Yes	NO
Do the staff seem to respond quickly to those who need help? Did they greet you and seem friendly as you toured?	Yes	NO	Yes	NO
Would you feel proud to have other persons visit you or your loved one in this home?	Yes	NO	Yes	NO
OTHeR OBseRVATIOns				
<b>Notes:</b>				

**OTHER OBSERVATIONS**

Notes:

**OTHER OBSERVATIONS**

Notes:

# OMBuDsMAn

(OM-BuDZ-MAn)

The word Ombudsman is Scandinavian. In this country the word has come to mean an advocate or helper. An Ombudsman protects and promotes the rights of long-term care consumers, working with residents and families to achieve quality care and quality of life. The program is required by both federal and state law. In Wisconsin the Board on Aging and Long Term Care operates the program statewide.

If you have a question or concern about resident rights please call our toll free number:  
1-800-815-0015



---

**state of Wisconsin  
Board on Aging and Long Term Care  
Ombudsman Program**

1402 Pankratz St., Suite 111  
Madison, WI 53704-4001  
1.800.815.0015

website [longtermcare.wi.gov](http://longtermcare.wi.gov)  
email [boaltc@ltc.state.wi.us](mailto:boaltc@ltc.state.wi.us)



STATE OF WISCONSIN  
BOARD ON AGING AND LONG TERM CARE  
1402 Pankratz Street, Suite 111  
Madison, Wisconsin 53704  
(262) 654-4952  
Fax (262) 654-6194  
Ombudsman Helpline 1-800 815-0015  
<http://longtermcare.wi.gov>

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---

(DATE)

Dear RESIDENTS, FAMILY MEMBERS and INTERESTED PARTIES

Please allow us to introduce ourselves and to offer you our services as a state agency, provided at no charge. (REGIONAL OMBUDSMAN NAME) and I both work for the State of Wisconsin as Ombudsmen. We are advocates for residents living in nursing homes and assisted living facilities as well as for publicly-funded long term care recipients living in the community. We are writing you in response to an announcement made at (FACILITY NAME) about a plan to close the facility and the need to relocate residents from the home.

We will be involved and making ourselves available to the residents and their friends and family members throughout this transition. Some of the things that we're able to do that might be of some help are to answer questions about the plan and about your options; to attend meetings and planning sessions with you to advise and support you; and /or to assist with resolving problems and with possibly filing any complaints and appeals.

Please feel free to contact either (REGIONAL OMBUDSMAN NAME) or myself if you have any questions about this letter or if we can be of any assistance. Thank you.

Thomas La Duke; Ombudsman  
State Of Wisconsin-BOALTC  
1402-Pankratz Street, Suite 111  
Madison, WI 53704  
(262) 654-4952  
1-800-815-0015  
[Thomas.Laduke@wisconsin.gov](mailto:Thomas.Laduke@wisconsin.gov)

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1-800-815-0015  
(REGIONAL) [@wisconsin.gov](mailto:@wisconsin.gov)

# Discharge Planning Guide Book





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# PREFACE



**For the resident of a long term care facility, moving, whether back home or to another assisted living facility, can be both exciting and stressful. Careful consideration of options and thorough planning are the best ways to minimize any negative impact of having to relocate.**

The Wisconsin Board on Aging and Long Term Care is a government agency that works to resolve problems and improve conditions in long term care for the elderly. It encourages the resident and other interested parties to become well-informed and actively involved in discharge planning activities with staff at the facility in order to maintain as much control as possible in the upcoming decisions about where he or she will live. It is beneficial to attend all discharge planning meetings and care conferences that are held on the resident's behalf. This is an opportunity to express thoughts and preferences for the kinds of care and services the resident will want to receive and in what kinds of settings. At these meetings there should be a discussion of the resident's current needs for care and support as well as all available options to meet those needs. Either returning home or moving to an assisted living facility in the community might be a possible option. Consider asking about meeting with a representative from the county human services department to explore

eligibility for funds and supports to do so. It is important to take advantage of opportunities to visit several different locations to aid in better choosing where the resident will live. This facility can assist with arranging transportation for the resident to revisit his or her home or to tour new facilities under consideration.

An ombudsman with the Wisconsin Board on Aging and Long Term Care is available to answer questions and to lend support throughout this transition. We can provide information about options; about



kinds of residential services and settings, about specific care facilities and service providers, and about possible funding sources to help pay for them. We can advise the resident in the exercise of rights and can assist in resolving any concerns and problems that might occur while planning to move.

