

Wisconsin Guidelines

Wisconsin has one of the most detailed list of requirements and has a major focus on the need to lessen any transfer trauma (relocation stress). You may find ideas for your state.

NOTE: This summary was prepared from Wisconsin's "Resident Relocation Manual for Nursing Homes, Facilities Serving People with Developmental Disabilities, Community Based Residential Facilities" by the Department of Health Services, Division of Long Term Care. You can find the manual here: <https://www.dhs.wisconsin.gov/relocation/relocationmanual.pdf>. You can find Wisconsin's statutes on nursing home closures here: <https://docs.legis.wisconsin.gov/statutes/statutes/50>.

1. Closing Plan must include:

- The date and reason for facility closure, for changing the type or level of services or the means of reimbursement or for the downsizing of the number of facility beds.
If the facility is relocating 5 to 50 residents, the proposed closing date may be no earlier than 90 days from the date the Department approves the facility Resident Relocation Plan.
If the facility is relocating 50 residents or more, the proposed closing date may be no earlier than **120** days from the date the Department approves the facility Resident Relocation Plan.

Note: The facility must remain open until all residents are properly relocated even if the proposed closing date has passed. The facility may close sooner than the closing date if the last resident has relocated to their new home.

- Name of the individual who will function as the facility relocation coordinator.
- A proposed timetable for planning and implementation of facility closure/resident relocations.
- The resident census at the time of the plan submission or the census on the day the closure was announced or became known to residents and their representatives. The resident census will be the one reflected on the date the first of these events occurred.
- Full completion of all the data elements of the Resident Roster.
 - Note the following included points need to be observed when completing the roster.
 - The Department must receive all requested resident roster information before the Resident Relocation Plan can be approved.
 - The roster must include a listing of residents who the facility has determined may need to be assessed for guardianship.
 - All communication/usage of the roster must provide for Protected Health Information (PHI) security.
 - The facility must update the roster and keep it current at all times.

- The results of any prior resident options counseling is noted in the comments section of the roster.
- The means the facility will utilize to inform staff of the plans for facility closure or downsizing and the relocation of residents.
- 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.
- Initial Announcement of Closure and Relocation of the Residents. The means the facility will utilize to notify the residents, legal representatives and families of the plan to close or downsize the facility and relocate the residents including written notification.
 - The communication will include the date and time of the announcement meeting. For purposes of confidentiality, the initial announcement of the meeting may or may not include the purpose of the meeting. In this case the announcement meeting must be followed by a letter to all residents/legal representatives/families announcing the closure: the tentative date and reason for closure must be included.
 - The announcement meeting participants will include facility staff, the state relocation team lead, the DLTC Member Care Quality Specialist assigned to MCOs operating in the county (ies) where the residents are from, staff from the advocacy agencies, representatives of the ADRC and/or staff from the county waiver programs, and representatives of any residents' managed care organization (MCO).
 - The facility and the state relocation team lead will collaborate on the scheduling and content of the meeting.
 - The means of notification of attending physicians and the county.
 - The facility may include in the initial announcement the following entities: • Municipalities • Legislators • Other key stakeholders.
- Initial Informational Meeting for Residents/Families/Legal Representatives. The informational meeting usually occurs a few days after the initial announcement meeting and will include the relocation team members from the announcement meeting and may include some or all of the following representatives:
 - Aging and Disability Resource Centers (ADRCs), Managed Care Organizations (MCOs), IRIS (Include, Respect, I Self Direct) Independent Consultants, and select other agency representatives as appropriate.
 - The facility may provide, at this family and resident informational meeting, the opportunity to schedule individual relocation planning meetings to reinforce information received at the meeting regarding placement alternatives and to provide opportunities to seek out resident preferences for placement.
 - The ADRC or county waiver programs may choose to schedule residents for options counseling if the residents desire this assistance at this time.
 - The facility will create an area with resources to assist the resident and/or their representatives in identifying possible alternate placements and explaining county waiver program, ADRC, MCO and IRIS services available to them for community placement. Additional resources may include facility directories and

other community provider informational hand-outs.