Some of the **potential issues** could be:

- Inadequate care and treatment or services to meet needs
- Objections to being told to leave or to a particular proposed future placement setting
- Lack of information, or involvement in discharge planning
- Objections to any part of a discharge plan
- Any abuses or rights violations

Residents of long term care facilities have rights under state and federal law. A list of those rights should have been provided upon admission to this facility and shared again upon entering another care setting. These rights should be made available in writing and in a language and format that is easily understood. The Board on Aging and Long Term Care has a booklet available that is intended to inform the reader of those rights and to assist in exercising them. A copy of that booklet can be provided, at no cost, by contacting an ombudsman.

**Keep in mind that residents don't forfeit any of their constitutional rights by living in a nursing home or an assisted living facility.**

Ombudsmen advocate for residents aged sixty or over. **Please call the Ombudsman program, at (800) 815-0015**, if there's anything we can do to help make the transition go as smoothly as possible.

## LEARNING ABOUT OPTIONS



The resident should expect that staff from the facility is available to begin discussions about where it is that he or she might want to live. The social worker or facility manager/administrator may be approached to answer questions or to hear about preferences for alternate living arrangements. The resident is entitled to a discharge planning session and may designate anyone to accompany him or her to these meetings. At the request of the resident or authorized decision-maker, an ombudsman can be contacted to attend and advise the resident at a discharge planning meeting.

**Independent arrangements for moving can be made, but the resident is entitled and encouraged to take full advantage of the planning and assistance to be offered by the facility.**

Agencies in county governments can be contacted to consult with the resident about residential and other services options. They can usually provide written information about programs and funding sources to help pay for community-based services. These county agencies usually have lists of other facilities and directories of local care providers.

## ASSESSMENT OF NEEDS AND PREFERENCES

**The resident may request an assessment by the county Human Services department to determine eligibility for receiving public funding and support to safely return home or to move to an assisted living facility.** The resident may be approached by someone from the county offering this assessment. A social worker, facility manager/administrator or an ombudsman can be asked to arrange for someone to visit.

Should the resident prefer to move to nursing home, the staff can be asked to call a particular facility to begin their assessment process and to see whether they have any room available and can

meet his or her needs. At any time, the assistance of representatives from various state and county agencies can be requested to advise the resident about his or her options.



## EXCHANGING INFORMATION ABOUT THE RESIDENT AND ABOUT WHAT HE OR SHE WANTS AND WILL BE NEEDING



**When being referred to another facility or care provider, information about the resident's preferences and any needs for assistance should be provided.** There should be notification including a request for authorization, in writing, to release and exchange information. This is done so that the new care provider can prepare to adequately meet the resident's needs. Exchanging information, early on, between service providers is critical in promoting a smoother transition and better continuity of care. This information should be shared only when the written release form has been signed by the resident or legal representative, and the authorization can be limited or withdrawn at any time.

A document prepared by a nursing home called a discharge summary should have been written and then reviewed at the discharge planning session. This should also be sent on to any new providers. It should include information about the resident's current medical condition as well as instructions for his or her care. It should summarize the resident's course of treatment while at the nursing home and identify his or her potential for rehabilitation. Finally, the resident should be provided with a post discharge plan that is meant help him or her adjust to a new living environment. This should include any instructions and referrals for community services when moving home or to a community based setting.

## TOURING NEW PLACES



**It's a good to idea to tour and to see a proposed new place to live, first hand.**

The facility should arrange transportation so that the resident is provided with opportunities to visit potential alternate living arrangements.

A request can be made that staff accompany the resident on a tour that is arranged at a time that's convenient for the resident and a friend or family member. He or she has the right to meet with any potential roommate(s) and other residents to ask

**He or she has the right to meet with any potential roommate(s).**

questions about the place and to see State inspection reports. Advocates can help locate and review inspection reports of licensed facilities. Checklists are available that can help to focus on things to look for or questions to ask when visiting a possible new home. These

checklists can be taken from the internet or gotten by asking an Ombudsman to assist in obtaining one. When returning home or moving to an apartment, the resident is entitled and encouraged to first visit with qualified staff to see that he or she can get around and safely manage.

## PLANNING FOR THE MOVE

**The resident has right to be involved in the planning of a move and to determine where he or she is to live by choosing from among the available alternatives.** After having toured,

applied for and been accepted, and the resident has approved the placement, the opportunity to select the date for moving should be offered.

The resident may move as soon as he or she, and the new care providers are ready, and plans have been finalized. This may include needing to have

a service plan approved by state and county agencies if using public funds to return home or to move into an assisted living facility. The

move should be on a date that is convenient for the resident and for any persons assisting with the move. The resident is entitled to, at least,

thirty days written notice prior to the relocation.

The notice should confirm when and to where he or she will move. This written notice should

provide information about how to appeal any part of the discharge plan and how to contact an

advocate for assistance in doing so. He or she may waive this thirty day waiting period or might want

to contact an advocate if feeling pressured into moving before being ready.

**The resident is also entitled** to a planning session to confirm the details of the move. At least fourteen days before moving, a meeting should be held to develop and discuss a discharge plan that includes counseling on how the nursing home resident, and his or her records and belongings will be moved. Written notice of this meeting should be provided in writing at least seven days in advance of the planning conference. The resident may ask any other person to join him or her at this meeting or can waive it altogether. He or she may choose to move sooner than the planning process allows, and can waive those timelines as well.

**It's important, however, that the resident feel well prepared and comfortable about the move, and that all interested parties be informed about and know what to expect of the discharge plan.** Please note the addendums

in the back of this booklet that include lists of questions to assist in developing and evaluating the quality of the discharge plan.



## BELONGINGS AND PROPERTY



**The resident has a right to have and to use his or her clothing and other possessions, and to expect that they be safely transported to the new location.**

It's recommended that the resident directly supervise the packing of belongings, if able, and that they be inventoried and recorded in writing. This written inventory should accompany the resident to his or her new home. The resident may choose to pack his or her own things or to ask a friend or family to assist, but can also expect help from facility staff, if preferred. While still limited, adequate space for things ought to be provided in the room at the new facility as well as there being some secure storage space for extra possessions. If returning home or moving into a new apartment, the resident should inquire into any available funding to assist with the cost of equipping the new place.

Upon discharge, the resident is entitled to a statement of any funds being held by the closing facility. This statement should show all expenditures, disbursements and deposits made to any account managed by the facility. The resident should decide and dictate how those funds will be transferred at the time of his or her relocation (whether by check given to the resident or a responsible party,

or sent directly to the new facility.) Arrangements will need to be made to see that funds and all other business, are routed to the new home. Each agency may need to be contacted separately to let them know that the resident is moving and what his or her new address will be. Some sources of payment

**The resident is entitled to a statement of any funds being held by the closing facility.**

or income to consider include a Social Security check, Supplemental Security income (SSI,) Pension funds, Insurance policies, Bank/Credit Union information on certificates of deposit, checking and savings accounts, Trust funds, Stocks, etc. A change of address form should be completed and submitted to the post office,

as well as arrangements made for any business to be transferred to the new location. The nursing home social worker or facility manager/administrator can assist with all of this.

## ON THE DAY OF THE MOVE

The resident and interested parties should have already been informed of the specifics of the plan for moving, as to when and how, at the planning session. Belongings should have been packed and inventoried, and should accompany the resident on the move. His or her address should have been changed and instructions should have been submitted for redirecting any business expenses like the telephone or cable bill, etc. A summary of care needs should have been sent ahead to the new care providers. Family and friends, with the resident's permission, should have been notified as well as the physician as to the new location.

The resident may want to inform staff that he or she would like to take some time to say goodbye to other residents and staff before leaving.

**It's important that everyone involved be mindful of how the resident may be feeling, and any signs or symptoms of illness or change in condition should be promptly reported to current and new staff.**

## SETTLING IN



**Upon arrival at a new facility, the resident should be shown to and around the new room, introduced to any roommate and offered a tour of the facility.** Everyone involved should be alert to potential hazards in a new location and increased lighting should be offered to the resident while acclimating to the new environment. At a minimum, he or she should be informed of the location of the bathroom and where meals are to be taken. It may be helpful to ask about the availability of any programs or activities that might be of interest to the resident and that might provide opportunities for him or her to meet new people. The resident should be given an opportunity to discuss preferences for certain routines such as when he or she likes to rise in the morning and go to bed at night, and for bathing, food preferences, etc. He or she should ask, if not already instructed, about how to alert staff when assistance is needed.

As belongings are being unpacked, items should be checked against the written inventory to see whether anything is missing. The inventory should have been completed as things were packed and should have accompanied the resident. It's recommended that any lost or damaged belongings be promptly reported to either the social worker or manager at the new facility, or case-manager if the resident is receiving assistance from the county. An ombudsman can be called to help in trying to locate or get missing things replaced.

## POST DISCHARGE

The nursing home is required to develop, with the participation of the resident and his or her family, a post-discharge plan of care that is meant to help him or her adjust to the new living arrangement. It's to be designed to ensure that needs are met, and should be done regardless of whether the resident is returning home, or moving to an assisted living facility or to another nursing home.