- A description of how and when the facility will involve the Aging and Disability Resource Center or county waiver program staff in the planning for the relocation of residents. Adult Protective Services (APS) may also need to be included. If the county of legal and/or financial responsibility is different from the one the facility is located in, the facility needs to inform that county of the need to relocate residents. It is strongly recommended that the county or counties and/or ADRC be contacted as soon as possible, even before the Chapter 50 Resident Relocation Plan has been approved. Facilities should inform the county/ADRC of the time line for the initial resident and family closure announcement meeting and the subsequent informational meeting so that the county/ADRC resources can be scheduled to assist on a timely basis with the facility's Resident Relocation Plan implementation.
- The resources, policies, and procedures that the facility will provide or arrange for in order to plan and implement the resident relocations.
 - How will the facility:
 - **Mitigate relocation stress syndrome**/transfer trauma.
 - Address the special needs of persons with a mental illness, an intellectual disability, a physical disability, or other residents who are relocating.
 - Identify approaches the facility staff will initiate to assist the resident with the relocation process.
 - Address resident preference/choice for relocation settings.
 - Provide opportunity for the resident to visit potential alternate living arrangements and provide for transportation.
 - Identify the process the facility will initiate identify residents the facility believes to be incompetent.
 - A description of the medical record documents that will be included in the transfer of resident records.
 - Minimally these records shall include: • Physician history and physical, and physician orders. • Medication Administration Record. • Record of current treatments. • Relevant consultation reports • Nursing Notes from the last 30 days. • The most recent complete minimum data set. • The most recent quarterly minimum data set.
 - The interdisciplinary care plan. • The nurse aide care plan or instruction sheet. • Recent social service notes. • PASRR documents if the resident has a developmentally disabled and/or mental illness diagnosis. • Recent resident weights. • Discharge Summary including information on the presence or absence of characteristics of resident relocation stress syndrome. • Legal documents: power of attorney, guardianship and protective placement records.
- **Resident Relocation Planning Conference**. How the facility will conduct relocation planning conferences with each resident and/or their representatives and implement the individual relocation plan developed.
 - The following components will also be addressed:
 - A written notice of the initial relocation care planning conference will be

sent to the resident or decision maker 7 days or sooner before the planning conference. The resident may choose to be referred to the ADRC or county waiver programs for options counseling prior to this initial planning meeting. This choice may influence the timing and content of the relocation planning conference. Also the choice to enroll in Family Care, Family Care Partnership or IRIS will affect the facility role in relocation planning. The facility relocation plan will acknowledge, as indicated, the role of the ADRC and the MCO in resident relocation planning.

- At each planning conference, an individual relocation plan will be developed with the input of the resident, legal representative, if any, family and physician, as well as the MCO if the resident is a member, or the county waiver program staff, as indicated, and other appropriate professionals involved in the care and treatment of the resident. The resident's family/legal representative will be invited to the planning conference, as practicable, unless the resident requests that family not be present. If the resident would like an advocate present at the planning conference, the facility will notify the advocate of the date and time of the conference.
 - An assessment of the individual's continuing care needs and needs for relocation supports. **Assessing and care planning for individual resident relocation stress syndrome/transfer trauma.**
 - Services that are needed to effect a positive relocation and how services will be accessed.
- The planning conference is resident centered. The relocation process is focused on the resident's and/or legal decision maker's preferences/choice for an alternate living environment. The resident and/or representative must be actively involved. The timing of relocation planning conferences needs to accommodate resident and representative schedules including week-ends and evenings.
 - As a result of the relocation planning conference, the resident may be referred for options counseling by the ADRC or the county waiver program.
 - Note the facility's responsibility to transport residents to tour possible relocation destinations if other arrangements are not available to the resident.
 - If indicated, how the facility will meet the responsibility to assist with the procurement of needed medical equipment.
- How the facility will meet the responsibility to provide needed interventions and procedures to effect a healthful relocation e.g. TB skin tests, etc.
 - When indicated a description of the training that will be offered, prior to relocation, to the resident/caregiver to meet care needs of the resident after discharge.
 - When indicated, how the facility will meet the responsibility to contact Social Security, assist resident with application for Supplemental Security Income (SSI) and Medicaid, notification of address change, notification of move date.
 - A description of how the facility will consult the physician regarding the effects of the

potential relocation on the resident's health and how the facility will involve each resident's physician in the resident's planning conference.