The receiving facility, upon the resident's admission, is required to develop and implement an initial plan of care based on the physician's plan and orders for care. It should also include approaches to address any new problems identified in a nursing assessment. **It's critical that this plan be thorough and specific enough to meet the needs of the resident immediately upon their arrival at the new home.**

## PROBLEMS IN THE RESIDENT'S NEW HOME



The resident should feel comfortable asking any question or reporting any problems at the new location. He or she has a right to be listened to and to have concerns responded to in a timely and respectful manner. He or she also has a right to have any complaints addressed without fear of retaliation.

In the new home, the resident should know who to contact to report a problem or concern. He or she may want to ask about the name of the social worker or manager/administrator at the facility and how that person can be reached.

**He or she also has a right to have any complaints addressed without fear of retaliation.**

Within weeks of admission, the resident should be offered a care-planning session, but may request that one be scheduled at anytime to address a specific care concern or issue. A formal grievance may be filed with any facility or provider, and the agency is required to provide the

complainant with their determination. The written findings of their inquiry or investigation, may be requested, and a decision can be appealed. A formal complaint with the regulatory agency having oversight of any licensed program can be filed as well. An ombudsman can be contacted to discuss options for and provide assistance with redressing concerns, filing complaints and seeking appeals.

***In a private residence, the names and phone numbers of care providers, the physician, emergency services and for a case or care-manager (where assigned) should be made readily available.***

## WHEN A FACILITY CLOSES



Wisconsin has seen an increase in the number of closing or down-sizing nursing homes. These situations can be even more stressful as the resident may not have much control over the decision to move. When it's been decided that a facility is to close, it is required by law to inform the State and to submit a plan to the Department of Health and Family Services that describes how it will assist the resident to move safely and with as little stress as possible.

The State will approve the plan or, if unacceptable, ask the facility to revise it. The residents and their families should, then, be invited to an informational meeting with staff from the facility and representatives from state and county agencies as well as from advocacy organizations. The purpose of this meeting would be to formally announce the facility's plans, and to inform the participants about options and about what kinds of help one can expect. We encourage attendance at this meeting to ask any questions about the closure. This is an opportunity to meet with professionals who can advise and assist the resident in finding another nursing home, or in exploring whether he or she can relocate to an assisted living facility or return to live at home with support. Questions about options can be

asked of advocates who can offer their help and support. Arrangements can be made to meet with the social worker at the home to begin making plans to move. There should be much written information at this meeting as well.

An anticipated date for closure should be announced, but the facility has a responsibility to see that each resident moves to a place that can adequately meet his or her care needs. There should be time to learn about options, to have the residents' needs and preferences assessed, to visit potential alternate living arrangements, and to plan the move. A resident has rights in choosing his or her final destination and may not be forced to remain in any place without



a court order. **No one should be required to move without first having suitable alternate living arrangements made.**

There should be a place at the closing facility designated as a Resource

Room where written information including lists of other facilities and local directories of care providers can be obtained. Contact information for people and places that can assist the resident in deciding where to live should also be made available. There are descriptions of a variety of

different kinds of long term care facilities and information about public funding to help pay for them that can be made available.

A team of state and county representatives, along with advocates, will regularly meet with the facility to monitor the closure and to discuss the relocation plans of each resident. The resident or authorized decision-maker can contact an ombudsman to represent his or her interest at these meetings. The ombudsman can advise the resident about options and make the facility aware of his or her preferences, and can participate (with the resident's permission) in any discharge planning activities. An ombudsman can also discuss options for redressing care concerns or complaints about the facility.

***In the event of a room change while still at the closing facility,*** to bring residents closer together for safety reasons, he or she has the right to receive reasonable advanced notice and some accommodation of preferences. He or she also has a right to have personal possessions promptly unpacked and accessible throughout the closure.

## IN THE MEANWHILE



All persons involved with a nursing home resident who is relocating should be conscious of the potential impact of the changes in his or her life and allow that person a period of time to adjust, but to also recognize and promote some of the possible positive aspects of moving.

The resident should be included in discussions and listened to at every phase of the relocation process. It should be understood that as options are presented and become clearer that that person may need time to decide and may change his or her mind. Plans must be sufficiently flexible to accommodate the resident. He or she should be made to feel comfortable about asking questions and actively encouraged to voice any opinions and concerns before, during and after move.

He or she should be consulted, and asked to consider and share thoughts on what might be done to make the transition easier and to help him or her feel more at home in the new living environment.

**Everyone involved with the relocating resident should be aware of and watch for any indications of stress as a result of this transfer.**

The Board on Aging and Long Term Care realizes the complexity of all that's involved in the relocating of persons living in a long term care facility, and has created this booklet in hopes of improving care and enhancing the quality of life for elderly residents.

***We appreciate your taking the time to read it to better understand ways to help minimize the stress to residents having to do so.***



Please know that our ombudsmen remain available to help in any way that they can.

**PLEASE CALL**

**1-800-815-0015**

to ask any questions or to seek direct assistance in making the best possible discharge plans for elderly residents.

# ADDENDUMS



## QUESTIONS TO ASK STAFF WHILE MAKING PLANS TO MOVE

- How much time do I have to make my moving plans?
- What kinds of help with planning can I expect and from whom?
- What exactly do I have to do? What happens next?
- What are my current needs for care or support?
- Will I need any special equipment or adaptive aids in my new home?
- Who will help me get this equipment or these aids?
- What services are available to help me get these needs met?
- In what kinds of places can these care needs be best met?
- If I want to live in my own home or apartment, what are my options?
- If I want to live in an assisted living facility, what are my options?
- If I want to live in another nursing home, what are my options?
- What government programs might help me pay for these services?

- How do I get into these programs and who'll help me apply?
- When can I visit some possible new places to live?
- How can I get to see these places and who will accompany me on a tour?
- Once I decide on where I'd like to live, what do I need to do?
- How long until I'm able to move?
- Will I be able to stay in my current room until I move?
- Who will help me pack and move my belongings?
- Do I have money in any account and how soon will it be made available?
- How will people be notified of my move to a new location?
- Will I be able to keep my current doctor?
- Will my doctor come to see me at my new home?
- What arrangements will be made for my care in a different setting?
- What records, equipment and supplies will be sent to my new care providers?
- What chance will I have to work out the final details my plans?
- What if I change my mind and don't want to move there?

## **QUESTIONS TO ASK WHILE REVIEWING THE DISCHARGE PLAN**

Knowing your rights as a resident in a long term care facility can help you make informed decisions about where you will live and who will provide the care you may need. You have the right to be kept informed about options throughout the period of time it takes for you to make plans to relocate from this facility. This should involve several discussions with the staff at the facility that ends in your being invited to participate in a discharge/relocation meeting where your plan is finalized and reviewed with you. It's another opportunity to ask questions and to be sure that the details of your move have been addressed. You also have the right to ask an ombudsman, your guardian, your family and/or friends to join you at this or any other meeting for support in making sure your preferences are heard and considered. The following list of questions might help you to make sure you get all of the information and assistance that you have a right to receive.

- 1) Was I given an opportunity to discuss my options and to tell the facility staff about where it is I'd like to live?
- 2) Did I receive enough information about services and supports available to me? Was this information clear and easy to understand?
- 3) Was I offered an opportunity to meet with my county agency to discuss community living options?

- 4) Did anyone offer me an assessment for funding to return home or to move to an assisted living facility?
- 5) Was I informed of the outcome of that assessment and do I feel that it accurately described my condition? If not, was I advised on any appeal rights?
- 6) Has the facility made arrangements for me to visit possible places to live? Has anyone followed up with me on the results of that visit? Was I given an opportunity to ask questions about any of these places?



- 7) Was I given an opportunity to decide whether I'd like to move to one of these places?
- 8) Once I had decided on a location and my arrangements were made, was I offered a discharge planning conference?
- 9) Did I receive a written notice informing me about the date, time, location and agenda of the discharge / relocation meeting?

- 10) Was I given the chance to change the date and/or time of the meeting if it wasn't convenient for me or my representative?
- 11) Was sufficient notice of my discharge / relocation planning meeting provided?
- 12) Did the facility inform me that I have the right to have an ombudsman or another person present to help me voice my preferences at this meeting?
- 13) Was there enough time scheduled at this meeting for me to discuss all of the things that are important to me?
- 14) Did I receive a written summary about what was discussed at my discharge / relocation meeting?
- 15) Was I given a written notice at least thirty days before the date I anticipate moving? Did it identify when and to where I'm expected to move?
- 16) Do I know how my belongings will be taken to my new home?
- 17) Do I know who to talk to at the facility if I have questions or concerns about my discharge / relocation plan?