- A description of how the facility will work with residents and their families/guardians to resolve complaints or concerns.
 - The facility will attempt to resolve any grievances voiced by residents, guardians, agents and family members that relate to the relocation process as follows:
 - The facility will not make any reprisal against an individual for initiating a grievance.
 - Any grievance will be brought to the attention of the facility's Administrator, who will review the grievance and provide a response to the aggrieved party within five calendar days after the initial presentation of the grievance to the facility Relocation Coordinator. This step will involve oral communications.
 - If an individual files a grievance, the facility Administrator will provide written notice and actively assist that individual to contact, at any time, an Ombudsman or Disability Rights Wisconsin staff person to assist in resolving any concerns. For individuals receiving treatment for mental illness or chemical dependency, or for persons with developmental disabilities, the facility will assist in accessing the grievance procedure under DHS 94. The Administrator or facility's Relocation Coordinator will inform the State Relocation Team Leader.
- The procedure the facility will follow in the event the facility is approved to transfer residents within the facility during progress toward closing the building. This room transfer procedure must follow room transfer policy pursuant to relevant state and federal regulations.

2. Discharge Notice:

Note: the resident may appeal the discharge plan, they may not appeal the fact the facility is closing.

- The discharge notice must include:
 - Reason for discharge
 - Effective date of discharge
 - Location to which the resident will be discharged
 - A statement that the resident has the right to appeal this transfer or discharge decision to the State of Wisconsin by written letter to the appropriate Division of Quality Assurance Regional Office.
 - Provision of the name, address, and telephone number of the Long Term Care Regional Ombudsman for individuals over the age of sixty (60) years.
 - If the resident is determined to be chronically mentally ill, physical or intellectual disabilities or under the age of sixty (60), the facility must also list the state's protection and advocacy agency, Disability Rights Wisconsin, and provide that agency's, address and telephone number.

- Submit a draft of the proposed written notice of the formal discharge planning meeting to be sent to each resident/legal decision maker at least seven (7) days prior to the meeting day, which day must be at least 14 days prior to any discharge date, and any other noticing requirements pertaining to the facility specific licensure type.
- The facility must have a provision for sending written notice to the attending physician and the appropriate county agency or Managed Care Organization at the time the discharge notices are sent.
- The facility must have a provision of waiver forms for the above 30 day notice and discharge planning meeting. If a resident's discharge is to take place in less than 30 days from the date of the written notice, the resident or the resident's guardian or agent, if any, may decide whether to waive the thirty day notice requirement and accept the living arrangement. Note: The resident/legal representative may waive the right to the noticed, dated discharge planning conference described above. However the resident has the right to all appropriate discharge planning as indicated in state and federal regulations.

3. Post Discharge Plan of Care/ Discharge Planning Meeting will address the following points:

- Assessment of the resident's status with regard to **resident relocation stress syndrome**.
- Identification of specific resident needs after discharge such as personal care, wound dressings, type of therapy, special diet, etc.
- How care will be coordinated if continuing treatment involves multiple caregivers
- A description of what agencies will be involved post discharge and the contact individual in each agency (name, role, phone number).
- Medications, medical procedure to follow, and the contact person in the closing facility available for follow up questions.
- How the facility will provide for the transfer of resident financial accounts to the new facility/provider.
- Identification of a new physician if the resident is unable to retain his/her current physician.
- How the discharge plan will be implemented.
- Family Care, Family Care Partnership, IRIS consultants, and or county waiver program staff should be in attendance and are responsible for the majority of the discharge plan of care including its implementation.
- As appropriate, the facility's plan to provide follow-up of each resident after relocation and to be available for follow-up questions and consultation.
- Provision for retention, storage, and retrieval of resident records and appropriate facility records per state law.
- The facility's plan to provide status reports to the relocation team regarding efforts to prevent, identify and address Relocation Stress Syndrome.

4. Recommendations for Enhancing the Resident Relocation Process

- Facilitating Resident and Family Council Meetings on a regular basis to enhance communication.
- Involving the ombudsman/advocate to regularly participate in resident and family council meetings and other informational sessions.
- Tailoring activities to address the changing environment and focus on move related events i.e., 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” past new living arrangements to help residents become oriented to new and unfamiliar locations.
- Inviting relocated residents back to the facility for “going away” parties (for remaining residents) and/or to council meetings to reassure current residents that their relocation is going well and hopefully their relocation also will.
- With permission, posting addresses of relocated residents and giving updates on how relocated residents are doing in their new homes.
- Providing training on Resident Relocation Stress Syndrome for residents’ families and other representatives.
- Arranging pastoral care, if appropriate, and individualized visitation by volunteers and staff.
- Designating staff to individual residents to monitor condition including any signs and symptoms of resident relocation stress syndrome and to assist with relocation orientation.
- Creating opportunities for regular updates to residents, families and staff on the status of the facility.