If you'd like help in developing or do not agree with the discharge plan already developed by the facility, you have the right to appeal the decision. You may seek assistance in making your plan or with an appeal by contacting an ombudsman at:

**1-800-815-0015**

**AN OMBUDSMAN CAN  
ADVISE AND ASSIST YOU.**

## LIST OF DOCUMENTS TO BE SENT TO THE NEW CARE PROVIDER

- Medical Records including a face sheet, physician's orders for medication and treatment, current history and physical examination reports, assessments, plans of care, relevant progress notes and any other information needed by subsequent care and service provider.
- Discharge Summary that includes current medical condition and findings, final diagnoses, rehabilitation potential, a summary of the course of treatment, nursing and dietary information, ambulation status, administrative and social information and any other instructions for needed continued care.
- Post Discharge Plan of Care that provides pertinent information for continuing care that's based on assessed needs and includes strategies for ensuring those can be met after discharge.



- Legal papers that include any Power of Attorney Instruments and Statements of Incapacity, Letters of Guardianship and Determination and Orders (Protective Placement,) Social Security Cards, Medicaid Cards, documentation of citizenship or visitor status, etc.
- Financial Records including bank and facility trust account statements, documentation of any pension funds, insurance policies, other bank/credit union information on CD's, checking and savings accounts, trust funds, stocks, and documentation of public benefits.
- Inventory of Personal Property including a written checklist of clothing and personal effects, furniture, equipment and supplies on hand, deeds and titles to vehicles, homes and property.
- Family and other personal information including names, addresses and phone numbers of friends and relatives. Correspondence and photographs.
- Burial Information including documentation of pre-paid arrangements and trust fund accounts, preferences for funeral directors, cemetery plots and markers. Obituary information.

# OMBUDSMAN

(OM-BUDZ-MAN)

The word Ombudsman is Scandinavian. In this country the word has come to mean an advocate or helper. An Ombudsman protects and promotes the rights of long-term care consumers, working with residents and families to achieve quality care and quality of life. The program is required by both federal and state law. In Wisconsin the Board on Aging and Long Term Care operates the program statewide.

If you have a question or concern about resident rights please call our toll free number: 1-800-815-0015



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**State of Wisconsin  
Board on Aging and Long Term Care  
Ombudsman Program**

1402 Pankratz St., Suite 111  
Madison, WI 53704-4001  
1.800.815.0015

website <http://longtermcare.state.wi.us>  
email [boaltc@ltc.state.wi.us](mailto:boaltc@ltc.state.wi.us)

You can reach **YOUR**

**Long Term  
Care Ombudsman**

for information or assistance  
by calling the toll free number

**1-800-815-0015**



Serving Residents  
Aged 60 and over



State of Wisconsin  
Board on Aging and Long Term Care  
Ombudsman Program  
1402 Pankratz St., Suite 111  
Madison, WI 53704-4001  
1.800.815.0015  
website <http://longtermcare.state.wi.us>  
email [boaltc@wisconsin.gov](mailto:boaltc@wisconsin.gov)

# Should Your Facility



## You Still Have Rights!



# You have the right to:

- Be appropriately informed of the closing of the facility
- Attend relocation or discharge planning meetings
- Be provided information on alternative living arrangements and the options available
- Be assessed for eligibility for funding and supports to safely return to live in your home or community
- Visit other facilities to help you better decide where you'll live
- Be given advanced notice of and be actively involved in your discharge planning
- Seek representation by an Ombudsman, your County Case Manager, or a legal representative without fear of reprisal
- Expect to receive adequate care and treatment services during the closing process
- Meet with the facility staff to express your concerns, explore placement options or vent your frustrations
- Continue to attend and participate in facility activities
- Be notified of any changes that may affect you
- Seek a review of any discharge decision with which you disagree
- Expect that your rights, while a resident of this facility, will not be violated**

## How can an Ombudsman Help?

### A Long Term Care Ombudsman Can Help Elders by:

**Discussing** with you and providing you information about long term care, in general, or helping you research a particular service or facility.

**Speaking for** your interests throughout the closure and advocating on your behalf.

**Accompanying** you to discharge planning meetings to advise you and support you in your choices for where to move.

**Consulting** to help you, your family, and the facility to avoid and resolve problems before they become crises.

**Investigating** complaints with the facility and suggesting solutions.

**Protecting your rights** and assisting you with your relocation efforts as the facility closes.

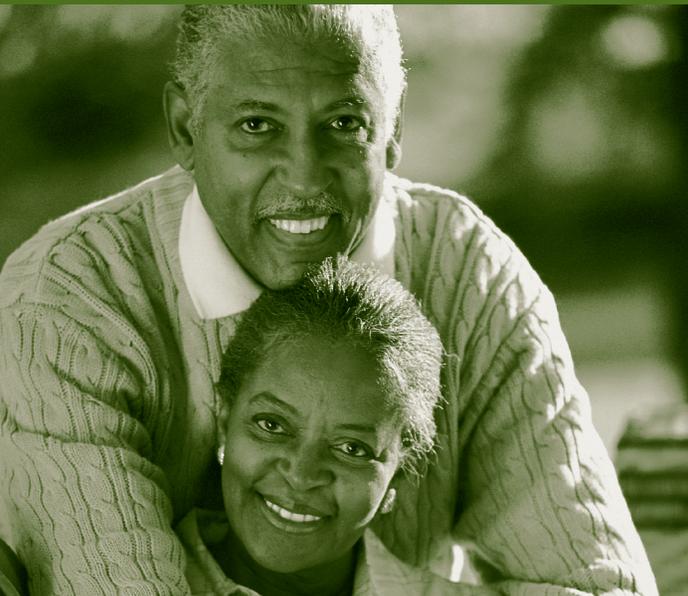
## Who Can Contact an Ombudsman?

Residents and their families

Staff at facilities or community agencies

Anyone who has questions or concerns about the rights of long-term care consumers or suspects that someone in a long term care setting is not receiving proper care.

*Residents have many rights which are guaranteed by federal and state law. An Ombudsman can help you protect these rights. You may contact us whenever you have questions or problems. If you wish, your name can be kept confidential.*



State of Wisconsin

Board on Aging and Long Term Care

Ombudsman Program

1402 Pankratz st., Suite 111

Madison, WI 53704-4001

1.800.815.0015

website

<http://longtermcare.state.wi.us>

email

[boaltc@ltc.state.wi.us](mailto:boaltc@ltc.state.wi.us)

# A Voice for Residents

## The Long Term Care Ombudsman

*Serving Residents  
Aged 60 and Older*



## What is an Ombudsman?

The word *Ombudsman* (Om-budz-man) is Scandinavian. In this country the word has come to mean an advocate or helper. An Ombudsman protects and promotes the rights of long-term care consumers, working with residents and their families to achieve quality care and quality of life. The program is required by law. In Wisconsin the Board on Aging and Long Term Care operates the program statewide.

## Our Services are Provided at No Charge.

You have a legal right to express concerns without fear of retaliation.

Complaints can be made by phone, fax, email or letter. Contact us at our statewide toll free number:

**1-800-815-0015**

## How Can an Ombudsman Help?

**Answer** questions about care options, such as community care, community-based residential facilities (group homes) or nursing homes.

**Investigate** complaints in these long-term care settings, and suggest solutions.

**Help** residents and their families resolve problems.

**Promote** the rights of nursing home and CBRF residents.

**Provide** consultation services to help residents, families, or facilities avoid problems, or solve them before they become crises

**Speak** to facility or community groups about long-term care issues, especially resident rights.

**Work** with resident or family councils, community organizations, state and federal enforcement agencies to improve residents' quality of life.



**NURSING & COMMUNITY RESIDENCE PROTECTION § 44-1004.03**

**SUBCHAPTER IV. PRIVATE RIGHTS OF ACTION.**

**§ 44-1004.01. Injunctive relief.**

A resident, a resident's representative, the Long-Term Care Ombudsman, or the Corporation Counsel may bring an action in court for a temporary restraining order, preliminary injunction, or permanent injunction to enjoin a facility from violating any provision in subchapter III of this chapter, any rule issued by the Mayor pursuant to that subchapter, or any standard or resident's right established pursuant to § 44-504(a)(3) and (4).

(Apr. 18, 1986, D.C. Law 6-108, § 401, 33 DCR 1510.)

**Historical and Statutory Notes**

**Prior Codifications**

1981 Ed., § 32-1451.

**Legislative History of Laws**

For legislative history of D.C. Law 6-108, see Historical and Statutory Notes following § 44-1001.01.

**§ 44-1004.02. Mandamus.**

A resident, a resident's representative, the Long-Term Care Ombudsman, or the licensee or administrator of a facility may bring an action in court for mandamus to order the Mayor or any District government agency to comply with subchapter III of this chapter, any rule issued by the Mayor pursuant to that subchapter, or any other District or federal law relevant to the operation of a facility or the care of its residents. Any person bringing an action under this section shall give the Mayor at least 5 days advance notice (excluding Saturdays, Sundays, and legal holidays) before the action is filed in court.

(Apr. 18, 1986, D.C. Law 6-108, § 402, 33 DCR 1510.)

**Historical and Statutory Notes**

**Prior Codifications**

1981 Ed., § 32-1452.

**Legislative History of Laws**

For legislative history of D.C. Law 6-108, see Historical and Statutory Notes following § 44-1001.01.

**§ 44-1004.03. Civil action for damages.**

(a) A resident or resident's representative may bring an action in court to recover actual and punitive damages for any injury that results from a violation of subsection (b) of this section, subchapter III of this chapter, any rule issued by the Mayor pursuant to subchapter III of this chapter, or any standard or resident's right established pursuant to § 44-504(a)(3) and (4). Upon proof of a violation and subject to subsection (c) of this section, the resident shall be awarded 3 times the actual damages or \$100, whichever is greater, and may be awarded punitive damages of up to \$5,000.

(b) No owner, licensee, administrator, or employee of a facility shall take any action that adversely affects a resident's rights, privileges, or living arrangement in retaliation for that resident, his or her representative, or the Long-Term Care Ombudsman having exercised a right conferred by District or

Justia › US Law › US Codes and Statutes › District of Columbia Code › 2014 District of Columbia Code › Division VIII. General Laws › Title 44. Charitable and Curative Institutions › Chapter 10. Nursing Homes and Community Residence Facilities Protections › Subchapter II. Receiverships › § 44–1002.03. Petitions for receivership.

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## 2014 District of Columbia Code

### Division VIII. General Laws

### Title 44. Charitable and Curative Institutions

### Chapter 10. Nursing Homes and Community Residence Facilities Protections

### Subchapter II. Receiverships

### § 44–1002.03. Petitions for receivership.

**Universal Citation:** [DC Code § 44–1002.03. \(2014\)](#)

(a) Notwithstanding the availability of any other remedy, the Attorney General for the District of Columbia may, in the name of the District and based on one or more of the grounds listed in § 44-1002.02, petition the court to appoint a receiver for any facility.

(b) Notwithstanding the availability of any other remedy, a resident, a resident's representative, the Long-Term Care Ombudsman, or any other advocate representing the interests of a facility's residents may, based on one or more of the grounds listed in § 44-1002.02(2) through (6), submit a written request asking the Attorney General for the District of Columbia to petition the court to appoint a receiver for any facility. If the Attorney General for the District of Columbia denies the request or does not file a petition within 5 days (excluding Saturdays, Sundays, and legal holidays) after receiving a request, the requestor may file with the court a petition for the appointment of a receiver.

(c) The licensee of any facility may, based on one or more of the grounds listed in § 44-1002.02, petition the court to appoint a voluntary receiver for that facility.

#### History

(Apr. 18, 1986, D.C. Law 6-108, § 203, 33 DCR 1510; Apr. 13, 2005, D.C. Law 15-354, § 67, 52 DCR 2638.)

This section is referenced in § 44-1002.04, § 44-1002.05, § 44-1002.07, and § 44-1002.10.

### Prior Codifications

1981 Ed., § 32-1413.

### Effect of Amendments

D.C. Law 15-354 substituted "Attorney General for the District of Columbia" for "Corporation Counsel".

### Legislative History of Law 6-108

For legislative history of D.C. Law 6-108, see Historical and Statutory Notes following § 44-1001.01.

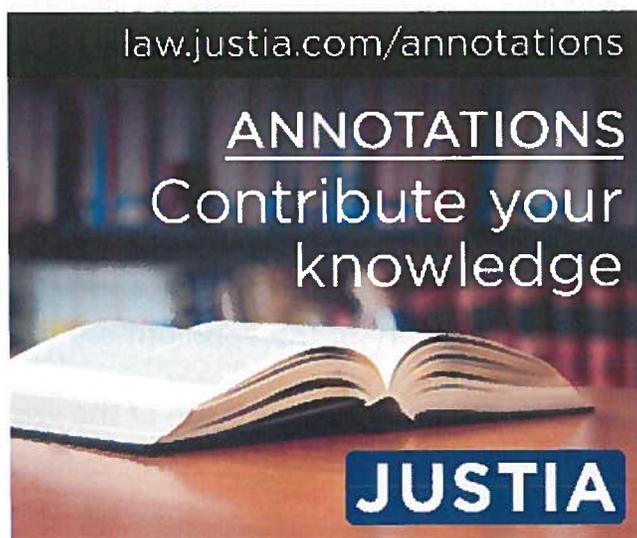
### Legislative History of Law 15-354

For Law 15-354, see notes following § 44-212.

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## Ask a Lawyer

### Question: